

Sexual Addiction, Trauma and Healing

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Editors' Note

Fr. Chiola presented his experience and thoughts on sexual addiction and trauma at the 2008 Summer Leadership Conference in Minneapolis, MN. As Director of Ongoing Formation for Priests, he is a well-informed “insider” who also has excellent clinical credentials. The attentive reader will see similarities between his approach and the reflections of our other contributors to this issue of *Guest House Review*.

The purpose of this paper is to develop an understanding of the addictive effects of trauma, to describe how chemical and process addictions commingle, to define sexual addiction as a process

addiction, and thus to indicate why recovery from addiction, especially sexual addiction, is a long term and multidimensional process. In pursuit of this purpose the paper defines addiction as an aspect of human behavior in general and indicates how the physiology of the brain in particular is affected by trauma and in turn is numbed by addictions.

While this paper is limited to the interaction of trauma and addictions and the treatment of this interaction, readers should also keep in mind the pressing issues of *communio*. Our dioceses and religious communities engage in a multi-phased process of assisting members with addictive behaviors and recommending remediation, supporting those entering recovery, and encouraging some to step aside from ministry for a time of intensive treatment. Later we assist them to re-enter ministry while maintaining recovery, or help both the community and the person to separate and continue healing. In each of these phases we risk making “them” our goal and ignoring the communal dimensions of recovery. Yet it is precisely within *communio* that recovery reaches into the spiritual dimension as conversion; and in our faith perspective conversion is never simply personal but also relational in both its initiation and effects (cf. Luke 15).

How to Begin

Among our religious and clergy are those who suffered from diverse traumas prior to entry. Others may have experienced trauma in formation or while in vowed or ordained life. While engaged in pastoral care we feel vicariously the trauma of those who come to us for solace and healing. We recognize trauma and pain are always both personal and communal. The same is true of recovery from addiction. Recovery is an intensely personal conversion to *the freedom of desire* for the addict but also an ongoing call to conversion for the culture of the institution of

which the addict is a member.

An essential conversion necessary for institutions and institutional leaders would be to understand the interaction between trauma and addictions. This would allow us to (a) assess and support processes of recovery for members which integrate phased and multi-dimensional treatment, (b) move both members and communities toward *communio* and not simply personal recovery, and (c) recognize and correct trauma producing attitudes and behaviors within community cultures.

Cases

Trauma comes in many forms. There has been an emerging realization, for example, that sexual abuse of minors is a major cause of PTSD later in adults and that a significant number of religious women as well as men have suffered this experience. Likewise, workplace harassment, seduction, and even abuse by peers and authorities within their congregations have been documented as causes of adult trauma for women religious. While the prevalence of these experiences appears to be similar to the general population, these forms of trauma have become a significant aspect of treatment among women religious. What seems less well documented is the trauma in boys and men who are candidates for priesthood and religious life.

Consider, for example, the high school freshman who discovers that his father is having an affair. Despite remonstrations, the father continues cyclic affairs throughout the young man's seminary years right up to the mother's death. The future priest never develops the ability to see the social consequences of his own actions and is alternately manipulated by and controlling within his relationships with significant persons in his life. He uses internet porn and is conflicted about his sexual orientation. He is particularly susceptible to being emotionally abused by his bishop.

Or in another instance, an infant's young mother gives him into the care of her parents who adopt him, and afterward she is known as his sister. The (grand-) father is emotionally absent. The boy grows up "not knowing" the real circumstances of his parentage. As a seminarian and priest this man suffers from the inability to enter healthy relationships, becomes a workaholic, and is emotionally abusive to persons who work closely with him. Power and status are his addictions of preference. It is not difficult to see this in his careerism.

Then there is the priest whose mother died when he was eight and his father was a raging alcoholic. As a young man, he physically cared for his father and their home. As a priest, he continues to care for the old and the weak but has no insight about the negative consequences of acting out his obsessive-compulsive disorder (OCD). He uses internet porn to numb himself, and isolates himself emotionally from both authorities and peers. And, in yet another case, a young priest sent for graduate studies is groomed, sexually seduced, and then abused by a priest who is a few years older and a student in the same program. The young priest struggles to accept his sexual orientation and re-establish trust in clerical relationships. He uses masturbation and emotional distancing for self-soothing.

Or again, a boy grows up silently seduced into being his mother's emotional confidante in her battle to gain her husband's emotional support. All his life long the fighting between his parents awakens him at night into a sickening ache. He continues as a priest to believe he must take responsibility for all broken relationships in ministerial settings, but without being able to accept emotional support himself for fear of seduction. He uses food and compulsive television watching to soothe himself, while finding it difficult to relate professionally to his brother priests.

Addiction

Trauma happens not just because of physical but frequently because of emotional threats to the

self and one's identity. In response to trauma, a person's desire for safety and acceptance can be "nailed" to a chemical or process which numbs the pain, soothes the hurt, or distances one from the fear. Gerald May defined addiction as the nailing of desire to just such an object or process. May wrote,

"Addiction is the flip-side of repression: While repression stifles desire, addiction attaches desire, bonds and enslaves the energy of desire to certain specific behaviors, things, or people. These objects of attachment then become preoccupations and obsessions; they come to rule our lives (1988, p. 3)....

"Detachment (non-attachment) seeks the liberation of desire, the enhancement of passion, the freedom to love with all one's being, and the willingness to bear the pain such love can bring" (1988, 15).

As a hallmark of detachment, the ability to bear such pain (the pain of *Eros*, as Pope Benedict has indicated) is qualitatively different than trauma pain which can become fixed and spawn addictive behaviors. This kind of detachment is a measure of emotional maturity and an image of Christ as head of his body, the Church.

May also noticed that "detachment in various spiritual traditions is freedom *of* desire, not freedom *from* desire. Authentic detachment... uncovers the basic desire for God and sets it free from [addictions] (1988, p.14; *italics mine*)." He was convinced that addiction, while "a state of compulsion, obsession, or preoccupation that enslaves a person's will and desire," is nonetheless synonymous with the human condition. He stated: "To be alive is to be addicted, and to be alive and addicted is to stand in need of grace" (May, 1988, p.11).

The reason for this is simply that "the human brain works, learns, and grows by developing patterns that differ only in degree from major substance and process addictions. Some of these are attraction to anger, pleasing, comparison, television or aversion to anchovies, boredom, failure, and traffic" (May, 1988, pp. 38-39). "While addictions to alcohol and drugs are obvious and tragic, everything – ideas, work, relationships, power, moods, fantasies, etc. – holds the

potential to become an object of addiction.” To be sure, some attachments or addictions are more destructive than others; but all addictions have this in common, that they “impede human freedom and diminish the human spirit” (May, 1988, p. 39).

Trauma

Kevin Creeden (2004, p. 231) points out that the brain sets up its “synaptic connections in an activity dependent manner” over a lifetime of developmental phases and from the stimulations available in the environment.

“If specific brain structures are being regularly activated by abuse and other forms of trauma then those circuits are the ones which are more firmly programmed and easily activated. The amygdala, which sends projections to all areas of the cortex, establishes an emotional bias to cognitive functions. Higher intensity stimuli, identified as indicative of reduced safety (or increased arousal), are given privileged attention. If threat and trauma persist, the brainstem and mid-brain become under-modulated and the neurobiological responses to trauma (fear/flight/freeze) become established with little influence from cortical control.”

The DSM-IV-TR defines *trauma* as “intense fear, helplessness, or horror” in relation to “the actual or perceived threat of death or serious injury, or a threat to the physical integrity of self or other” (PTSD, 309.81). Bessel Van der Kolk (1996), who is one of the best known names in trauma studies, very clearly states that the same event may well be traumatic for one person but not for another. Trauma is a matter of perception and reaction formation and there are multiple forms of post-traumatic stress disorders. Perhaps trauma’s occurrence is most clearly indicated by the consequent intrusive thoughts and feelings that the person tries to avoid, and the hypervigilance which characterizes those who suffer from PTSD.

Peter Levine’s 30 years of research led him to define trauma in terms of the overwhelming of “our ability to respond to a *perceived* threat.” “Trauma is about loss of connection – to ourselves,

to our bodies, to our families, to others, to the world around us” (2005, pp. 8-9. Patrick Carnes, an important researcher and author in the study of sexual addiction, following van der Kolk, points out that trauma’s influence varies according to the interplay between frequency and impact (or severity) and can result in delayed recognition of its consequences. “Little acts of degradation, manipulation, secrecy, and shame on a daily basis take their toll. Trauma by accumulation sneaks up on its victims”(1997, p. 5).

This may be one of the features of clerical formation to keep in mind when taking a second look at the John Jay research data on abuse cases in the U.S. Morcotte (2008) encourages a re-examination of the social factors in the formation of abusing clerics whose reported acts peaked between 1960 and 1979.

Trauma and Formation

What are the trauma bonds and reactions set up by formation itself, in addition to those trauma effects that a cleric might experience prior to seminary?

Cozzens (2000) offers some insights into the attachment formation of seminarians and priests with Church authorities and its potential for abuse. Pat and Sue Fleming (2007) on the other hand offer accounts of the abusive backgrounds out of which the abusers sprang. Trauma is more than “compassion fatigue,” the secondary or vicarious trauma one feels in caring for survivors of trauma (Figley, 1995, 2002; Rothschild, 2006). Trauma is a behavioral “highjacking” agent which creates trauma responses that are compulsive, continuous – despite adverse consequences – and obsessive.

To understand the way trauma is itself a formation in addiction, Carnes (1997, pp. 44-45) offers a “post-traumatic stress index for self-assessment” based on eight longitudinal ways people respond to trauma. They are:

T-Reactions: the past invades the present experience.

T-Repetitions: repeating behaviors or situations that parallel earlier experiences.

T-Bonds: loyalty to people who are dangerous, shaming, or exploitive.

T-Shame: lack of self-worth because of trauma experience(s)

T-Pleasure: finding pleasure in the presence of trauma stimuli.

T-Blocking: numbing negative feelings that arise from trauma.

T-Splitting: dissociating from experience or self.

T-Abstinence: trauma-reactive deprivation of need or desire fulfillment.

Addiction Interaction

Trauma shame is the substratum of self-judgment that underlies additional chemical and process addictions. *Trauma blocking* and *trauma abstinence* in particular are the seed-ground for addiction interactions with other process and chemical agents. Carnes describes the neurochemistry of the interaction of these addictions as a committee process. The committee is composed of three brain members, “the triune brain” (2005, p. 99).

The most primitive (mechanical, reflexive, and stereotypical in its output) is the brain stem common to us and lizards [See George Vaillant’s article later in the **Features** section on the reptilian brain]. Loosely patched to it is a second brain which adds “primitive values, drives, and affect to the emotionless reflexive behavior of the lizard.” The third member is the neocortex which evolved in mammals. “The cortex contributes the ability to formulate ‘as-if’ scenarios that make judgment or revision of the affective states and emotional values possible.” The cortex allows finely tuned, thoughtful control of affect (and hence lying). Controlling the balance between emotion and logical evaluation is the essence of the interactions between the cortex and primitive brain regions.

In an addiction reaction, “the highjacking agent is recognized as a novel stimulus (chemical or behavioral), followed by a learning sequence involving both implicit and explicit memory processes that embrace the brain’s own reward system in support of addictive behavior” (Carnes, 2005, p. 99). Alcohol, drugs, and behaviors like sex, gambling, and spending can highjack these neural processes. They appear to do so in a variety of ways appropriate to their own chemical makeup or route of processing. Carnes (2005, p. 98) holds that sexual addiction, like any addiction, is a brain disease; it highjacks the brain’s fundamental mechanisms. He says that “addictive processes ‘tap into’ and subvert [‘hijack’] existing neural circuits that have evolved to process information about natural drives and their reinforcers.” His definitions of sexual addiction, the arousal template, and addiction interaction disorder follow.

Sexual Addiction – “The addict substitutes a sick relationship to an event or a process for a healthy relationship with others. The addict’s relationship to a mood altering experience becomes central to his life” (Carnes, 2001, p.14).

“The sick relationship is with an event or process in which the person becomes sexually aroused or seeks to avoid sexual arousal (sexual anorexia). The sexualized event or process is unmanageable and interferes with the person’s life and relationships” (Carnes, 2001, 14).

Cybersex in particular “involves rapid escalation of amount and variety of sex; the escalation of cybersex use becomes obsessional, with new behaviors becoming quickly fixated; cybersex addiction involves significant relational regression; and compulsive cybersex accelerates already addictive behavior, can result in offline sex addiction, and [even] the computer and internet [themselves] become sexualized” (2001, pp. 84-86).

Research indicates that “cybersex has the potential for further template distortion. Usually it is about the arousal template and something unresolved. Computers and the Internet can

easily accelerate the process” (Carnes, 2001, p.91).

Arousal Template – Carnes (2001, pp. 87-92) posits that “arousal occurs in the brain... [and that] there are three basic neuropathways in sex. The most primitive one, the one that evolved first, causes us to be sexually aroused by others.... Between the ages of five and eight, most of us already have formed this map about what is sexually arousing to us.” The second is for attraction to the most advantageous partner. “There evolved a neurochemistry to romance that involves great arousal, intensity, and obsession. It actually creates a period of ‘insanity’ in which dopamine levels go up and serotonin levels decline.” The third creates a more permanent attachment. “An attachment neuropathway emerged allowing us to bond with another. Some of the most powerful neurochemicals in the brain are generated by this bonding process.”

These three neuropathways establish our love-map or arousal template. “It serves as a template with which we decide whether a specific situation is arousing – and then we act on it.” Fisher’s (2000) research on birds is the basis for Carnes’ description of these sexual neuropathways in the human brain. In addition to these pathways for arousal, attraction and attachment, Fischer points out that the evolution of the human cerebral cortex also makes it possible for persons to make commitments and keep them.

Addiction Interaction Disorder (AID) – All addictions have been shown by multiple studies to access brain neuropathways. In doing so, any distinction between chemical and behavioral access is purely an artificial construct. In fact, there is enough evidence to indicate that the interaction, reinforcement, and joining of addictions to each other can be called Addiction Interaction Disorder (Carnes, 2005, pp. 85-86). Carnes believes that AID is one of the reasons that the treatment for any singly identifiable addiction 1) must include

the assessment for others and 2) cannot be the sole determinate for the length of time needed to establish recovery (Carnes, 2005, pp. 112-117). This adds crucial complicating factors to the treatment of addictions, and ongoing recovery.

Carnes (2005, pp. 87-98) describes addictions interacting in multiple ways.

Cross Tolerance – indicated by either simultaneous increase in addictive behavior in two or more addictions, or by a sudden shift in addictive practice (for example, extinguishing one addictive behavior with unusually high use of another).

Withdrawal Mediation – in which one addiction serves to moderate, relieve, or avoid withdrawal from another addiction.

Replacement – an addiction emerges after another has shown recovery but with a majority of the same emotional and compulsive features as the first, a period of time having intervened between the two.

Alternating Addiction Cycles – a patterned systemic cycling of addictions, for example, between promiscuity and aversion.

Masking – the use of one addiction to cover a more shaming one, such as alcohol abuse masking the presence of a sexual addiction.

Fusion – two addictions always appearing together.

Ritualizing – a sequence of actions leading to addictive behavior and capable of merging thus leading to behaviors joining.

Intensification – used at the same time two or more addictions make for a more potent experience either as *Partial Fusion*, when behaviors can be independent some of the time or as *Fusion Dependence*, when the behaviors always occur together.

Multiple Bingeing – describes the environmental use of several addictive behaviors.

Numbing – compulsive behaviors are used to soothe or numb, often following PTSD arousal behaviors and are thus tied to the originating trauma repetition. *Disinhibiting* – lowering inhibitions for another addiction.

Combining – sustaining a high for as long as possible, involving for example sex, high risk activities, and drugs.

Treatment, Conversion, and Ongoing Formation

Van der Kolk (1997, pp. 425-431) maintains that PTSD responds best to phased treatment.

Addictions rooted in traumatic experience require similar care. Since trauma is first a physical response before it is a mental meaning (Levine, 2005, p. 31), the originating trauma and its constructed meaning must be addressed, and not just the symptoms of the presenting addiction.

Phased and multiple treatment regimens are usually necessary for addictions because there is usually an underlying trauma for addictive behavior.

Creeden and many other authors rely on Herman's (1992) division of trauma recovery into three stages: establish safety, engage feelings, and reintegrate into life. These stages take time to develop and bear fruit. Carnes (2000) indicates that the period of work needed to establish a healthy relationship to sexuality in recovery from a sexual addiction is from five to seven years.

This is because he recognizes the need for multidimensional therapy which includes treatment for trauma and other addictions which reinforce, interact, and join with sexual addiction.

The critical issues for clergy/religious recovery from addictions, and from sexual addiction in particular, is 1) the person's own willingness to do the work, 2) the amount of time and resources that will be made available for recovery by the diocese or community, and 3) whether the ordinary or superior should have confidence in a recovery process unless it engages in both a) multiple addiction assessment and b) treatment regimens which address the intermingling of

addictions and the healing of trauma? In addition, the answers to these questions must be framed – and accepted by the priest or religious! – within the theological framework of conversion which itself is lifelong and multidimensional. Recovery from an addiction is ultimately a reinvigoration of *communio* and so the growth in humanity and spirit of the person in relationship to others.

“Faith-based therapy presumes that the essence of the human spirit and the origin of the highest human hopes is the created inborn desire for God felt in our longing for wholeness, completion, fulfillment, and meaning, in the desire to love, be loved, and be one with love’s Source.... Love, which creates us, haunts but does not enslave us. We are not determined like puppets but have the freedom to choose for or against God, love, life” (May 1988, pp. 1, 13).

Carnes, pointing to the spiritual dimension of all who recover, indicates that of the thousands of cases he has followed, “those whose spiritual lives flourished were also usually active participants in a spiritual community” (2001, p. 269). As May puts it: “Unable to think rightly about our addictions (because of "mind tricks") or will our way out of addictions (because of a divided will), the first step to healing is to admit one’s addictions, and even more important, see our addictions as doorways through which the power of grace can enter our lives” (1988, p. 31). The same is true of a community’s – or an entire Church’s! – response to trauma and addiction as doorways through which the power of grace can enter as conversion into any family or institution, including local churches and religious communities. It is not only the individual person but our communities which need conversion to a contemplative way of being, the path to real freedom of desire which leads to God.

Conversion can begin with the way the priest is asked to enter treatment. A man may be asked to seek recovery for his own sake. Indeed, finding the self-motivation for recovery is a necessary step in countering the trauma shame that is the substratum of addictions. However, the priest who endures the discipline of recovery from trauma and addiction is an asset to his brother priests and to the faithful at large who daily encounter addictive tendencies in their own humanity. In

some Catholic cultures such priests are known as the best confessors, since they have endured the same human failures they are asked to heal in the penitent. Consequently, a priest might be asked to enter recovery as an assignment from his bishop for the sake of his local church and for his ongoing human and spiritual formation as a priest in the image of Christ who abased himself for our salvation (Heb. 2:17-18).

Recovery from sexual addiction in particular offers the opportunity to be converted to the freedom of desire rather than from desire. One of the crucial steps in recovery for married sex addicts is to establish healthy intimate relationships with their spouses. Celibate priests also are confronted with the tasks of establishing healthy intimacy with God, their brother priests and bishop, and the people of their parishes. What is the path to that intimacy for celibate priests? Isaiah 56:4-5, Matthew 19:10-12, and I Corinthians 7:29-31 taken together outline a purpose for the charism of celibate chastity as witness to the coming of Christ at the end of time as the fulfillment of all our desires. Celibate chastity is primarily a witness to the freedom of desire and its fulfillment in the person of Christ the Bridegroom. To preside at the Eucharist is to proclaim that Christ will fulfill every desire when he who has destroyed our death and restored our life comes again in glory. A sexually addicted priest may discover anew affection for Christ and for those with whom he is bound in offering Christ to the Father until he comes in glory.

Addicts are able to sustain recovery to the extent they can relinquish pathological control. The first three of the 12-Steps are designed to do just that. Yet in the face of misplaced attempts at control, therapeutic wisdom concludes that there is truly only one addiction which manifests in multiple forms. The one true addiction is the addiction to power. And the power to protect self and others from trauma inevitably shields one from the pain which love endures willingly. As if in response, Pope John Paul taught in *Pastores Dabo Vobis* that by ordination a priest is inserted into a presbyterate which forms them, a bishop is to behave as a brother and a father to priests,

and that the ordained are placed by ordination within the community of the church and as such are able to be leaders of the church in the image of Christ the head. Bishops and religious superiors who seek to shepherd their priests in “the liberation of desire, the enhancement of passion, the freedom to love with all one’s being, and the willingness to bear the pain such love can bring” (May, 1988, p. 15) must consider how ministry to priests in recovery is itself an exercise in detachment.

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