Let's Talk about Sex !

More and more people are presenting to addiction services for problems with compulsive sexual behaviours and problematic pornography use. And whilst many of the issues are common to other addictions, sex addiction presents unique challenges. Some say 'addiction is addiction is addiction' and it matters little what you're addicted to in terms of developing treatment protocols. But few addiction professionals are trained in sexuality and if a therapist isn't confident talking about sex, it can reinforce shame and become a block to recovery. Conversely, over confidence can result in being too explicit and underestimating erotic transference which may trigger a client to act out.

In this article we will explore some of the most common dilemmas when working with sex addiction and consider some options for managing them.

Diagnosing Sex Addiction

The first challenge for any addiction professional is how to know when sexual behaviours and pornography use is an addition; when it's a high sex drive and when it's simply a 'habit' that challenges the client's personal value system. Traditional questions around quantity of usage and harmful life consequences are often not sufficient to make an accurate diagnosis. For example, a client who visits sex workers once a week may be troubled by his behaviour because it breaches his values of monogamy to their partner. But if their partner is non-sexual for some reason, how can you know that this isn't simply a substitute for a non-existent relational sex life that satiates a physical desire? There are two key questions that can help a therapist determine this:-

1. *What is the function of the behaviour?*

   Sex addiction is not about sex – it's about addiction. People who compulsively view pornography, visit sex workers, engage in cybersex, go cruising, use hook up apps, or any number of other sexual behaviours, are not doing it for sexual satiation. The behaviour is driven by dopamine, by a craving akin to that of any other addiction, not a desire for sexual release and orgasm. When you see a client who says they're 'addicted' to porn, it may be helpful to ask how many hours a week they use it, but it's even better to ask what they're doing when they do. Do they masturbate throughout, as some assume, or is a second porn screen always open to distract from boredom at work? Or are they collecting and cataloguing images? Or crafting an animated storyline? Or 'chatting' to other users? Or 'edging' (the term used when you stimulate to maintain erection but avoid ejaculation)? If the purpose of the behaviour is to ejaculate, then perhaps it's not addiction (and unlikely to take much time), but if the function is to escape reality for hours, to numb emotional pain, to defuse anger – it's more likely to be addiction. Similar questions can be used for relational acting out behaviours, is it really for the sex, or to ease loneliness or to feel validated or wanted?

2. Has there been escalation?

Like all addictions, sex and porn addiction almost always escalates and this can be a key indicator that the motivator is dopamine not testosterone. Sexual desire does of course fluctuate, but when someone reports that they need more sex at 60 then they did at 20, or need more online porn than they ever did offline, then it is not their drive that has grown but their addiction. Similarly research into what's known as erotic plasticity, shows that sexual tastes, especially men's, don't vary much over the life cycle. But many people addicted to porn say that their tastes have morphed into images that no longer match their sexual orientation or behaviours that used to repulse them.

The bottom line is that when someone is engaging in sexual behaviours that they frequently do not enjoy or find satiating, but nonetheless can't stop, it's probably an addiction.

Establishing Sexual Sobriety

Establishing sexual sobriety is perhaps one of the biggest challenges that traditional addiction specialists face because abstinence, at least for most, is not the goal. And whilst this might also be true when working with eating disorders, unlike food, there are no standardised 'healthy' guidelines' to adhere to. So how do we define healthy sexuality? The term itself is a value loaded one because after all, the opposite of healthy is 'unhealthy', and perhaps 'unnatural'.

One of the hardest factors when helping a client determine their sexual sobriety goals is to ensure you're not inadvertently prescribing your own, or societally imposed moral values and sexual norms. And hence it's more helpful to talk about 'positive' sexuality. A way of living and being that is fulfilling emotionally, physically, psychologically and perhaps spiritually. The goal of recovery from sex addiction is better sex and greater fulfilment, not less, and this needs to be an integral part of establishing long term recovery.

Clients can be helped to think about their sexual behaviours by asking themselves if they are: -

- In line with personal values
- Respectful of self and others
- Pleasurable
- Mutually fulfilling (when partnered)
- Not shameful
- Confidence and esteem building

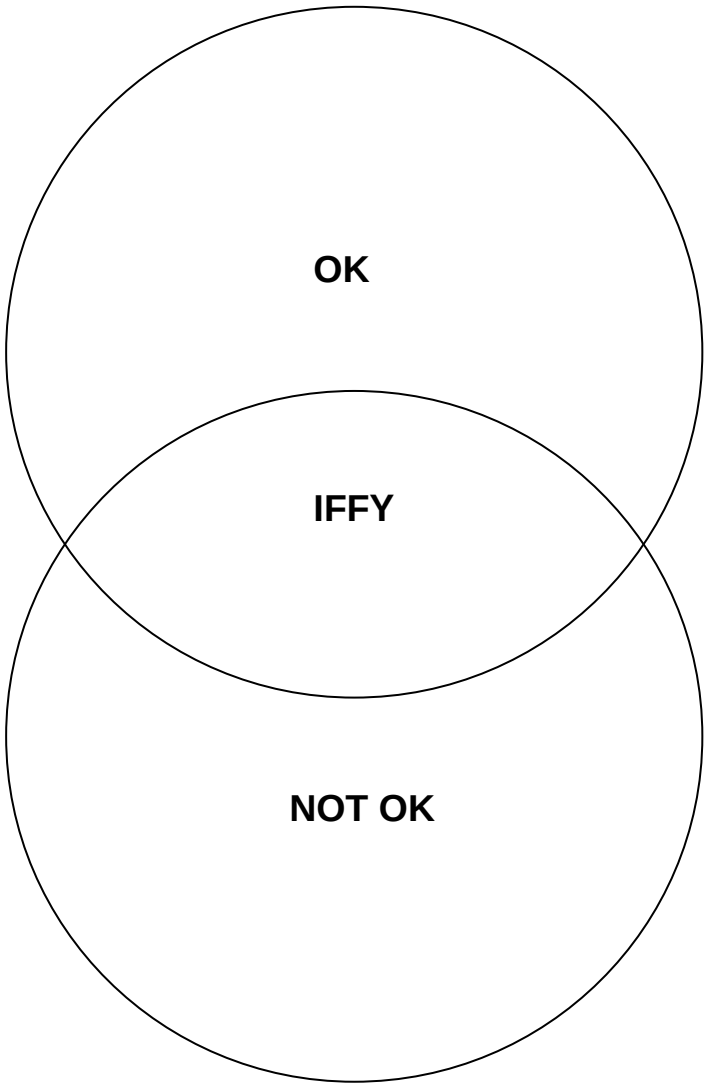
Once a client has begun to think along these lines they can then be asked to complete the circle exercise below as a tool for discussion with their therapist:-

The circle exercise

This exercise has been adapted from the 3 circle exercise used by Sex Addicts Anonymous. To complete it, the client first needs to get a sheet of paper and list every kind of sexual activity they have ever been involved in, alone and with other people. That might include masturbating with porn, masturbating without porn, having sex with a partner, engaging in cyber sex, telephone sex, viewing late night TV channels, voyeurism, visiting massage parlours, sex cinemas, sex workers, dogging sites, stranger sex, affairs, one night stands and so on and so on.

Once this has been done, the challenge is to separate the list into the appropriate areas. The top OK circle is where they write all the behaviours that fit with their values and they're completely comfortable with. The bottom NOT OK circle is for the behaviours that are definitely outside of their value system. The overlap IFFY area is

for those behaviours they're still currently unsure about. They may be unsure because they need more time to think about it, or because it might lead to the NOT OK circle. For example, someone who's addiction has been to visiting sex workers may not have an addiction to internet pornography but they may put internet porn in their middle circle because they know they are much more likely to be tempted to visit sex worker sites when online.



This exercise is more challenging then it looks as ultimately there should be nothing in the IFFY section. So, where will you put masturbation? And what about fantasy? If you were working with a chemically addicted client, you would not be supporting the idea that they 'fantasise' about injecting heroin or snorting cocaine, so if masturbation is to be continued, how will you teach a client to masturbate 'mindfully'? There are also cultural differences. What about working with people of faith; or people in open non-monogamous relationships? How will you challenge what may be limiting cognitive distortions without appearing judgmental?

Therapist comfort and competency

Working with sex addiction requires a level of sexual comfort and competency that is rarely found in counsellor training. Therapists need to have an understanding of ethics and the law to know when a client has strayed into offending behaviour. Therapists also need to be knowledgeable and confident when talking about fetishes and paraphillic behaviours. A first step for anyone who finds themselves, or chooses to work in this field is to read up on the topic. Good basic books obviously include my own Understanding & Treating Sex Addiction (Routledge 2012) and I'd also recommend Sex at Dawn by Ryan & Jetha (Harpers 2010) which looks at some of the social and evolutionary theories of sex addiction and A Billion Wicked Thoughts

by Ogas and Gaddam, (Plume 2011)which provides an up-to-date overview of gender differences and diverse behaviours.

Therapists also need to know how to work positively with erotic transference. It is not uncommon for a client to be sexually attracted to their therapist, or to find themselves triggered by a shapely figure or well meant physical gesture such as a smile or an encouraging compliment. Comfort with your own sexuality is essential in this field as is self awareness of both the sexual, and shame messages, that your body may unconsciously convey. It's also helpful to consider in advance how you will respond empathically and ethically to the courageous client who confesses that they have fantasised about you.

Conclusion

There is not enough space here to explore all the nuances of working with sex and porn addiction, let alone their partners – but below you will see details of further training available. It is a challenge to keep up with the ever growing body of research on the neuroscience of sex and pornography and the links with sexual problems such as erectile dysfunction, delayed ejaculation and loss of libido. Sex and porn addiction is a problem that is growing year on year as technological advances provide ever more ways of administering the 'drug' and so our learning must also go on.

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For details of 'Sex & Porn Addiction - Theories & Treatment Strategies' 17th-20th November, Priory NW London, please email info@TurnerandHall.co.uk