Dhuffar, M. & Griffiths, M.D. (2018). The role of shame in sexual addiction: A review of empirical research. In Benfield, J. (Ed.), *Routledge International Handbook of Sexual Addiction* (pp. 144-153). London: Routledge.

Introduction

According to Fossum and Mason (1986: 8), 'addiction and shame are inseparable'. Shame has been understood as an emotion intrinsic to hypersexuality and sex addiction, as noted by a number of researchers and therapists (for example, Carnes, 1983; Gilliland et al., 2011). Similarly, Kaufman (1989: 5) argued that 'shame disrupts the natural functioning of the self '. Wilson (2000) asserted that shame is a hindrance, which prevents addicts from breaking the cycle of compul- sive sexual behaviours and establishing successful recovery. More specifically, Fossum and Mason operationally defined shame and claimed that:

Shame is an inner sense of being completely diminished or insufficient as a person. It is self-judging the self.A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or, worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as human being (Fossum & Mason, 1986: 5)

For the purpose of this review, the authors acknowledge that the concepts of sex addiction and/ or hypersexual disorder can be understood and defined from a number of viewpoints, and are also mindful that hypersexual disorder is a recent phenomenon, reintroduced by Kafka in 2010 (see Dhuffar & Griffiths, 2015a). Despite how the disorder is defined, shame is a key character-istic of problematic excessive sexual behaviour. Although the role of shame has evolved simultaneously with the use of online technologies (with anonymity leading to a reduction in shame), the concept of sexually problematic behaviour remains, despite what it is called (Schneider, 2000). Therefore, the terms sex addiction and hypersexual disorder will be used interchangeably throughout this chapter.

Given that sex addiction has been viewed as one of the most shame-based of disorders (see Birchard, 2004; Carnes, 1991; Wilson, 2000), it is not surprising that shame is used to manage and anaesthetise hypersexuality. If addiction is about the maintenance of internal emotions, then shame is considered an idiopathic emotional state that is medicated by addiction (Dhuffar & Griffiths, 2014). Birchard (2004) has referred to this process as the oscillating cycle of control and release. More specifically, sex addiction creates a temporary relief and/or fix of pleasure and self-soothing (Carnes, 1991) that is accompanied by an increased level of shame. Carnes stated, 'shame emerges from addiction. Shame causes addiction. Whichever way the shame is flow- ing, whether consequences or cause, it rests on one key personal assumption: somehow I am not measuring up' (Carnes, 1991: 91). In support, Ryan (1995) asserted that sex addiction is a 'bottom-line behaviour' and is 'behaviour driven by shame and producing shame'.

Other scholars (for example, Elison et al, 2006; Nathanson, 1992; Parker, 1998) have described shame as a multifaceted emotion that is experienced as an agonising, internalised affect. Shame has been outlined as a negative feeling about oneself as a person, associated with feelings of unworthiness, wrongness, being unwanted, powerlessness and inferiority (Dearing et al., 2005). Where guilt offers the possibility of reparation and personal growth that can be a part of motiv-

ation towards optimistic change, shame is inhibiting and offers no positive effects (Fossum & Mason, 1986; Nathanson, 1994). Potter-Efron (1987) argued that the onset of shame is the incongruity between the 'ideal' self and the 'actual' real self, leading to feelings of incompetency and disgust.

Many researchers (for example, Baldwin et al., 2006; Brown, 2004; Garcia & Thibaut, 2010; Gilbert,2000; Harder,1995; Lewis,1971,1987; Nathanson,1992,1994; Reid et al., 2009; Tangney & Dearing, 2002) have argued that shame (alongside sex addiction) is associated with a plethora of psychopathologic difficulties (including anxiety, depression, aggression and violence, personal distress and diminished self-esteem). Shame as a subtype of hypersexual behaviours has also been studied in axis II disorders, such as borderline personality disorder, in patients who present with sex addiction (Rizvi & Linehan, 2005). Some authors (for example, Dhuffar & Griffiths, 2014; Reid et al., 2009) have noted that consequences of sexual behaviours are a strong predictor of internalised shame and this relationship has been recognised as interlinked. Additionally, individuals who present for treatment exhibit intense guilt and shame (Reid, 2010). However, Garcia and Thibaut (2010) have argued that such feelings (during treatment) are predominately linked with the consequences of hypersexual behaviours.

From a critical standpoint, Reay et al. (2013: 8) claimed that 'sex and shame have such an enduring relationship that it was easy to popularize the concept of sex addiction'. Despite the viewpoint, it is plausible to surmise that the role of shame in hypersexuality is ever-present. Key factors often neglected in the shame literature are age and gender (Dhuffar & Griffiths, 2014). Weiss (2013) suggested age plays a major role in how individuals in society engage in sexual exploration. Technological shifts in contemporary society, and the generation gaps between 'digital natives' (people under 30 years) and 'digital migrants' (people over 30 years), have the capacity to alter levels of shame (as anonymity assists in the elimination and/or suppression of shame).

While much literature has noted the role of shame in hypersexual behaviours, very little is known empirically about how shame has transitioned in an online and technologically literate society. Shame in female sex addiction has often been described theoretically (see Dhuffar,2015). Therefore, the purpose of this chapter is to briefly present and critically evaluate the empirical evidence concerning the role of shame in sex addiction and/or hypersexual disorder in adults.

Method

A systematic literature search strategy was utilised in order to identify studies to be included in the form of best evidence synthesis. The *Web of Science* and *Google Scholar* databases were used. The most frequent search terms and their derivatives were entered including: 'sex addiction', 'hypersexuality', 'hypersexual disorder', 'sexual impulsivity', 'sexual compulsivity' and 'shame'. Other search terms included 'cybersex', 'excess' and 'adults'. The inclusion criteria were that the study (i) was published in peer-reviewed journals, (ii) reported assessment and/or the role of shame in sex addiction and/or hypersexual disorder, (iii) was based on empirical data, and (iv) was published between 2005–2015, as few empirical studies (specifically measuring the role of shame in hypersexuality) were undertaken prior to 2005.

Following a systematic review of the current empirical literature (see below for details), a total of seven empirical studies were identified that have specifically examined the role of shame in sex addiction and/or hypersexual disorder (Reid et al., 2009; Gilliland et al., 2011; Reid et al.,

2011b; Reid et al., 2014; Petrican et al., 2014; Dhuffar & Griffiths, 2014; Giordano et al., 2015). All seven studies were quantitative in nature (there were no qualitative studies) and are presented chronologically below.

Shame and sex addiction: empirical studies

Study 1

Reid et al. (2009) investigated the relationship between shame and hypersexual disorder in a sample of 71 male hypersexual patients currently in outpatient treatment (with an average age of 30.9 years), comparing them with a control sample comprising 73 participants with an average age of 25.6 years. More specifically, the authors examined which coping strategies associated with defence against shame were most noticeable among these participants. The control sample comprised university students (the authors noted that some data for the control sample were collected from non-traditional students – those who held full-time jobs, took evening classes and were older than the average students – to provide data that were representative of a com- munity sample). Participants completed a number of measures that included the Hypersexual Behavior Inventory (HBI; Reid & Garos, 2007) and the Compass of Shame Scale (CoSS; Elison et al., 2006a). The HBI comprises 19 items that assess the degree to which individuals feel their sexual thoughts, feelings and behaviours are out of control. A score of 53 and above (out of 95) indicates greater hypersexual behaviours. Additionally, the CoSS encapsulates coping strategies used to defend against shame and, as with the HBI, an increased score denotes greater use of maladaptive coping with experiences of shame. There are four subscales of the CoSS: (i) Attack Self, (ii) Withdrawal, (iii) Attack Others, and (iv) Avoidance. Each subscale is associated with different motivations, mood states, cognitions and behaviours. The patient sample was also pro- vided with additional measures (namely, a clinical interview that explored their hypersexual behaviours) combined with the HBI (scores of 53 and above indicated hypersexuality) to classify hypersexuality.

A majority of the hypersexual disorder sample (96 per cent) indicated increased scores on the HBI. Results indicated that there were significant differences on the HBI and CoSS among the hypersexual and control group, with hypersexual participants displaying higher levels of Withdrawal (minimal exposure to shame through the means of withdrawing), Attack Self (anger of shame directed to self, including self-criticism and contempt, consequently intensifying the feelings of shame) and Attack Other (transfer of negative shame to others to lessen an individual's own intensity of shame). Results of the study suggest the hypersexual group have awareness of their shaming experiences but may not identify their feelings as shame. Furthermore, there were no significant differences among hypersexuals and controls in the Avoidance variable (for example, denial and disassociation from shaming event) of the CoSS. This study adds to the hypersexual disorder literature by offering one of the first empirically-driven investigations on the multifaceted role of shame, despite the small sizes of both samples. However, it has several shortcomings. Firstly, it is a correlational design and cannot be taken to imply causation. Second, the control group did not undertake exactly the same measures as those in the treatment sample (who undertook a clinical interview prior to the completion of self-report measures). Finally, self-report measures have a number of known biases (including social desirability and memory recall).

Study 2

Gilliland et al. (2011) investigated the associations between shame, guilt and hypersexuality in a treatment-seeking sample. The sample comprised 177 participants (including 2 females), aged 18–73 years (average age 34.46), all of whom were undergoing treatment for pornography addiction. Data were collected via an online survey and consisted of demographic measures, Test of Self Conscious Affect–Short Version (TOSCA-S; Tangney & Dearing, 2002), HBI (Reid & Garos, 2007), Sexual Concerns Outcome Questionnaire (developed by therapists at the Brigham Young University counselling centre) and University of Rhode Island Change Assessment (URICA; McConnaughy et al., 1983). Results demonstrated the shame component had a significant positive predictive relationship with hypersexual behaviours. While these findings do not establish a causal link between shame and hypersexual behaviours, they are consistent with theories that hypersexual behaviours may be engaged in as a maladaptive substitute for existing shame, rather than viewing shame only as the result of such behaviour (Gilliland et al., 2011). The study was limited in a number of ways. For example, the sample only included two females, was self-report only and there was no report of the potential influence of gender on the role of shame. Furthermore, the sample was limited to treatment-seeking individuals and therefore the findings cannot be generalized.

Study 3

Reid et al. (2011b) investigated whether maladaptive patterns of shame have direct effect on hypersexuality or if they are indirectly linked through the mediation of other variables (such as, facets of neuroticism). According to the authors, the conceptualisation of hypersexual behaviour is 'reflected in the criteria proposed for the classification of hypersexual disorder' (Reid et al., 2011a: 264). Data were collected from a clinical sample in an outpatient clinic that provided treatment for hypersexual behaviours. In terms of general characteristics, the sample comprised 95 adult men aged 29–54 years (average age 31.8 years). All participants reported a sexual preoccupation that had impeded various aspects of their lives (such as relationships, work and education), alongside a number of other consequences of hypersexual behaviours, including financial loss and legal consequences. Measures used in the study consisted of the Compass of Shame Scale (Elison et al., 2006a), Neuroticism, Extraversion, Openness Personality Inventory-Revised (NEO-PI-R; Costa & McCrae, 1992) and HBI (Reid et al., 2011a).

The results showed that shame had a significant bivariate association with hypersexuality (in other words, shame predicted hypersexuality and hypersexuality predicted shame). However, in a test of association (the examination of a relationship between the different categorical variables) shame was not a predictor of hypersexuality. Further analyses indicated the effect of shame on hypersexuality was mediated by neuroticism. The authors suggested that although shame had a significant relationship with hypersexual behaviours, when assessed as an additional contributor, shame failed to improve the prediction of hypersexuality (Reid et al., 2011a).Another important finding to mention is the inability to guard against the painful effects of shame activated facets of neuroticism (such as anxiety, angry hostility, impulsivity, depression, vulnerability and self- consciousness) that contribute to hypersexual behaviours. This study further highlighted that neuroticism potentially has a significant role in mediating hypersexuality. The main limitations of the study were that the findings were limited to a small male-only, treatment-seeking sample among individuals that self-reported on hypersexual measures.

Study 4

Reid et al. (2014) reported the potential negative impact shame and rumination have on hyper-sexuality. The study comprised 172 male participants (mean age 43.4 years) recruited during a DSM-5 field trial, which examined the proposed diagnosis of hypersexual disorder. Most of the sample (83 per cent) identified as heterosexual. The aim of the study was to investigate if self-compassion could potentially mediate the association between shame, rumination and behavioural dysregulation (that is, sexual appetite) in a sample of hypersexual men. Measures of assessment included the HBI (Reid et al., 2011a), Shame Inventory (Rizvi, 2010), Self-Rumination Scale (Elliot & Coker, 2008) and the Self-Compassion Scale-Short Form (Raes et al., 2011). Results showed that self-compassion mediated the effects of both shame and rumination on hypersexual behaviours, supporting predictions made by the authors.The main strengths of this study were that the role of self-compassion (as a variable in shame and hyper-sexuality) is particularly useful when implementing a treatment intervention. More specifically, self-compassion can be introduced during the early stages of treatment with individuals who exhibit hypersexual behaviours presenting with increased feelings of shame. Similar to the limitations reported in the previous study, results should be interpreted with caution, given data were collected among a small male-only, treatment-seeking sample using the proposed criteria for hypersexual disorder, which is not listed as diagnostic criteria in the DSM-5 (American Psychiatric Association, 2013).

Study 5

Dhuffar and Griffiths (2014) undertook one of the first studies that assessed the role of shame in hypersexual behaviours among a non-clinical sample of British females. Data were collected from 102 adult females in the UK, who completed an online survey on hypersexual behaviours, consequences of sexual behaviours, shame and online sexual activities. The aim of this study was to extend the previous findings of Gilliland et al. (2011) and Reid et al. (2009) by attempting to understand both hypersexual behaviours and consequences of hypersexual behaviours as distinct entities and their respective contributions to shame. The authors hypothesised there would be a strong association between the negative affect of shame and hypersexual behaviours and the con- sequences of hypersexual behaviours. Measures administered included demographic information (which included history of sexual activities over the last 12 months), Hypersexual Behavior Consequences Scale (Reid et al., 2012), Hypersexual Disorder Questionnaire (Reid, 2010), HBI (Reid et al., 2011a), Shame Inventory (Rizvi, 2010) and Internet Related Activities (Daneback et al., 2006).The mean age was not assessed, as data were categorised into young adults (41.7 per cent, aged 18–29 years) and older adults (53.9 per cent, aged 30–42+ years). Demographically, 41.7 per cent per cent of the sample participants were students, 32.4 per cent were employed full-time, sexual preference was primarily heterosexual (87.3 per cent) and two-thirds (65.7 per cent) of the sample had viewed pornography at least once over the past 12 months.

Additionally, the results indicated that consequences of sexual behaviour was the strong- est variable that predicted shame. However, results also showed significant association between shame and hypersexual behaviours. Further tests revealed at least six participants met the criteria for hypersexual disorder, and there were significant differences in experienced levels of shame among young and older adults. Despite the main limitations (namely, a small sample size, and missing data that resulted in the exclusion of the Internet Related Activities instrument), the study offered important insights into the presence of shame in women who are digital natives compared to digital migrants, residing in a Western society, specifically the UK. Furthermore, digital natives (age 30 and under) reported lower levels of shame compared to

digital migrants (age over 30), thus supporting the viewpoint of Weiss (2013) that technology plays a significant role in the way shame is conceptualised.

Study 6

Petrican et al. (2014) undertook an innovative experimental study that tested if the induction of shame leads to an increased interest in erotically suggestive targets in a non-clinical sample of heterosexual participants. The study comprised 74 university students (26 males and 48 females) with a mean age of 21.7 years. The experiment comprised a non-predictive gaze-cueing task in which participants were asked to look at 'flirtatious' or 'emotionally neutral' faces of the same or opposite gender after they had recalled a shameful or emotionally-neutral experience. Participants were also asked to rate the attractiveness of the faces they had viewed and asked to complete three psychometric instruments relating to sexual compulsivity, executive con- trol and socio-sexuality. The authors reported that higher sexual compulsivity predicted weaker gaze-triggered attentional orienting in response to the flirtatious opposite-sex face in the shame condition, and that the finding was accounted for by higher attractiveness ratings of the flirtatious opposite-sex face. The study indicated that shame appears to increase the sexualisation of erotically-suggestive targets in individuals who were sexually compulsive. The authors asserted that the effect appeared to be specific to sexual compulsivity because the interactions remained significant when controlling for individual differences in executive control and sexual orien- tation. Although the findings were both significant and interesting, it should be noted that the study was experimental, only used university students and had a relatively small sample size. In addition, the number of individuals that were sexually compulsive is likely to have been very small. Consequently, the findings should be treated with some caution until they have been rep- licated in larger numbers in a more representative sample and with larger numbers of sexually compulsive individuals.

Study 7

Giordano et al. (2015) sought to extend the research of Gilliland et al. (2011), Reid (2010) and Reid et al. (2009) by examining the contribution of four self-conscious emotions (shame-proneness, guilt-proneness, externalisation and detachment). Giordano et al. referred to com- pulsive sexual behaviours as hypersexuality, in line with the diagnostic criteria of hypersexual disorder proposed by Kakfa (2010). They also acknowledged previous studies had focused (almost) entirely on a male sample and therefore designed the study to include female participants. The sampled comprised 136 males (57.9 per cent) and 99 females (42.1 per cent) with an average age of 20.9 years. Measures administered included a demographic questionnaire, the HBI (Reid et al., 2011a) and TOSCA-3 (Tangney et al., 2000). The results obtained from the male partici- pants indicated that increased shame-proneness and externalisation predicted hypersexuality. In contrast, while females scored higher on shame-proneness than men (mean 45.63 and 43.12 respectively), only detachment was a significant predictor of hypersexual behaviours.

The authors also noted that neither shame-proneness nor guilt functioned as significant predictors of hypersexuality with female participants (Giordano et al., 2015). In summary, as with Dhuffar and Griffiths (2014), this study aimed to extend previous research by including females in their analyses. In support of the study by Gilliland et al. (2011), the authors found there was a positive correlation between shame-proneness and hypersexual behaviour, indicating sexual con- quests are used as a means to cope with negative emotional states. One of the main limitations of the study was the correlational design and a majority of the sample

(94.5 per cent) identified as heterosexual (given hypersexuality is potentially more prevalent in homosexuals [Reid & Garos, 2014]). Furthermore, data were self-reported, collected from a relatively small number of college students, and previous literature (see Dhuffar, 2015) has reported that hypersexuality in university students is controversial, as many students typically engage in sexual exploration; therefore, findings may not be applicable to the general population. Nevertheless, the study was useful for a number of reasons: (i) it highlighted significant differences in the ways in which shame was experienced by males and females and its associations with attachment theory (Bowlby, 1969); more specifically, the authors addressed the clear differences in the feelings of detachment and/or emotional connection among female participants; (ii) added to the limited findings on the rela- tionship between shame and self-conscious emotions (shame-proneness); (iii) provided a number of suggestions for practitioners that could be of potential benefit when working with shame as a precursor and a consequence of hypersexual behaviours; for example, the recommendations encourage therapists working with male patients to explore self-conscious emotions, as well as assist in adopting a healthy sense of guilt relating to behaviours that potentially contradict the beliefs and values of the individual.

Conclusion

The empirical studies presented in the current review highlight that shame appears to be one of the contributory factors in the acquisition, development and maintenance of hypersexuality and vice versa. Whether the problematic sexual behaviour is termed sex addiction or hypersexual disorder, the scientific literature agrees with theoretical speculations that shame leads to hyper-sexuality (Birchard, 2004; Carnes, 1991; Ferree, 2001), and that hypersexual behaviours lead to shame. The studies discussed in this chapter are the few that have sought (empirically) to explain the role of shame in individuals who show hypersexual behaviours. The majority reported shame as a clear feature of hypersexuality, even within an increasingly technological society in which a lot of sexual behaviour is carried out via internet-enabled applications. Despite the considerable theoretical debate in the last three decades, it is evident from the above that research that empirically assesses shame as a predictor of hypersexuality has only begun to emerge in the last six years. Although each study (except for Petrican et al., 2014) consistently used three psychometrically-validated measures of shame (CoSS [Elison et al., 2006b]; Shame Inventory [Rizvi, 2010]; TOSCA-3 [Tangney & Dearing, 2002]), it must be noted the way in which shame is assessed across all three instruments differs significantly. For example, Part I of the Shame Inventory comprises only three questions, whereas the TOSCA-3 is a more comprehensive measure of maladaptive shame and allows for shame and guilt to be assessed independently.

The studies identified in the systematic review have many of the same methodological short-comings. All seven studies had small sample sizes, six used self-report measures (subject to many well-known biases, including social desirability and recall), three used male-only samples, four used treatment-seeking individuals only, two used a university sample and all the studies were cross-sectional. To ensure rigour and transparency in measurements of shame, qualitative studies, in addition to further quantitative studies, could potentially provide deeper insight into the roles of shame in individuals who show hypersexual behaviours (see Dhuffar & Griffiths, 2015b).

The limited number of studies comprising a female sample lends support to the theoretical speculations provided by Ferree (2001) over a decade ago, who critiqued mainstream definitions of sex addiction as being set up to exclude females. This gender difference remains

universally understudied in the sex addiction and hypersexual disorder literature (Dhuffar, 2015; Ferree et al., 2012). Given the significant gender differences in the presentations of shame (see Dhuffar & Griffiths, 2014), it becomes imperative that theoretical speculations are investigated by empirical studies. A number of researchers in the female sex addiction field (for example, Dhuffar, 2015; Dhuffar & Griffiths, 2014, Ferree et al., 2012) have suggested hypersexuality has far greater consequences in females than males (such as, unwanted pregnancies, abortion and/or adoption). It is hoped that chapters such as this stimulate more shame-based research on hypersexual females to help inform gender-specific psychotherapeutic interventions.

Clinical implications and future research

While sex addiction and hypersexual disorder have recently become areas for empirical investigation, there is still much empirical research to be undertaken to look at the role of shame in the acquisition, development and maintenance of hypersexual behaviours. This chapter has highlighted that the function of shame is fluid, so treatment for hypersexual behaviours should incorporate shame-minimising interventions (such as Acceptance and Commitment Therapy and Transactional Analysis) to increase an individual's understanding of the relationship between deep internalised shame and hypersexuality. The fact that sex addiction and hypersexual disorder are yet to be officially clinically defined as a behavioural addiction can pose a barrier to the assessment of shame. Additionally, shame conceptualised in such behaviours could also present difficulties for future research in this area, given that the validity of sex addiction and hypersexual disorder remains unclear.

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