

Sex Addiction

An Extraordinarily Contentious Problem

Abstract

Sex addiction has a variety of names and even more meanings depending on who you talk to, and each of these interpretations impacts the clients who seek help. By adopting a comprehensive and inclusive model, both clients and therapists can be helped to consider the multiple layers of compulsive sexual behaviour and consider the most appropriate, and most urgent, therapeutic objectives.

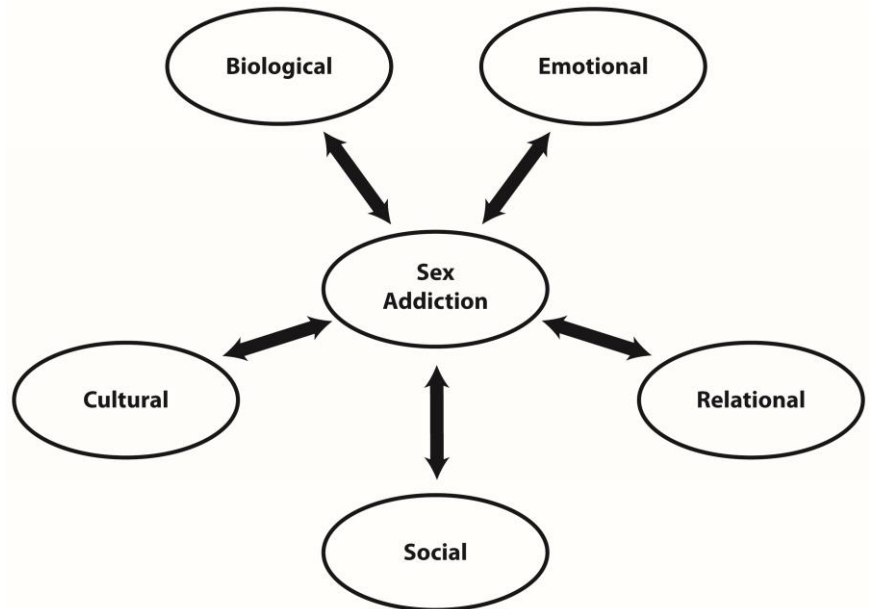
Sex addiction, sexual compulsivity, hypersexuality, problematic sexual behaviours – or whatever you want to call it - continues to be a highly controversial problem (Ley 2012, Moser 2013). So when clients present with difficulties with their sexual behaviour, they come not just with the problem and a range of names for it, but also with a range of diverse opinions.

Whilst the client may experience their behaviour as feeling out of control, they will be challenged to consider if this is really true. Also, is the term 'addiction' just an excuse for their impoverished impulse control or poor morality? Or a mask for a deeper unmet need? Or perhaps it's part of their biological heritage from an alcoholic father? Or a narcissistic or attachment wound from their absent and neglectful mother? A symptom of ADHD? Or a consequence of PTSD? Or are they just acting like a 'typical bloke'? Or a sexually liberated woman? A victim of social stigmatism? Or in the wrong relationship? Or not ready to settle down?

And what about the partners? Unlike most other addictions or compulsive behaviours, sex and porn addiction affects a couple's relationship in the most intimate of ways. Even when no physical infidelity has occurred, many partners report feeling hurt and betrayed, saying that porn has robbed them of their sex life, as their partner's libido and arousal wanes. What meaning do they give to their predicament? Some find the label sex addiction an easier pill to swallow than accepting what they often see as the 'darker side' of their partner or worse still, a failing within themselves or their relationship. They too are affected by the controversies that abound in public and professional discourse and whilst some couples find themselves united against the lack of consensual information and therapeutic approaches, others are further divided.

In an effort to provide a more comprehensive and inclusive approach, I have found it useful to use the BERSC model to explain the complexities of sex and pornography addiction. The BERSC model (Hall 2013) is an expansion of the biopsychosocial view of sex addiction (Hall 2011) and explores five significant influencers - namely Biology, Emotion, Relationship, Society and Culture. All sexually compulsive behaviours are complex and whilst the addiction model is increasingly recognised in the US and focuses on changes in the brain (Kor et al 2013), this should not be used to the exclusion of other factors. Addictions are frequently used to regulate emotional states (Adams & Robinson) and in relationships, sex addiction may be used to create or regulate intimacy. The social context of easy availability and opportunity is perhaps the biggest modern influence but in addition to that it's important to note the individual cultural influences of clients as they relate to gender, family system, faith, work environment or peers.

Using the BERSC model can also be a useful tool for reducing shame and provide a template around which to consider options and motivation for change. Sex addiction is not only impacted by each of these five factors, but in turn, the behaviours also influence these factors. For example, compulsive use of pornography or adult hook up apps may affect a person physically if they're not getting enough sleep or placing them at risk for contracting STI's. It may affect a person emotionally through increased feelings of anxiety, depression or shame. The behaviours may have negative consequences on primary relationships and on social systems and it may impact individual cultural systems such as religious values and work ethics. By exploring each of these elements a client can be helped to consider how big a problem the problem is, and also for whom the problem is a significant issue.



The BERSC Model, (Hall 2013) Understanding & Treating Sex Addiction, Routledge

Case example

Jon and Amanda came for couple counselling 8 months after Amanda had discovered that Jon had been visiting prostitutes for 7 years of their 12-year marriage. She had always known that he'd watched pornography when she was away on business and on occasions had 'caught' him watching it late at night when he said he was working. It had always frustrated her as she felt he probably used porn more than he said and suspected it contributed to his lack of desire for her. The couple had had numerous arguments about it over the years but she'd concluded it was "what men do" and had resigned to put up with it. But eight months ago, the day after Jon had stayed up late again to do work, Amanda found he'd left his smart phone at home and she decided to look through the history. Not only did she find pornography in his browser history but also links to sex worker sites and explicit emails.

Jon was mortified when Amanda turned up at work with his phone and confronted him with the content. At first he tried to deny knowledge of its existence but quickly realised this was futile and tearfully confessed all. Amanda kicked Jon out of the house immediately saying she never wanted to see him again and she would do everything in her power to prevent him from seeing their children. Like many men in Jon's situation, he could not offer any explanation for his behaviour. He swore on his children's lives that he loved Amanda and the children and would do anything to get them back. Adding that he hated what he was doing and enjoyed sex with her more than anything else. He said he wanted to stop and had tried to stop on many occasions but always ended up going back again. As far as Amanda was concerned, this was just more lies and deceit and she was not going to be taken for a fool any longer.

That had all been eight months ago. Since then Jon had been on a recovery course for sex addiction. He had stopped 'acting out', both with sex workers and with porn, and he understood why he'd done what he'd done. Furthermore he was confident that he

wouldn't do it again and wanted to work on rebuilding Amanda's trust and their marriage. During the eight months they'd been apart, Amanda had started coming to terms with what had happened and had done some reading on sex addiction. She explained that she didn't want to throw the good stuff in their marriage away and admitted that apart from Jon's secret other life, their marriage had been good and she wanted to do the best for the children. But like many partners she struggled with the addiction label. "Isn't that just an excuse?" she asked "a way of not accepting responsibility?". She still had so many unanswered questions- "How could he have kept going back to visiting prostitutes if he didn't enjoy it?", "How did it all start?" "How can he possibly love me and do something that he knew would break my heart?".

Before Amanda could seriously consider getting back together, she wanted to fully understand how they'd got where they were – the BERSC model provided an objective tool, not just for understanding sex addiction, but more importantly for Amanda, for understanding Jon's addiction.

We started by exploring the latest thinking in terms of the neurobiology of addiction and in particular the role of dopamine in the reward system part of the brain. Jon talked about his father's alcoholism and his adult diagnosis of ADHD and I explained that there were indications that both of these may contribute to a biological disposition towards addiction. Amanda was also comforted to hear how dopamine is a chemical associated with motivation, drive and wanting, rather than satiation, pleasure and liking. And hence addictions are often characterised by an overwhelming drivenness to do things that don't necessarily provide enjoyment or satiation. And how the reward is in the brain, not in the genitals. As an ex-smoker, this resonated with Amanda as she recalled the times she smoked in spite of chronic bouts of tonsillitis. We also looked at biological principles of escalation and reduced impulse control.

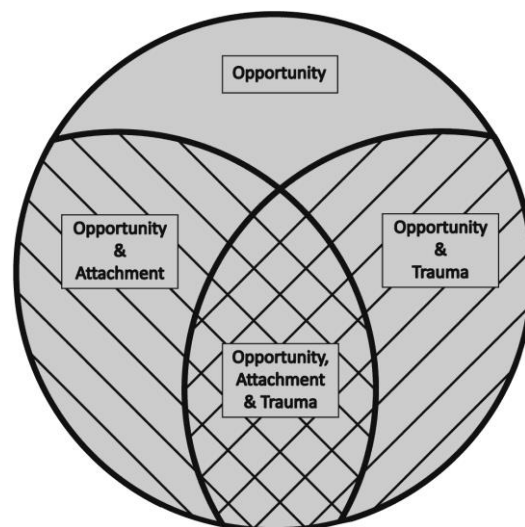
Emotionally Jon had always struggled with assertiveness and managing anger and he explained to Amanda that he had always used some kind of acting out behaviour when he felt frustrated or powerless. His father had at times been a violent man and Jon was determined not to follow that path. But regrettably he had not found a healthy way to manage anger and so, ever since adolescence, he'd self-soothed either with alcohol, computer games, exercise or porn. Anger had also been an ongoing issue within their relationship. Amanda had also come from a home with violence and was determined never to be the victim as she'd seen her mum become. She had often accused Jon of being too passive or even a wimp and saw herself as having to be the strong one who took control. She confessed that in arguments she had often pushed Jon to see how far she could go and usually lost respect because he would never fight back – whilst realising that if he did, she might respect him even less. They both recognised that the issues between them had worsened since the children were born and they had increasingly polarised in their views of what appropriate discipline and assertiveness meant.

By now, Amanda understood addiction much more and was beginning to see that Jon had probably had a number of issues for many years that he sought to soothe, but in an unhealthy way. "But why sex?" she asked "Why choose the thing that would hurt me most?. This was where the social and cultural parts of the BERSC model are often most useful. Because of Jon's family background he knew the risks of alcohol and so had steered clear of this. He had also been a budding footballer in his teens and he remembered the team coach constantly warning him against drugs lest he became a heroin junkie like the coach's brother. Like most teenagers he had started using paper porn early in adolescence and by the age of 14 or 15 he remembered he'd developed the habit of going to his room to look at porn whenever he parents argued. He had continued to use porn occasionally and had never considered it a problem until he got a laptop and broadband for a new sales job 10 years ago. The new job involved long

periods of time away from home in strange hotels with nothing to do. There were also regular sales meeting and nights out for the sales team where visiting strip clubs was the norm. Jon said his time in the company which spanned a further 5 years were a complete eye opener with colleagues who talked freely about porn and casual sex. At first he had resisted their encouragement to fully 'join the team', but regrettably his issues with non assertiveness did not help and so he gradually extended his boundaries until he'd completely crossed the line. "I'd opened Pandora's box" Jon said "and I couldn't get the lid on again".

I continued working with Amanda and Jon over the next few months as they talked through not only the past, but also what they would need for the future. Amanda continued to fluctuate between rage and despair, but the occasions became less often and less severe. And Jon and Amanda began to get back in touch with the good times too. When they left they were still in the process of rebuilding trust with appropriate accountability measures, but both were confident that they were definitely heading in the right direction.

Another model that I find useful for exploring therapeutic objectives and priorities regarding sexual addiction is the OAT model which classifies the primary drivers of addiction as Opportunity induced, Attachment induced or Trauma induced – or a combination of each. Historically sex addiction was seen as a disorder of intimacy and attachment (Flores, 2004, Hudson-Allez 2009), but the profile of those with addiction is changing. The increased availability of pornography and other sexual stimuli via the internet and smart phone has significantly increased accessibility and the opportunity to become 'hooked'. Easy access to high speed, ever changing and infinitely novel pornography is often referred to as a supernormal stimuli (Barrett 2010) and there are suggestions that compulsive use of the internet and pornography can actually change the structure of the brain (Doidge 2007, Kuss & Griffiths 2012). and in its wake comes an increase in clients with no previous attachment difficulties. There are also a number of clients presenting who have found pornography an effective tool for managing hyper and hypo arousal states post trauma (Fisher 2007), only to find that this self medication can create additional difficulties.



The OAT model can also be used to help both client and therapist explore the predisposing, precipitating and maintaining factors of the behaviour and develop a tailored treatment approach. For example, those who present with an attachment induced addiction may benefit from psychodynamic work on early childhood wounds and may also identify feelings such as loneliness, rejection or lack of autonomy as key triggers for their behaviour. Those with a pure trauma-induced addiction may require body work to relieve physical symptoms as well as lifestyle changes to minimise common triggers such as stress and anxiety. In my experience, a psycho-educational approach to explain the

The OAT Model, (Hall 2013) Understanding & Treating Sex Addiction, Routledge

neurobiology of craving and impulse control as well as establishing relapse prevention strategies is also essential for any presentation of compulsive sexual behaviours.

Case example

Tim was a 36 year old man, married for 6 years with two children aged one and three. He initially presented with erectile dysfunction but detailed assessment revealed that he had no problems with erections to pornography which he was now accessing most evenings for three or four hours at a time. He was very aware that his pornography use was getting in the way of him having sex with his wife and realised he'd got himself into a Catch 22. Watching increasingly hard core porn was making him feel numb when having sex with his wife, but because sex with his wife was now so difficult, he was watching even more porn. In fact the only times he could get an erection with his wife now was if he fantasised about porn which left him feeling guilty and distant from her. The problem had been gradually worsening over the past three years until it came to a head a month ago when his wife had begged him to get some help.

Detailed history taking revealed that Tim had enjoyed a relatively stable and happy childhood and adolescence and on the whole he was a confident and content man. His marriage was also a happy one and he still felt a strong sexual attraction to his wife. Over the years he had used porn occasionally and had no issues with it. There was a period of time in his early 20's when porn use had become quite an issue for him but he had managed to control it without help and had hoped he could do so again. Using the OAT Model and assessment questions tailored to explore attachment and trauma issues revealed that Tim's pornography addiction was trauma and opportunity induced. When he was 25 Tim had been in a serious car accident. He had been the passenger when the car veered off the road into a tree, killing his best friend instantly. He had been trapped in the car for six hours before help came and he was cut free. Tim spent a month in hospital with multiple fractures and it was a further six months before he was able to walk unaided. It was during this time that his pornography use exploded. "There was nothing else to do" Tim explained "and it stopped me thinking". Tim shared how terrified he had been whilst trapped in the car. He knew his friend was dead and there was nothing he could do. By the time the emergency services turned up Tim said he had already given up. As he retold the story, he almost physically shrank, cold and motionless, his voice becoming quieter and more monotone. He was dissociating.

Over the coming weeks we used the OAT model to explore how he had used pornography to manage his hyper- and hypo- arousal states immediately after the trauma; motivational interviewing techniques were useful for getting him in touch with the resilience he'd shown in the early days and the resources he'd used to stop his porn use and get into relationships again. Having initially thought there was no explanation for why he started again, he remembered that it was after the traumatic birth of their first daughter who had gone transverse in labour and was then in an incubator for the first three months of her life. He saw how this experience had triggered his old trauma and he began also making connections to everyday triggers of when he feels trapped, helpless or powerless. He also recognised that what in the past he had named as boredom, was actually something much greater than that. It was a fearful emptiness and numbness that unconsciously reminded him of those hours in the car. Social changes in accessibility to pornography gave him the explanation he needed for why he had failed to stop alone. 10 years ago his porn use had been restricted to magazines and videos that he had to leave home to go and buy, but now he had broadband and a smart phone and infinite, boundless access.

Over the coming weeks of therapy we used a combination of sensori motor techniques to work on the trauma and psycho-educational addiction treatment principles to help Tim

understand why his pornography use had escalated and impacted his erections. We also explored how he could avoid his triggers and develop alternative strategies for managing the unavoidable ones. Six months after stopping pornography use, Tim's erections were back to normal and he was once again enjoying sex with his wife.

During the past 10 years that I've specialised in sex addiction, the most 'extraordinary' therapeutic approach I've discovered has been group work. Group work has been the backbone of addiction services for many years (Nerenberg 2002, Miller 2005) and therefore felt like an appropriate extension to individual work. And whilst the group will never be an alternative to individual therapy, in my opinion it serves a number of unique, and essential functions. I have found group work for sex addiction to be profoundly powerful as it breaks through shame and isolation in a way that individual therapy can't replicate. And by providing the opportunity to address old attachment wounds in the here and now, it creates a space for shared empathy and emotional attunement between group members that the boundaries of a professional therapeutic relationship do not allow. Furthermore, group becomes what Yalom described as a microcosm of the real world where members can experience, and be seen to experience, how they operate in the real world. And a place where Yalom's 11 therapeutic factors: instillation of hope; universality; imparting of information; altruism; the corrective recapitulation of the primary family group; development of socialising techniques; imitative behaviour; interpersonal learning; group cohesiveness; catharsis and the existential factors, are interplayed (Yalom 1985). Witnessing the openness, courage and humility of group members as they share and grow together has undoubtedly been one of the greatest privileges of my career.

It may be many more years before we reach consensus on what to call sex addiction and we may never find a definition or diagnostic model acceptable for DSM. But does that really matter? Bereavement is not in DSM and neither is relationship breakdown but we still provide help for those who struggle with these issues. Some prefer an existential or systemic approach, others focus on attachment or changing thinking patterns. And some will use outcome measures to assess the efficacy of their therapy. It is my hope that while research continues in the US to establish a more accurate definition of sex addiction and wider understanding, we in the sex therapy community will remain open minded and focus our attention on the needs of clients.

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