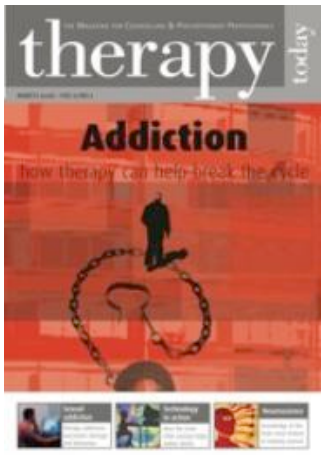

Understanding Sex Addiction

by Paula Hall

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Sexual addiction is a real problem. The term is regularly over used and misused, often being attributed to anyone with a high sex drive or to a media celebrity who's lack of discretion or impulse–control, has led them to be caught with their trousers down. In common parlance, the term may be met with a snigger or a raised eyebrow, and perhaps even a little salacious curiosity. All of which adds to the shame and confusion of the true sufferer, who is often desperate for understanding, empathy and help.

Defining sexual addiction

Sexual addiction, also referred to as sexual compulsion and sexual dependency can be defined as any sexual activity that feels "out of control". The sex addict feels compelled to seek out and engage in sexual behaviour, in spite of the problems it may cause in their personal, social and work lives. It may encompass any single or multiple type of sexual behaviour. For example:

- Compulsive masturbation
- Compulsive use of pornography
- Having multiple, ongoing affairs
- Exhibitionism
- Fetishes
- Dangerous sexual practices
- Prostitution
- Anonymous sex
- Voyeurism
- Telephone sex
- Chat room/online sex
- Partner sex
- Illegal sexual practices

The type of behaviour does not define addiction. The essential difference between the addict and the non-addict is that these behaviours **feel out of control**. An addict may spend an inordinate amount of time planning, engaging in and recovering from their chosen sexual activity. And in spite of the physical, emotional, relational, financial and even judicial cost of these activities, they feel unable to stop their behaviour. Or at least, unable to stay stopped.

Another key factor is that the chosen sexual behaviours are used to anaesthetise psychological pain. In the same way an alcoholic may get lost in a bottle or a compulsive gambler fixates on the next win to avoid the pain of life, the sex addict chooses sex as their way to cope with the world.

Prevalence and Profile

The true prevalence of sexual addiction is unknown but estimates range from 3 to 6 percent of the population[1] . According to Sex Addicts Anonymous, 6% of the British population are ***I suspect they got that figure from Carnes and just applied it to the UK*** sexually addicted[2]. Dr Patrick Carnes, one of the world's leading *researchers* and authors on sexual addiction reported that approximately 20% of all patients seeking help for sexual dependency are

women and further research went on to observe that there were significant differences in the types of behaviours engaged in by male and female sufferers[1]. Men tended to engage in sexual activities that revolve around a sex object such as voyeurism, prostitution and anonymous sex while women tend to use sex for power for example, pain-exchange sex, fantasy roles, particularly seductive roles and trading sex[1].

A survey of over 1,000 sex addicts and their partners[3] concluded that many sex addicts had come from severely dysfunctional families. 97% reported emotional abuse, 71% physical abuse and 83% sexual abuse. They also found that 87% had come from families where at least one other family member had an addiction. There was also a pattern of dual addictions. 43% reported chemical dependency, 38% an eating disorder, 28% compulsive working, 26% compulsive spending and 5% compulsive gambling.

The Internet explosion

The advances of the internet have significantly changed the landscape of sexual addiction. The accessibility and anonymity of the web has allowed many people to explore their sexuality in a way that has been hitherto impossible. An estimated 20-33% of internet users engage in online sexual activities[4]. The most common online sexual activity is viewing pornography, sited by 69% of male users and 20% of women. One report estimated hardcore pornography is now accessed in the UK by 33% of all internet users[5].

Online pornography is big business. In 2002, sex related sites became the number one economic sector of the internet, estimated to be worth a staggering 2.5 billion dollars. There are 4.2 million pornographic websites making up 12% of all websites. 70% of pornography is viewed between the hours of 9 and 5 which may explain why 1 in 6 employees reported having trouble with sexual behaviour online[6].

The significance of all these statistics to clinicians is that both the profile of a sex addict and prevalence is changing. The internet accelerates arousal because anonymity reduces the fear and shame that would normally act as a suppressant. What's more, evidence suggests that the internet can tap into powerful, suppressed unresolved sexual issues from childhood. This means that behaviour is intensified and escalates both in the amount of time spent on the activity but also the variety of activities engaged in[7].

Narcissism and sexual addiction

Thaddeus Birchard, one of the UK's leading researchers and therapists in sexual addiction believes the psychological root of sexual compulsive behaviours lies in narcissistic damage[8]. He proposes that this wounding happens in childhood and results both in the self being experienced painfully and also, the self being experienced as unacceptable. This negative self image results in depression, chronic anger, core loneliness and unremitting shame.

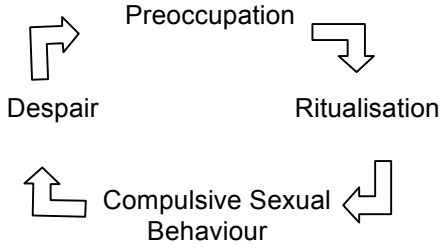
Much has been written over the years about narcissism and its impact on adult relationships and self-regulation and many have made connections between this and addictions. Instead of resolving narcissistic damage, the addict either consciously or unconsciously chooses to anaesthetise the resulting pain. But why do some choose sexual behaviours as their drug of choice?

Birchard suggests that there are 2 additional components in the family of origin of the sex addict. Firstly that there has been a history of sexual addiction over previous generations. In some cases this is very apparent with addicts recalling finding a family member's pornography or a parent engaging in multiple sexual relationships outside of the marriage. In other cases the sexual pre-occupation may have taken the form of sexual avoidance or abstinence. The second component is overt or covert sexualisation in childhood. This can take many guises and some clients may be painfully aware of specific incidents of abuse or inappropriate sexual behaviour, while others may have more difficulty accessing or acknowledging any disturbance of this kind.

Shame is both a principal result of narcissistic damage and a principle driver for addictive behaviour. No where is this more apparent than in sexual addiction. With so many societal taboos and boundaries around sexual behaviour, the sex addict is quickly trapped by the addiction cycle.

The Addiction Cycle

In between the highs of sexual fulfilment are the lows. The feelings of shame, regret, remorse and anxiety. Most sufferers will have tried and failed to curb their behaviour on many occasions and consequently they feel powerless to change. They are alone and isolated and soon they find themselves seeking out sex as a way to escape from difficult feelings. Sex becomes a pain reliever, an escape from the very problem that it has created itself.



The four stage addiction cycle proposed by Carnes in his book Out of The Shadows begins with preoccupation. The addict thinks about nothing but their next sexual conquest. Each conversation they have, image they see, person they meet or place they go is somehow fitted into a story they create about sex. This total absorption in their favourite subject blocks out the rest of the world. Not only are problems blocked out, but also important relationships and work. The ritualisation stage allows the addict to prepare for their next conquest in a systematic and obsessive way. Each will have their preferred routines which intensify the preoccupation and arousal. This then builds to the sexual behaviour of choice – the end goal of the preoccupation and rituatlisation. But as the addict comes down from the rush of excitement of the sexual experience, they slip into despair. Knowing they have failed to control their behaviour again, they feel powerless and filled with self loathing. They also feel a great sense of shame and often humiliation. For the addict, the easiest route out of these feelings is to lose yourself in the trance-like state of preoccupation. And so the cycle continues.

A Case Example

Michael was a 44 year old secondary school teacher. Married for 18 years with 2 children, 9 and 12. He was parent governor in his local primary school and was also an active member of the amateur dramatic group. He described himself as well respected and well liked.

Recently his wife had found porn on the computer by clicking on the history bar. It wasn't the first time. This had happened twice before and each time he had promised her that it would never happen again. The last time was about 8 months ago, when she had threatened to leave saying she couldn't trust him anymore. Michael managed to persuade her to stay and sincerely promised it wouldn't happen again. He explained that he had managed to stick to his promise for nearly 3 months, but after a particularly stressful time at work and a bad argument with his wife about unfinished DIY in the house (an ongoing source of tension between them) he had begun surfing again. With hindsight, he could see how he had justified his behaviour.

He felt desperately ashamed and very frightened. This time the marriage really was over. His wife had already started divorce proceedings. A few sessions into therapy he revealed

that it was his 9 year old son who had discovered the porn and showed it to his mother. His wife said she would never forgive him for "corrupting his son". Michael said he didn't blame her.

He slowly revealed the extent of his compulsive online behaviour. Over the past 8 years or so he logged on most days and masturbated to porn. At first it would just mean staying up a little later than his wife. But increasingly he would be up until 3 or 4 in the morning surfing for the perfect image to masturbate to. Michael cried when he confessed to becoming increasingly turned on by the images on Lolita sites of 'barely legal' teens. His life revolved around his night time activities. During the day he just tried to stay awake and keep his life on track. He couldn't remember the last time he'd made love with his wife.

Therapy focussed initially on finding some immediate coping strategies, looking at relaxation techniques and CBT. We then explored what he would do if tempted to go online again (he hadn't so much as switched on the computer since his wife's discovery). He was convinced that he would never surf again. He said he would just remember what he'd done to his son and that would stop him. Exploring his family of origin revealed a variety of addictions within the family and a history of unreliable and unresponsive parenting, especially from his alcoholic mother. From a young age he learnt to keep his mothers drinking a secret and in spite of her constant put downs, managed the home and cared for his two younger sisters. In his mid teens his whole family was rocked by the discovery that his youngest sister had been sexually abused by their grandfather on a number of occasions. It was around this time that he first started using porn, having discovered what he assumed were his fathers magazines in the shed.

We explored the impact of his childhood on how he felt about himself as an adult and particularly how he felt about himself as a sexual man. He soon recognised that he had struggled with low self esteem for a long time and often felt criticised by his wife in a similar way that he had by his mother when a child.

Michael stopped coming for therapy after 10 sessions. He recognised that masturbation had become his way of self-soothing and escaping the stresses of life, but felt that the shock of losing his wife and family had "sorted him out". He didn't feel any need to continue to explore the impact of his childhood, enter a group therapy programme, or look at what he would do if the problem began again. He was now living alone and was proud to say that he was using his computer again and had successfully managed to limit visiting porn sites to 2 x a week and only used 'mainstream' sites. He politely accepted my offer to return if he felt he needed to.

Treatment Options

The first step of treating any addiction is acceptance. Until the addict accepts the reality of their condition nothing will change. Sex addiction is no different. But unlike other addictions, abstinence is rarely the solution. Sex, like alcohol is not a problem in itself, it is the relationship the addict has with their substance of choice that is the problem. Until the addict realises that the way they use sex needs to change, they are unlikely to ask for help.

The following 10 step assessment tool, developed by Patrick Carnes, can be useful for both addicts and clinicians alike to consider if the sexual behaviour is compulsive.

1. Do you feel that the behaviour is out of control?
2. Could there be severe consequences if you continue, for example for your relationship, your work, your health, your finances or legal consequences?
3. Do you feel unable to stop your behaviour, in spite of knowing these consequences?
4. Do you persistently pursue destructive and/or high risk activities?
5. Do you want to stop or control what you're doing and have you previously taken active steps to limit your activities?
6. Do you use sexual fantasies as a way of coping with difficult feelings or situations?

7. Do you find you need more and more of the sexual activity in order to experience the same level of high?
8. Do you suffer from intense mood swings around sexual activity?
9. Are you spending more and more time either planning, engaging in or regretting and recovering from sexual activities?
10. Are you neglecting important social, occupational or recreational activities in favour of sexual behaviour?

There are various reasons why an addict may present for individual therapy. It may be that they are aware of and have accepted their condition. However, sometimes the trigger will be a relationship or work problem. As mentioned before, addicts will often have neglected other areas of their life for many years and sometimes it is the consequences of their behaviour that they first want to address, rather than the behaviour itself. But assuming that the behaviour is at some stage revealed, the first thing the clinician will need to do is decide if they have sufficient knowledge, training and supervisory resources to best support the client. If not, referral will be the ethical option.

Therapy needs to be focussed on two areas. Firstly on stopping and controlling the behaviour. This will often involve education on sexual addiction and CBT techniques to punctuate the addiction cycle. All the literature suggests that people relapse unless there is an involvement in group work and a culture of recovery. Unfortunately there are still only a handful of groups in the UK though this is rapidly changing. However, there are also online groups available through sex addicts anonymous

The second area of therapy needs to address the initial narcissistic damage. Within the context of a safe and reparative therapeutic relationship, the client can share and explore their woundedness and begin to develop further understanding and insight into it's consequences. Clients then need to create new stories of themselves and new ways of relating to others in their life. The goal being to fill the void that stopping their addiction will have created and find new ways of feeling and being in the world.

Where will it end...

Sexual addiction appears to be a growing problem with many organisations such as Relate and BASRT and individual therapists reporting growing numbers of enquiries. It's also an area that fascinates the media with an increasing number of documentaries being made about the subject.

Sex is one of the most powerfully restorative experiences a human can enjoy, but conversely, it can be one of the most powerfully damaging. Many practitioners are recognising links between sexually compulsive behaviours and sexual offending. This is a highly controversial subject and we have yet to see how conclusive any links prove to be. But in the meantime, clinicians have an additional burden of ethical responsibility, not only to their client, but potentially to society.

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Resources:

BASRT – PO Box 13686, London SW20 9ZH. Tel: 0208 5432707. Provide training in sexual addiction and a directory of individual therapists.

Dr Thaddeus Birchard and Associates, Psychosexual and Psychotherapy Consultancy, The Medical Suite, Bentinck Mansions, Bentinck Street, London W1U 2ER, Tel: 020 7224 3532, www.birchard.co.uk . Provides training in work with sexual addiction, individual therapy and group recovery programmes.

Relate, Herbert Gray College, Little Church Street, Rugby, Warks CV21 3AP - 0845 456 1310. Works with couples to help them manage the damaging effects of sexual addiction on their relationship.

Sex Addicts Anonymous, London Call Back Answer phone, 020 8946 2436, saauk@ukonline.co.uk, www.sexaa.org. An online international forum that provides information, education and resources for sufferers. Includes an online 'boundary group' and list of UK groups.

Sex and Love Addicts Anonymous, www.slaafws.org, UK Contact 07951 815087