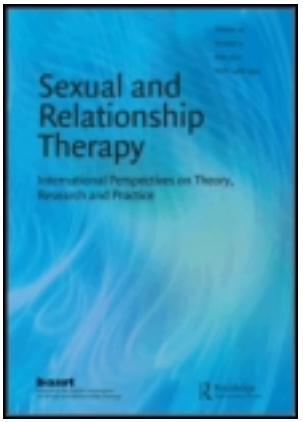

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A biopsychosocial view of sex addiction

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A biopsychosocial view of sex addiction

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In this article I explore both the name and the meaning of 'sex addiction' and offer a biopsychosocial view through which we might understand the complexity of cases presented before clinicians. Through published research and clinical experience, this paper looks at the biological, psychological and social influences of sex addiction in a hope that a broader understanding will increase dialogue between professionals of differing viewpoints and help develop multi-disciplinary approaches to treatment. The therapeutic dilemmas presented by this controversial and often maligned condition are also considered.

Keywords: sex addiction; sexual compulsivity; hypersexuality; attachment; trauma

Introduction

Sex addiction is controversial, both within society and within the therapeutic community and it is a topic that I'm sure will continue to be debated for many years to come. What I hope to achieve in writing this article is to offer a broader view of sex addiction that will give space for reflection on the multiple complexities of the condition and allow consideration of the different issues sexual addiction may present in the therapy room. Furthermore, I hope to address the therapeutic dilemmas that working with this client group can present and start a dialogue on how best to manage these.

The biopsychosocial model, first theorized by psychiatrist George L. Engel at the University of Rochester in 1977, has been a useful paradigm for exploring a number of different psychosexual difficulties. The key advantages are that it allows us to expand our thinking beyond the traditional medical model into psychological considerations and further into the societal context and construct of the perceived problem. Another advantage is that it enables us, as therapists and clinicians, to focus on the client as an individual, rather than on our preferred theoretical model or personal understanding. It can also encourage a comprehensive treatment approach that addresses the complexities of individual cases. As Watson and Vidall (2011) rightly said in a previous issue of this journal, "it is very likely that a client will not stop buying sex or using drugs for that matter, if they are unaware of the underlying relational mechanisms driving such behaviours" (p. 65). In addition, I would add that it's unlikely that a client will change their behaviour without having explored

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and understood why it is a problem to them within their individual cultural and social environment.

When looking at addiction generally, it is important to note that there are many different theories from a variety of perspectives including medical, psychological and sociocultural. Biopsychosocial views have increased in popularity (DiClemente, 2003; Perkinson, 1997; Ray & Ksir, 2004) and these new views allow addiction to be understood and treated in a more holistic way with regard to how the person becomes involved in addictive behaviour, stays involved in addictive behaviour and stops the addictive behaviour. Sex addiction has also been viewed through this lens before by Charles Samenow (2010), whose recent paper was published in the American journal, *Sexual Addiction & Compulsivity*.

What's in a name?

One of the biggest challenges facing clinicians at the moment is deciding what to call "sex addiction". Most people agree that an increasing number of people are presenting to practitioners saying that their sexual behaviours feel out of control, but we have yet to find a name for this that is clinically accurate. The term "addiction" is a grass roots term that seems to accurately explain how many "addicts" feel, but without clinical evidence of escalation and withdrawal it remains disputed. The term addiction, or rather "addict", is also highly stigmatising, especially with the pervading, but un-evidenced, 12-step philosophy of powerlessness. Alternative names have been offered but each has its limitations. "Sexually compulsive behaviours" is a possible alternative but, unlike other compulsive behaviours, which are classified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: APA, 1994), sex addiction offers a reward and is not done repeatedly to alleviate anxiety in the same way as, for example, hand-washing or checking. "Sexual dependency" is another term that is popularly used and the term "dependency" is preferred by many working with alcohol and drug problems, but it is a vague term that lacks any measurability. And while we may feel that alcohol and drugs should not be an essential part of our lives on which we "depend", many wouldn't say the same about the drive for sex, which many would view to be innate.

The proposed terminology to be used in the forthcoming to DSM-V is "hypersexuality", which implies high or above average activity. My difficulty with this is that many of the clients I have seen do not feel their behaviour, or their sex drive, is higher than normal, whatever we deem that to be. The term hypersexuality also implies that the behaviour is driven by sexual desire, which is misleading since much addiction is motivated by another primary need. For example, sex addiction may be used as a way of avoiding negative feelings such as boredom, depression or anxiety, or it may be driven by a desire for intimacy or validation by others.

Perhaps part of the problem is that there are so many different ways in which sex addiction can present. Some may be severe, some mild and, as with most diagnoses or labels, one size rarely fits all. For example, a porn "addict" client who rarely masturbates but feels compelled to go online and look at a minimum of 100 photos before he can get to sleep and gets distressed if he is unable to do so, may fit the definition of sexually compulsive. Another client whose sexual thoughts, fantasies and behaviours dominate his every waking moment to the point where his work and relationships are suffering, and who seeks sexual satiation multiple times a day, may

fit the criteria for hypersexuality. Another client who is a recovering alcoholic and drug user who turned to escorts to help him manage chemical sobriety rather than addressing deeper psychological issues may be best described as sexually addicted. And if the label ''dependent'' prevails, then a partner who chooses to leave a sex-less marriage because expressing their sexuality is an important part of their life, might find themselves wrongly accused of being sexually dependent.

The problem with any name or label is that it rarely fits all cases. Furthermore, it can create an extra burden for the client. Whilst it is true that having a recognised name for a problem can be a relief for many because it normalises the problem and may offer community support from other sufferers, it can also provide an opportunity to externalise the problem and overcome it. But for others, a label increases the feelings of personal shame and can restrict power to change, especially if they believe a label to be fixed and permanent. The recognition of a condition within the DSM-IV can similarly be both a blessing and a curse. It is important to remember that the DSM-IV is both a political as well as a therapeutic tool. When a problem formally exists in the DSM-IV then treatment and funding, however limited, are more likely to follow, but social and legal ramifications may also arise.

While the medical and therapeutic communities continue to debate the best name for the problem, the term ''sex addiction'' is becoming increasingly popular on the street and in the media and many therapists rightly worry that it is also being overused, misused and misdiagnosed. Whatever the problem is called, it should represent those clients who seek help to change what they personally experience as damaging sexual behaviours and not be a label for any wayward celebrity who has failed to live up to societal expectations of monogamy or someone who enjoys a rich and varied recreational sex life. I agree with the existential therapists, Kleinplatz (2001) and most recently Barker (2011), when they say that sexual difficulties are often not really about sex at all, but about the meaning constructed around it. Unfortunately the only commonality in all the proposed alternatives for sex addiction is the word ''sex'' but, in reality, sex often has very little to do with it.

For the rest of this article I will use the term ''sex addiction'' because, in spite of its many shortcomings, it is the term most commonly used by the clients I work with. I will now go on to explain how I define ''sex addiction'', from a biopsychosocial viewpoint, and then go on to explore the dilemma's faced by therapists.

The biology of sex addiction

Exploring the biological components of any problem may be construed as medicalising or falling into the trap of biological reductionism. Therefore it is important to stress that highlighting the physiological aspects of a problem does not necessarily undermine any other essential elements. Indeed, given the neuroplasticity of the brain, biology is inseparable from psychosocial aspects of life anyway, as we will see when we consider the ways in which our development and experience impact on brain chemistry and physiology. For many clients and clinicians, an understanding of the biology, and especially the neurobiology, of sex addiction can provide legitimacy for the psychological and emotional components. In my experience, sharing our biological understanding of sex addiction with clients can considerably reduce feelings of shame and confusion. There are still limited studies specifically on sex addiction and many of the published papers are based on wider

studies of other addictive disorders. However, there are a number of circulating hypotheses that are currently under investigation.

Dopamine dysregulation

It is now clinically understood that the common denominator in all addictions is dopamine (Robbins & Everitt, 2010). Dopamine is the neurochemical responsible for the experience of reward and pleasure and is naturally stimulated by eating, drinking and having sex. From an evolutionary point of view, dopamine is essential for our survival as it motivates us to continue to feed and reproduce. Dopamine can be similarly heightened through cognitive anticipation and fantasy, which is perhaps why so many of us enjoy cookery programmes as well as pornography! Dopamine is also involved in memory processing, and it biases the brain towards events that will provide reward (Berke & Hyman, 2000). These memories become stronger with repeated dopamine "highs". Evidence shows that addictive drugs, such as cocaine and heroin, flood the brain with up to 10 times more dopamine than the brain's usual base level and, over time, conditions it to expect artificially high levels (Blum et al., 2000; Duvauchelle, Ikegami, & Edward, 2000). With continued use, the brain requires more dopamine than it can naturally produce, and it becomes dependent on the drug, which never actually satisfies the need it has created. Current research is exploring the impact of early exposure during adolescence to dopamine stimulants as evidence suggest that early use increases the likelihood of adult addiction due to neuro-adaptation in the dopamine system (Manning et al., 2001).

Although sex is known to significantly increase dopamine levels, it still remains a hypothesis that a similar bio-chemical process takes place that leads to chemical addiction. There is also research underway to explore if early exposure to pornography may have a similar long-term impact on dopamine regulation as happens with addictive dugs. If this hypothesis turns out to be substantiated and translates to sex addiction, then the current levels of adolescent exposure to Internet pornography might result in the "Tsunami of sex addiction coming our way" as predicted by Patrick Carnes at the UKESAD conference earlier this year. Pornography is, of course, nothing new and young people have been enjoying pornography long before the Internet. However, there is increasing evidence that the Internet itself can become "addictive" (Weinstein & Lejoyeux 2010; Young & Nabuco de Abreu, 2011) and when this is combined with powerful erotic images, the Internet facilitates the addictive process (Hudson-Allez, 2009). This may be why clinicians and researchers to the Senate's Science, Technology and Space subcommittee referred to Internet pornography as the new "crack-cocaine" (http://www.wired.com/science/discoveries/news/2004/11/65772).

While research continues to be undertaken, there is one field in particular that appears to be supporting the hypothesis of dopamine involvement in addiction. Parkinson's patients are often prescribed dopamine agonists to improve motor and memory functions and one of the unwanted side-effects of this is impulsive and compulsive behaviours.

Brain development

There is growing evidence from neuroscience that deprivation of empathic care in early childhood creates a growth-inhibiting environment that produces immature,

physiologically undifferentiated orbitofrontal affect regulatory systems (Schore, 2003). A child who does not receive its needs for attention, soothing, stimulation, affection and validation may find the consequences structurally written into their developing brain. The altered prefrontal function is associated with high risk of drug and alcohol addiction (Bechara & Damasio, 2002; Franklin et al., 2002; Goldstein, Volkow, Wang, Fowler, & Rajaram, 2001) and research from Carnes (1991) also found a high amount of neglect in his sample of sex addicts. Hudson Allez (2009) proposes an explanation for this, saying that the insecure attachment template is not able to produce its own endogenous opiates and therefore individuals will reach for external opiates to stimulate their dopamine pathways in order to stimulate the pleasure centres and reduce the pain. Additionally, for the insecurely attached individual, the orbitofrontal area of the cortex may no longer produce sufficient dopamine or noradrenaline to facilitate sexual excitation and inhibition and, therefore, an external source may become increasingly relied upon for something that the brain has not learnt to manufacture for itself.

When a sex addict has experienced childhood trauma, it has been suggested that the addiction is not necessarily a pleasure seeking strategy but a survival strategy (Fisher, 2007). Van der Kolk (1996) found that the imprint of the trauma is located in the limbic system and in the brainstem – in our animal brains, not our thinking brains – and the amygdala, responsible for ''fight and flight'' may remain hypersensitive long after the trauma has passed. And indeed, long after any conscious memory of the trauma has passed. This hypersensitive amygdala may be triggered by any number of external sources throwing the body's sympathetic nervous system into hyper-arousal, or the parasympathetic system into hypo-arousal and temporarily by-passing the thinking part of the brain. Sexual behaviour may become a way for a trauma sufferer to numb feelings of hyper-arousal such as hyperactivity, obsessive thinking, rage and panic and also alleviate feelings of disassociation, numbness, depression and exhaustion experienced in hypo-arousal. In short, it is thought that addictive behaviours can become an effective technique to regulate the nervous system (Fisher, 2007).

The psychology of sex addiction

There are numerous psychological factors that feed into addiction processes and into the development and continuation of sexual addiction. An understanding and exploration of the emotional and cognitive influences are important for ensuring that treatment moves beyond biological symptom relief and change, to the deeper psychological processes that can both cause and drive the unwanted behaviours.

I hope that grouping the most common psychological experiences under the main therapeutic approaches will be a helpful way of presenting these issues, although inevitably there are crossovers. One notable common denominator throughout each theory is the role of shame in sexual addiction. Shame has been highlighted by many clinicians from varying viewpoints as a key influence in sex addiction and it is likely to arise in every modality since it may be experienced and endorsed personally, relationally and societally. The latter is explored under social influences.

A psychodynamic point of view

From a psychodynamic viewpoint, sexual addiction can be seen to be rooted in issues of attachment, trauma and/or object relations. Secure attachment is widely understood by psychodynamic theorists to be an important precursor for healthy adult relationships and healthy sexual expression. People with avoidant attachment styles are more likely to seek relationships and sexual encounters where there is little or no emotion or affection, such as sex workers and pornography, whereas those with disorganised attachment styles may find themselves drawn into an ever increasing number of sexual relationships or liaisons in order to receive validation and affection. People with ambivalent attachment styles may choose additional sexual relationships outside of their primary relationship as a way of warding off fears of rejection or suffocation (Samenow, 2010). A further hypothesis is that once an attachment has been made to an addiction as a source of comfort, it is harder for an addict to create a secure attachment within a relationship and, hence, the cycle of insecure attachments within relationships continues and the attachment to the addiction becomes stronger.

Not everyone who has experienced trauma will go on to develop an addiction but evidence suggests that sexual trauma, in particular, is over-represented amongst the sex addiction population (Schwartz, Mark, & Galperin, 1995). The biological explanations for this have been explored in the previous section but suffice to say that links between trauma and problematic sexual behaviours have been widely written about within psychological literature, including the impact of dissociation, depersonalisation, trauma bonding, vandalised love-maps and trauma re-enactment.

Sex addiction can be viewed through an object relations lens either through the splitting of the self or the splitting of the sex object. The self may be split into good and bad where the good part is expressed as the loving and faithful partner and the bad is acted out in shame inducing sexual behaviours. The sex object may be split such that ''good'' sex is enjoyed within relationships but ''bad'' sex is enjoyed with other sexual partners or online. The Madonna/whore syndrome would be one example of how this is played out.

From a psychodynamic perspective, therapy is likely to focus on developing secure attachment and self-integration whilst working through any trauma issues, perhaps with additional resources such as sensori-motor work or EMDR.

A systemic point of view

A systemic view of sex addiction might look at the role the problem plays in relation to other people within the systems which the individual is part of. Family of origin work might identify learnt patterns of addictive behaviour, a history of secrets in the family and/or poorly adapted coping skills. In my clinical experience, I have seen many clients who have received significant negative messages about sex being shameful and have consequently found it difficult to healthily embrace sexual needs and feelings. Conversely, I have seen many clients who have experienced very liberal attitudes to sex and sexual boundaries where pornography and the use of sex workers was seen as the norm. Systemic exploration might highlight the role the addict played in their original family and how an addiction, be that sexual or otherwise, might have developed as part of that role.

In relationship therapy the addiction may be seen as being part of the system, used for intimacy regulation or as part of an unhealthy collusive relationship. Seeing

the partner as co-addict or co-dependent, either consciously or unconsciously, is common from a systemic viewpoint.

Systems theory can also be helpful for exploring how sex addiction might fit within the wider cultural setting. That may be part of a business culture or peer group where what the addict may see as unwanted sexual behaviour is encouraged as part of the norm. Treatment approaches with a systemic view are likely to focus on every part of a client's past and current system, not just the addiction, and to help the client to understand the context and complex interplay of their problem behaviour. Partners of sex addicts who often already feel shocked, confused and betrayed when sexual addiction is disclosed, may feel pathologised and/or responsible for their partner's behaviour within this approach and therefore it is essential that adequate focus is also placed on their individual needs as well as those of the addict.

A cognitive-behavioural point of view

It is widely accepted within cognitive behavioural therapy that all addictions, both chemical and process, are used as a form of affect regulation. There is, of course, nothing wrong with using sex, or, depending on your viewpoint, alcohol, to alleviate difficult emotions and to create a sense of wellbeing, but if alcohol or sex become a primary coping mechanism on which a person depends, in spite of negative consequences, then it might be considered an addiction.

Cognitive practitioners would likely focus on the thoughts, feelings and behaviours triggered by sex addiction. Exploring impulse control, triggers, urges and negative thinking patterns can all be a way of initiating behaviour change towards coping mechanisms that the client feels more confident and comfortable with and the use of motivational interviewing techniques may help to cement change (Fuller & Taylor, 2010). A relative newcomer to cognitive therapy, developed by Young, Klosko and Weishaar (2003) is schema therapy. Schemas are a stable, enduring, negative pattern of beliefs and feelings about oneself that develop during childhood or adolescence and are elaborated, usually without awareness, throughout an individual's life. By bringing schemas into conscious awareness a client can be helped to re-write the script and thereby make more conscious choices about how they wish to feel, think and behave in their world.

A transactional analysis point of view

Transactional Analysis can be another useful model for exploring sex addiction. With some clients I have seen, the sex addiction behaviour is being expressed through the ego state of the adaptive child, and work can focus on moving their sexuality to either the ego state of their free child or adult. The deeper psychological issues that drive the unwanted sexual behaviours can then be explored with the help of the nurturing parent ego state, who might ensure that the free child remains safe and secure.

In couple therapy I have noticed that partners of sex addicts have often lost touch with their free child and found themselves trapped in critical parent, constantly monitoring their partners sexual behaviour that is trapped in adapted child. I have also found Karpman's (1968) drama triangle a helpful lens to use with the trauma client who may come to recognise how their addictive behaviour has become

alternatively both their rescuer and persecutor, keeping them endlessly trapped in the victim role.

These different psychological approaches will be common to most experienced therapists, many of whom work eclectically, integratively or pluralistically. Obviously this list is far from exhaustive and there are exciting directions in, for example, mindfulness, Gestalt, person-centred and existential therapies, which could also be usefully explored. Needless to say there are many different ways to explore a client's psychological difficulties and for sex addicts, like any other clients, the chosen approach should be the one that best fits their personal situation and personality.

Social influences

Sex addiction is a considered by some to be a myth, a bi-product of culture and other social influences. Some postulate that in our dominant hetero-sexist, monogamous culture, non-relational sex and excessive sex has become pathologised. This view has perhaps been compounded by the number of religious communities involved in addiction recovery who promote sex within an intimate relationship as the only "healthy" alternative. It's certainly true that the notion of sex addiction is a relatively modern phenomena and to understand it fully we need to be aware of the societal context within which a client brings their concerns and we as therapists need to be aware of what may be influencing our response.

Cultural sexualisation

Much has been written and talked about of the sexualisation of culture and the impact that this is having on people's sex lives and many are becoming increasingly aware of the paradox of sexual freedom. On the one hand we are now, as a society, more able to provide sexual education, information and advice, but there is also more access to erroneous and unhelpful information. There are more opportunities for people to explore their sexuality and more freedom to express their desires and needs without shame or reprimand, but there is also an ongoing rise in reported sexual crime (HM Government, 2011) and child sexual offences (NSPCC, 2011).

There is, of course, no evidence that a sexualised society is responsible for the increase in crime, but the advent of the Internet has certainly presented the would-be sexual predator with an increasing number of ways to find and groom victims. Whenever there is more freedom, there is also more choice, and choice can be experienced not only as a joy but also as a burden. With an ever-growing sexual menu to choose from, there are an ever increasing number of choices to be made about what might fulfil our appetite without damaging our chosen lifestyle. For someone with a pre-disposition to sexual addiction, from their unique biological and psychological make-up, our sexualised culture provides an environment within which the addiction can flourish. Clearly that does not mean, and should not mean, that as a society we should move towards prohibition – we know from the history of alcohol addiction that prohibition does not work. But as with the drink-aware and more recent gambling-aware campaigns, perhaps we would benefit as a society if we provided more information and support on sexual choices beyond the meagre sexual health campaigns that currently exist.

Shame

Both shame and guilt are emotions that can only exist within the context of others since both are judgements made about the self as viewed in relation to the overt or covert expectations of family, religious affiliation and/or society. Shame and guilt have a long tradition as both causes and consequences in people experiencing addictions but recent research has shown that whereas shame is likely to increase addictive behaviour, guilt can be a significant motivator to overcome it (Gilliland, South, Carpenter, & Hardy, 2011).

Shame can be described as a painfully negative emotion where the self is deemed bad and unworthy, whereas guilt is a negative judgement about a behaviour.

Hence a guilt script says "I have done something bad" whereas a shame script says "I am bad". Unresolved shame experienced in childhood can result in exaggerated feelings of shame in adulthood, which may be medicated against through an addiction. However the addiction often becomes a source of shame in itself and hence perpetuates an addictive cycle. The distinction between shame and guilt is particularly important for understanding sex addiction within a societal context. Although our world may appear to be more open about sex, there is no doubt in my mind that sexism, homophobia, sexual repression and religious fundamentalism still exist, as well as societally assumed norms of monogamy. These factors can fuel a sense of shame of those who step outside of these norms, taking the power away from the individual to decide if guilt, or indeed acceptance, is a more appropriate response.

Contrary to the belief of some clinicians, the shame experienced by sex addicts is frequently not from any ethical or anti-sex perspective. On the contrary, most of the clients I work with have no moral objection to watching pornography or visiting sex workers, their shame comes from prioritising these activities over and above their commitments to partners, children, friends, work, finances, health and career and personal development. Shame can damage an addict's sense of self to the point where they no longer see themselves as worthy of the love of a partner, or the respect of children, or the unconditional regard of friends, or the promotion from a boss. They may experience a sense of guilt at the number of times they have lied or let down others due to prioritising a secret sex life, but the shame can wound to the point where change feels impossible. To overcome any addiction, the client can be helped by empathically evaluating their behaviour and reducing shame. With shame removed they may then decide that their behaviour is no longer a problem or by reframing to guilt they may be more empowered to change (Gilliland et al., 2011).

Conclusion

As a therapeutic community, sex addiction presents many dilemmas – not least what we should call it. As discussed previously, all of the proposed names have their limitations and although "addiction" continues to be the most popular, it is certainly the most stigmatising. It seems we have two choices, we can either re-educate clients and society about what "sex addiction" really means or we can continue to try and find a better word to define the problem. I would be happy to do the latter, but with the term already so widely used within our culture, my fear is that we would be trying to close the proverbial door after the horse has bolted.

Another dilemma is how we work with a client whose behaviour contradicts their values and lifestyle choice. This is, of course, a dilemma we are faced with on

a regular basis, be it a woman with low desire who feels that she should have sex with her partner, or a man with erectile difficulties who feels he should be able to penetrate, or someone deciding whether or not to end a long-term affair, or a couple grappling with how to tell their children that they are separating. Perhaps more so than with any other addiction, sex addiction often contradicts a person's core values and they must choose whether or not to change their behaviour to fit their values or change their values to fit their behaviour.

There are treatment challenges too. Developing a bio-psychosocial model demonstrates the importance of not simply focussing on reducing behavioural symptoms through relapse prevention strategies and arousal re-conditioning, but also ameliorating the underlying psychological issues and exploring the societal context within which a client has developed their meaning of the problem. Achieving this requires multiple skills, which I believe are beyond traditional addiction treatment strategies and basic training in psychosexual therapy. Clients are understandably confused when professionals who not only cannot agree on whether or not their problem exists, or what it's called, then go on to dispute the mixed merits of rehab treatment, 12-step fellowships, cognitive behavioural therapy, existential therapy, Jungian analytical, psychosexual therapy, psycho-educational work, couple counselling, individual work, group work and so *ad infinitum*.

In my view, the biggest barrier to understanding sex addiction is professional defensiveness and misdiagnosis. We all have much to learn about this subject and even more that we can learn from each other's experience. In the meantime, clients continue to come to our door. I feel passionately about this client group and it frustrates me that so many are hearing the message that their problem does not really exist or that they simply need to develop more self-control or come to terms with their behaviour. I have heard countless stories of how sex addiction has devastated lives: how men have lost their partners, families, friends, jobs, homes and, perhaps most importantly, their self-respect and integrity. And the stories of women who are shocked and confused to discover that their loving partner, who they assumed had low desire since they rarely wanted to sleep with them, has been spending six hours a day, every day watching pornography and having cybersex. I am reminded of the estimated 250,000 UK Chronic Fatigue Syndrome/Myalgic Encephalopathy sufferers who battled through the 1980s with the label of "yuppie flu" or even "shirker syndrome". While professionals debated if it was psychological or physical, treatment services were stalled. It seems to me the same is happening now with sex addiction but with the additional problem that the shame caused by widespread misunderstanding further damages self-esteem and fuels the addictive cycle. Sex addiction is a controversial and complex problem that requires lateral thinking and multiple levels of therapeutic intervention – let's start talking about how we can provide the services that these clients both need and deserve.

Notes on contributor

Paula Hall is a COSRT Accredited Sexual & Relationship Psychotherapist who specialises in sex addiction from her private practice in Leamington Spa. She is one of the founder trustees of ATSAC (Association for the Treatment of Sexual Addiction and Compulsivity) and trains on their Professional Certificate in Sex Addiction Treatment. She also trains other therapists on sex addiction and has currently been commissioned by Routledge to write the first UK book on the subject, *Treating Sex Addiction*, due for publication October 2012.

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