An exploratory study of clinicians' perceptions and experiences of the phenomenon of 'sex addiction' in South Africa

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This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work or works of other people, has been attributed, cited and referenced.

Signed: Signed by candidate Date: 10·4·07

"I have come to appreciate suffering - addiction - as something that is very important and sacred and an important teaching place for us. It is a place where we are brought to ourselves, as a place where our spirit and our heart and our bodies are lined up so well that we get to that *true* sense of what we need as a next step to grow up."

Words of a practitioner working with sex addiction

Abstract

The naming of compulsive sexuality as sex addiction is recent and is a relatively new and emerging field abroad. While research in this field has proliferated in the United States since the 1980s, South African studies are limited. This study explores how mental health practitioners perceive and treat the phenomenon referred to popularly as sex addiction. Practitioners' perceptions and experiences in this field in Cape Town have not been explored and this thesis hopes to redress that.

The research is empirical, qualitative and inductive in nature. Drawing primarily on psychodynamic theory, and to a lesser degree, applying a social constructionist perspective, it explores perceptions and experiences of practitioners working in this field. Practitioners were selected by a purposive and snowball sampling process and a semi-structured interview schedule was administered to a sample of nine practitioners. The data was analysed using thematic analysis.

Key conclusions drawn from the data include: as a concept, sex addiction remains contested and is utilised by only a small number of health professionals. The majority of mental health practitioners refutes its existence or prefers not to work with this phenomenon. Those working with the clinical problem insist that it has a circumscribed clinical picture with clearly identifiable criteria. It is seen to have an extremely complex aetiological base, requiring a variety of intervention models and techniques. Intervention is seen to be long-term, concerned with addressing fundamental developmental injuries, and is fraught with setbacks and resistance on the part of the clientele. At the same time, practitioners experience it as exciting and rewarding work. As part of the field of human sexuality, it is beset by society's sexual taboos which makes for decreased disclosure and hampers effective intervention. While it is seen as primarily a male problem, it is acknowledged that sex taboos are more pronounced for women. Some respondents assume that women endure similar difficulties but have more prohibitions around disclosure than men do. Further research, skilled diagnostic procedures and increased knowledge among clinical professionals of the phenomenon and its impact on their clientele, are seen as important avenues through which practitioners can offer a more comprehensive service in this field.

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Chapter One – Introduction

1.1 Introduction to the research project

This chapter introduces the study, describing its background and rationale. It includes the research questions, definition of concepts, a brief overview of the methodology and an overview of following chapters.

1.2 Background to the study

Sexual behavior that is seen as excessive and out of control has only been referred to as a sex addiction in the last 25 years. For the purposes of this study sex addiction refers to a pattern of engaging compulsively in sexual behaviour or fantasy that is felt to be problematic in some way for the person and cannot be stopped, despite the desire to curtail it. The term 'sex addiction' however, is contested and controversial. Debates in the literature centre on whether to call the behaviour hypersexuality, an addiction, an impulse control disorder or an obsessive-compulsive disorder (Delmonico, 2004; Gordon, 2002; Herring, 2001; Myers, 1995). It has also been contested whether sex addiction constitutes a 'real' addiction, because sex is not a substance, and is therefore not necessarily analogous to alcohol or drug addiction.

It is a clinical problem then, which is fraught with splintered and overlapping diagnoses. Schwartz (2004: 520) calls addictionology a "political minefield", sexual addiction even more controversial, and suggests that the field is "too vast and complex to integrate reasonably as yet". This study hopes to ascertain how the clinical problem is perceived and dealt with by a sample of Cape Town mental health professionals.

The research conceptualises sexuality and sex addiction as a concept that changes across time and place. If one takes the socio-cultural context into account, "concepts of sexuality, addiction and mental illness can take on different meanings throughout history, and all of these categories are subjective and value laden" (Giugliano, 2004: 43). This impacts on the clinical process and Giugliano postulates that clinicians are an integral

part of this process. He goes on to say: "Socially acquired definitions such as diagnostic categories serve to give meaning to a person's experience of self and the world" (Ibid, 2004: 43). In this way clinicians participate in naming and defining a client's problem and "therefore bear great responsibility in the socialisation process of sexual health" (Ibid, 2004: 43).

This study is based on the premise that "therapy is not a value-free enterprise" (Beutler & Bergen, 1991; Kessel & McBrearty, 1967; Strupp, 1980 in Hecker, Trepper, Wetchler & Fontaine, 1995: 261). Practitioners working within the field of addiction are part of the group of people who formulate and determine the construction of the concept. As Giugliano points out: "Clinicians along with their clients must be mindful that they are active participants in the process of definition and conceptualisation" (2004: 24). Their perception of this behavior has an impact on how the behaviour is understood, as well as on how the behavior is ultimately treated. It is the clinicians' perception, experience and understanding of assessment, diagnosis, formulation and treatment of sex addiction that will be explored in this dissertation.

1.3 Rationale

Sex addiction is believed to pose an extensive mental health issue for people who report this problem (Leilblum, 2003; Schneider, 2004). Finlayson, Sealy and Martin (2001:243) assert that problematic hypersexuality is gaining recognition as a hidden dimension of many significant problems facing society. The disorder, they claim, is associated with a range of negative consequences "including failed marriages, teen pregnancies, sexual harassment, exploitation of women and children, the spread of sexually transmitted diseases, loss of professional standing and legal charges". The result is "shame, secrecy, alienation from friends, social isolation and despair" (2001: 243). Carnes, who has been credited with naming 'sex addiction', estimates its prevalence at about 6% of the general population (in Schneider, 2004: 199).

The field is marginalised and under-researched

It appears that this area remains relatively unexamined, unchartered and somewhat marginalised. Weiss (2004: 234) points out that even mental health professionals and addiction counselors, while expressing interest in enhancing their knowledge in this field, reveal a range of responses to actually working with sex addiction from "curiosity and intrigue to outright fear". Delmonico maintains that "there are still thousands of professionals who are under-informed or misinformed about the basics of sexual addiction and compulsivity" (2004:1). Herring (2004:34) notes a lack of funding for research and services in this field: "The ubiquitous sexual shame of our culture prevents people from supporting this field to an extent that is sufficient to either its need or their interest. Integrated assessment, referral, and treatment services for this sexual disorder are scarce and education and prevention efforts are almost non-existent." As it is still a relatively new area of interest, it is not known how sexual addiction as a concept is recognised or worked with by clinical practitioners in Cape Town. According to a social worker engaging in this field it remains "highly undiagnosed" (Coetzee, 2005).

Sex addiction impacts severely on mental, physical and spiritual health

Sex addicts take risks that not only jeopardize their own physical and mental health, but that of those close to them as well. Sexually transmitted diseases, risk of infection, unwanted pregnancy, and arrests for unlawful sexual practices are all ramifications of this behaviour. Sex addiction can also be fatal. The fatality of sexual addiction is most directly related to the arena of HIV/Aids. Studies on HIV-positive men and women show a high scoring on standard sexual compulsivity measures (Dodge, Reece, Cole & Sandfort, 2004: 343; Schneider, 2004: 199). The social, emotional, legal, psychological and physiological impact of sexual addiction can be extensive and devastating to addicts and those close to them.

Sex addiction may be hidden behind other addictions or diagnoses

Importantly, practitioners working within the field of addiction have come to recognise that a high incidence of relapse of a recognised and treated addiction occurs when an undisclosed or hidden sex addiction has not been recognised as a separate entity and

addressed as such. Co-existing addictions are common as are dual diagnoses – that is, other co-existing psychiatric disorders (Carnes, Murray & Charpentier, 2004; Hagedorn & Juhnke, 2005). In a study undertaken by Blanchard (1990) sexual addiction symptomatology was observed in 55% of a variety of sex offenders, with child molesters meeting the criteria for sex addiction in 71% of the cases (Blanchard & Tabachnik, 2002). Hidden and undisclosed sexual addiction needs to be made transparent. Awareness of the importance of the dual diagnosis in relation to relapse also needs to be enhanced.

Working with sex addiction requires special knowledge and skills

Weiss (2004) alerts practitioners to special considerations when working with clients who have a problem with excessive sexual behaviour. These include awareness of countertransference and strict maintenance of boundaries. He says: "It is more important in working with sex addicts than perhaps with any other patient population that the counselor is cognizant and actively managing his or her own personal boundaries in regard to patient interactions" (2004: 257). Therapists' experiences, feelings and countertransference when working in the field need illumination.

Research is limited in South Africa

Research in this field has been conducted primarily in the United States of America. In South Africa research is very limited. Little is known and documented on a theoretical and practical level in Cape Town. This research project aims to ascertain what is happening in practice. That is, it will explore what paradigms are used and whether or not practitioners utilise an integrated approach drawing from different paradigms or are exclusively applying personally preferred paradigms.

1.4 Problem formulation

The research problem aims to explore how practitioners perceive, understand and construct the concept of sex addiction. Through the perceptions of practitioners working within the field, it will explore the theoretical debate and framework around conceptualisation and aetiology. It will also explore how their understanding affects treatment. It will identify the interventions and approaches currently being utilised and

found useful. As sexual behavior is essentially a relational activity, involving bonding and intimacy, it will ascertain therapists' understanding of the links between sex addiction and intimacy. Further, it will examine therapists' subjective experiences and countertransference issues in treating this client population. Recommendations for further development within the field in terms of knowledge, skills and awareness amongst practitioners will be explored.

1.5 Research objectives

This research aims to:

- Explore therapists' perceptions of the concept of sex addiction.
- Explore their understanding of the phenomenon of sex addiction.
- Ascertain which therapeutic models are being used for treatment in this field and why they are felt to be useful.
- Explore the subjective experience of the therapist working with the phenomenon of sex addiction.
- Ascertain what specific knowledge, skills and resources are needed for effective work in this field.
- Explore therapists' perception of the link between sex addiction and the current social context.

1.6 Research questions

Six primary research questions have been framed:

- How do practitioners working in this field perceive the concept of sex addiction?
- What aetiological models have they drawn on for their understanding of this phenomenon?
- What therapeutic models do they utilise in their treatment of persons with sex addiction?
- How do they experience working with the population of persons with sex addiction?

- What therapeutic knowledge/skills would practitioners need to work with this particular population?
- What role do they think the current social context plays in this phenomenon?

1.7 Concept clarification

Clinicians, therapists

Social workers, psychologists, psychiatrists and other practitioners working with clients presenting with sex addiction. The terms clinician, practitioner and therapist will be used interchangeably.

Perceptions

Clinicians' perceptions are subjective. They emerge from a combination of their own biographical history, experiences, internal object relations, gender, professional knowledge and socio-cultural context. Perceptions also describe the emotional experience and the felt nature of the object of perception.

Experiences

This refers to therapists' subjective encounters while working with persons with sex addiction.

Sex addiction

For the purposes of this study, sex addiction will refer to the behaviour of individuals in or outside monogamous sexual relationships. It will be defined as including some or all of the following characteristics:

- A preoccupation with sexual thoughts, feelings, fantasies and behaviour that is felt to be uncomfortable and unmanageable for the client;
- The behaviour is found to be impossible to control despite the intention to do so. An element of powerlessness to control the behaviour is therefore a component;
- The behaviour interferes significantly with the person's life and those close to them. However they continue to act out this behaviour despite real adverse consequences.

Other terms that will be used interchangeably with sex addiction are: out-of-control sexual behaviour, hypersexuality or compulsive sexual behaviour.

Treatment

The treatment models used to inform the theoretical position of the clinician in turn determine the treatment modalities chosen.

1.8 Brief introduction to the research design

As the study aims to explore the perceptions and understandings of therapists working with sex addiction, qualitative research has been selected as an appropriate methodology, given its ability to yield in-depth, rich data (Denzin & Lincoln, 1994). It draws primarily on psychodynamic paradigms and secondly on social constructionist methodology to approach and understand the data.

1.8.1 Research Methodology

Participants were selected using both a purposive as well as a snowball sampling method. The researcher set out to interview practitioners who were familiar with the behaviour under discussion and who had some experience in this regard. Known practitioners were also asked for referral to other practitioners working with the problem. Data collection was done by means of semi-structured in-depth interviews (See Appendix One) with each respondent. Interviews lasted between 60 and 90 minutes. Data analysis was conducted on the interviews that were taped and transcribed, using Tesch's method of analysing qualitative data (De Vos, 2001: 343). A contract which outlined interview procedure and assured confidentiality was signed by participants (See Appendix Two).

1.8.2 Reflexivity

As the researcher was interviewing colleagues on a topic that is to an extent taboo in society, she needed to be sensitive to this. Questions posed asked practitioners to reflect their personal attitudes and value system. These needed to be quickly established, given the tight interview timeframe, while still guarding against intrusiveness.

1.8.3 Ethics

Sexuality is a sensitive field. Some questions could have been felt to be of a delicate nature. In order to alleviate this, participants were fully informed of the research purpose beforehand. They were informed that questions relating to their personal experience and countertransference would be asked. Confidentiality of both their identities and that of their clients was promised. It was confirmed that anonymity would be upheld at all times in the research process. As mentioned, a contract stipulating these and other issues relating to the research was signed by participants before the interview was held (see Chapter Three).

1.9 Overview of dissertation

Chapter One has introduced the research topic undertaken. It includes the research problem, research objectives, research questions and concept clarification. It also includes an introduction to the methodology and research design used.

Chapter Two provides an overview of key literature relating to the research. Central areas covered include outlining the concept of addiction; the controversy around the concept of sex addiction; contextualising sexuality and sex addiction as a socially constructed concept; aetiological theories and models, and treatment issues.

Chapter Three covers methodology, research design and the method of data analysis used. It will include ethical considerations; limitations of the methodology used and the researcher's reflexivity.

Chapter Four comprises data analysis and discussion of key themes which emerge.

Chapter Five presents conclusions and recommendations which have arisen out of the research.

Chapter Two – Literature review

2.1 Introduction

In attempting to understand and explore the concept of sex addiction, it is necessary to contextualise it within the broader conceptualisation and theoretical discourse on addiction and sexuality, both of which constitute vast fields in their own right.

The development of the concept of addiction will first be presented. The concept of sex addiction will be delineated and the clinical picture described. Sexuality will also be contextualised as a socially constructed phenomenon. Following that, the debate and controversy over the term 'sex addiction' will be discussed. Thereafter aetiological theories of sex addiction will be presented and issues pertaining to assessment, treatment models and treatment challenges will be outlined.

2.2 The concept of addiction

Addiction as a concept has changed over time and is immersed in academic and scientific debate. Addiction, a word that is "used lightly and accepted colloquially in our culture" (Fossum & Masson, 1996: 123) emanates from the root word 'addicere', which means to "give oneself up" or to "devote or surrender oneself to something habitually or obsessively" (The Oxford English Dictionary, 1989). Jampolsky (1991) claims that the root of all addictions can be seen in the pursuit of happiness in something outside of ourselves.

Schierse-Leonard (1990: xvi) describes how an addict is pulled into a repetitive cycle "often without choice, and is held hostage by the addiction". She says addiction is "a disease in which the sufferer ceases to think clearly and to feel the genuine impulses of the heart" (1990: xiv). Schierse-Leonard goes on to say that addiction is "the act of giving oneself over to something as one's master – be it a substance, object, person or activity – so totally that one's entire being and meaning becomes possessed by it" (1990: 4). When one gives up one's whole being, and allows oneself to be ruled by something external,

one's freedom and personal integrity is lost. The act of reaching for an addictive escape, accompanied by overwhelming guilt, shame and sense of failure due to the inability to control the cycle, becomes so habitual that the addict "forgets who he is and begins to be unable to recognise himself any longer" and finally "loses his soul" (1990: 5).

2.3 Historical overview of the concept of addiction

Prior to this the establishment of Alcoholics Anonymous in the 1930's which lent credibility to the idea that people struggling with habitual dependence on alcohol had a disease, people struggling with substances were stereotyped as immoral and criminal (Smith & Seymour, 2004). These initial understandings, widely disseminated, reflected a perception that addicts had poor self-will and were derived from a degenerate sector of society. From this persistent view developed deviance theory (Orford, 1985) or the moral degeneracy/willful disobedience model (Smith & Seymour, 2004).

In the 1960s the concept of physical dependence gained ascendance. Addiction came to be seen as synonymous with physical dependence characterised by increasing tolerance and the onset of physical withdrawal symptoms (Smith & Seymour, 2004). It was believed that the action of drugs created physiological addiction. The goal of treatment became detoxification with some counseling aimed at helping the addict resume a clean and drug-free lifestyle. However, the frequency of relapse among detoxified opiate addicts made it clear that tolerance and withdrawal were not the only components at play.

Research also showed that, probably due to genetic predisposition, addiction could develop through accidental exposure to a potentially addictive substance or experience. This was seen to occur through the awakening of a compulsion that was until then dormant. An example was given of people becoming addicted to post-operative pain medication when they did not have a dependency before (Smith & Seymour, 2004). Schneider (2004) cautions against this conclusion and maintains that it is not true to say that given enough drugs a person will inevitably become addicted. It is about the relationship the person has to the drugs or behaviour and the role that the drug or behaviour plays in the person's life that determines whether an addiction develops or not.

That relationship is influenced by availability and accessibility *combined with* a person's genetics, family background and relationships, and life experiences. Vietnam veterans illustrated this by showing that although they returned home after the war having 'used' extensively for an extended period, they needed no addiction treatment on their return. A different context allowed the veterans to release their need to 'use' (Schneider, 2004).

It became evident from the early 1970s that the physical dependence paradigm was not comprehensive. Despite this, most of those working with addicts still saw addiction as "due to a combination of moral degeneracy, willful disobedience and physical dependence entered into intentionally by the addict" (Smith & Seymour, 2004: 12).

Biological research, together with the fact that in the 1970s the demographics of the drug-addicted population changed dramatically, deepened understanding (Smith & Seymour, 2004). Members from the 'middle-class' had shown themselves to be addicted to prescription medication used to self-medicate a variety of disorders, including chronic pain and long-term emotional disorders. This alerted researchers to the fact that addiction did not only belong to the domain of "the lower degenerate classes" (Ibid: 2004:12), and that other psychiatric disorders were found to co-exist with addiction problems, which necessitated dual diagnoses. The clinical picture emerged as more complex than previously recognised. Addiction was no longer seen to be a matter of physical tolerance, withdrawal symptoms, tolerance development and craving. The moral degeneracy perspective faded into clinical insignificance, although it retained a hold on popular mythology.

In 1999 Leshner declared addiction a 'brain disease', based on research from the National Institute on Drug Abuse in the USA and other corroborative research (in Smith & Seymour, 2004:12). He explains: "The path to drug addiction begins with the act of taking drugs. Over time, a person's ability to choose not to take the drugs can be compromised. Drug seeking becomes compulsive, in large part as a result of the effects of prolonged drug use on brain functioning, and thus, on behaviour" (2004: 12). Brisset referred to addiction as the 'three-headed dragon' composed of physical, mental and

spiritual components (in Smith & Seymour, 2004: 12). These three elements became the cornerstone of the 'disease concept', together with the idea of the progression of the disease. As the disease model advanced the impact of the deviance model further softened. Treatment models began to incorporate the concept of recovery into their goals and objectives. Where detoxification had been seen as the goal of treatment, it was now understood to be but the beginning (Ibid, 2004).

Since the 1980s a growing recognition emerged that addiction can occur in relation to a range of substances, with the notion of addiction to substances later broadened to the notion of addiction to varying kinds of behaviour (Smith & Seymour, 2004). While this point is still contested, as detailed below, it is within this context that sex addiction was identified.

2.4 Sex addiction in the literature

To date, very little systematic research, theory or treatment has dealt directly with sexual behaviour as an addiction (Giugliano, 2004; Herring, 2001; Hagedorn & Juhnke, 2005; Kafka, 2001). Giugliano (2004) maintains that much of the literature on the epidemiology and treatment of sexual addiction is anecdotal and extrapolated from the substance addiction field. Stein, Black, Shapira and Spitzer (2001) argue that the lack of an agreed-on term has contributed to the paucity of research and emphasize that the limited empirical literature in this area makes it difficult to endorse any single theoretical model. Finlayson, Sealy and Martin (2001) agree that the absence of clearly accepted nomenclature and diagnostic criteria limit the recognition, study and treatment of patients with problematic hypersexuality.

There is general agreement that out-of-control sexual behaviour is a recognisable phenomenon (Keane, 2002, in Birchard, 2004) but there is considerable controversy over how it should be designated. Attempts at classification and nomenclature have created numerous modifications, professional tensions and splits between allied mental health fields such as sexology, addiction medicine and psychiatry (Finlayson et al, 2001).

Carnes (1996, in Giugliano, 2004: 47) proclaims that "the interdisciplinary conflict is so acute that it makes it impossible to separate politics from science". Debates centre on whether to call the behaviour a disease, a psychological disorder, a symptom of a broader diagnosis of an impulse control disorder, an obsessive-compulsive disorder in and of itself or an addiction (Finlayson et al, 2001). The Diagnostic and Statistical Manual of Mental Disorders IV (2000) does not officially recognise sexual addiction as a disorder although addiction specialists are calling for such an inclusion (Delmonico, 2004; Herring, 2004; Schneider, 2004). The conservative perspective holds that calling out-of-control sex a disease excuses immoral behaviour and the liberal perspective sees the sex addiction label as a "moral judgment by people who do not like another group of people's behaviour dressed up as a scientifically validated concept" (Levine, 1999: 33).

2.4.1 Current psychiatric classification

a) The term 'sex addiction' and diagnostic classification

The term 'sex addiction' was mentioned in two places in the DSM II but both references were removed in the DSM IV. The term 'addiction' does not appear anywhere in the DSM IV and problems with substance use are referred to as either substance dependency or substance abuse. Sexual disorders are subdivided into four categories under the heading Sexual and Gender Identity Disorders. The four categories are sexual dysfunctions (disturbance in sexual desire or performance); paraphilias; gender identity disorders and sexual dysfunction not otherwise specified which includes those dysfunctions that do not meet the criteria of sexual dysfunction (Kaplan & Sadock, 2003: 718). Sexual compulsivity, referred to as excessive sexual drive, is now referred to under this last category. Compulsive sexuality is mentioned in an additional category called 'Sexual Disorder not otherwise specified'. This category is reserved for a sexual disturbance that does not meet the criteria for any specific sexual disorder and is also not a sexual dysfunction. The reference to compulsive sexuality comprises the following statement: "Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (cited in Kaplan & Sadock, 2003: 727). Criteria in this category remain incomplete and conflate sex and relationship Addiction.

b) Paraphilia and compulsive sexual behaviour. These are not mutually inclusive terms. Paraphilias are defined as "abnormal expressions of sexuality". They range from "nearly normal behaviour to behaviour that is destructive and/or hurtful only to the self and or to a person's self and partner, to behaviour that is deemed threatening to the community at large. They are seen as deviant behaviours in that they can involve acts of aggression, victimisation, and extreme one-sidedness" (Kaplan & Sadock, 2003: 718). Paraphilic urges may occur rarely, intermittently, or compulsively. While some Paraphilic behaviours may have a hypersexual dimension, problematic hypersexuality can occur within or outside paraphilic categories (Finlayson et al, 2001: 243). Compulsive sexuality is also referred to by some theorists as non-paraphilic hypersexual disorder (Kafka, 2001).

c) 'Sex' can be substituted for 'substance' in the diagnostic criteria for substance dependence. Schneider and Irons (2001) maintain that while the traditional term for addiction has been reserved for the ingestion and continual use of chemical substances, a general definition of addiction can be extrapolated from the diagnostic criteria for substance dependence found in the latest edition of the Diagnostic and Statistical Manual IV. They maintain that all the criteria required for the diagnosis of substance dependence are evident in compulsive sexual behaviour. These include the criteria of tolerance, withdrawal, the activity needing to be increasingly indulged in so as to bring on the same effect, loss of control over 'use', preoccupation, constriction of activities not related to the compulsion, and continuation despite adverse consequences. They also point out that only three of the above criteria need to be present for a diagnosis of maladaptive pattern of use.

2.4.2 'Sex addiction' proponents describe indicators that denote addiction

a) Biological indicators Advances in neuroscience show that any distinction between biological and psychological addiction is outmoded and artificial and that people suffering from sex, work, gambling and other addictions not involving psychoactive substances, go through the same chemical processes described where psychoactive substances are used. Craving, withdrawal, tolerance and addiction to endorphin or

dopamine reward inherent in substance addiction, are present in sex addiction (Huebner 1993; Schaffer, 1997; Milkman & Sunderworth 1987, in Smith & Seymour, 2004: 32). According to Carnes et al (2004), sexual expression involves pleasure. When pleasure centers in the brain are stimulated, endorphins are released into the bloodstream. Endorphins are believed to be associated with mood changes that follow sexual release. Any chemical that causes mood changes can be addictive, the repeated exposures altering brain chemistry to the point where more of the chemical is sought in order to feel 'normal'.

b) Psycho-socio-behavioural indicators

1) The behaviour continues despite the person wanting to stop. This reflects the component of powerlessness seen in other addictions.

2) The behaviour continues despite adverse circumstances that have a real and deleterious effect on the person's life. A clinical profile develops not unlike those seen in the lives of addicts dependent on a substance. Carnes (in Schneider, 2004) reports that sex addicts, obsessed or preoccupied with sex, display a lack of control over their sexual activities and continue their behaviour despite adverse consequences such as arrests, broken marriages, financial debt and risk or contraction of infection.

3) Forced withdrawal from the compulsive use of sex to ameliorate mood evokes marked signs of anxiety, depression and feelings of distressing emptiness.

4) Progression of the 'disease' is evident. Carnes (in Schneider, 2004) outlines the progression of an untreated sex addiction which begins at an initiation phase and goes on to include the establishment, escalation, de-escalation and acute phase. He maintains that while progression can take years, with the advent of the Internet, this process can accelerate to months or even weeks. For this reason "cybersex has been referred to as the crack cocaine of sex addiction" (Schneider, 2004: 216).

5) Vulnerability to escalating levels of addiction where no compulsion existed before. The way the clinical picture of sex addiction has changed since the advent of the Internet supports this point. People suffering from a sexual addiction may have in the past indulged in pornographic magazines and extra-marital affairs; now they have access to more instant, graphic and available sexual material. Virtual sex with another human being

has become possible and so is more easily engaged in (Carnes, 2001; Flores, 1988; Orford, 1985; Schneider, 2004). Schneider claims that people perusing the internet for 'soft' pornography become trapped in a significant addictive problem that they did not have before they found this new pleasure (Schneider, 2004).

In sum, **the significant factor in defining sex addiction is "the pattern of self-destructive or high-risk sexual behaviour that is unfulfilling and unable to be stopped despite the person wanting to"** (Barth & Kinder, 1987). While compulsive or addictive sexual behaviour can take on varying forms, including what many regard as 'normal' sexual behaviour, the type of sexual activity and even the frequency or number of partners is not of great significance in diagnosing this problem.

2.4.3 The clinical picture

Despite controversy over definition, what appears to be undisputed is that the behaviour remains a "source of considerable shame and conflict [which is] disruptive to their lives and those closest to them" (Leilblum, 2003: 535). The ramifications of this problem on an intra-psychic and interpersonal level are extensive. The first major study of sexual addiction was published by Carnes in 1991, based on a questionnaire completed by 752 male and 180 female diagnosed sex addicts (in Schneider, 2004). His study ascertained that sexual addicts were typically unable to form close friendships and that their feeling of shame and unworthiness hampered their ability to engage in real intimacy. They reported anticipation of rejection if people were to 'find out who they really were' and so they developed a variety of ways to avoid closeness with friends and/or sexual partners. Despite a large number of superficial contacts, intense loneliness was experienced. Many developed a sense of living two separate lives – a life where activity centered on their occupation or a more ostensibly 'normal' life and another secret sexual life, devoid of closeness.

The findings in Carnes' survey (1991, in Schneider, 2004; 201) are illustrated below.

TABLE 1: Sex addicts' behaviour when in active addiction

Behaviour	Percentage
Leads to loss of self-esteem	97%
Feelings of extreme hopelessness or despair	91%
Strong fears about future	82%
Emotional costs of guilt and shame	6%
Feeling like two people	8%
Acting against personal values and beliefs	90%
Strong feelings of guilt and isolation	94%

Carnes (1993, in Schneider, 2004: 202) points to **three levels of sexually addictive behaviour:**

- Level one includes behaviours that are regarded as normal, acceptable or tolerable such as viewing pornography, multiple affairs or prostitution.
- Level two includes illegal behaviours that are victimising and regarded as nuisance crimes, such as voyeurism or obscene telephone calls.
- Level three includes illegal behaviours that have severe emotional or medical consequences for the victim and severe legal consequences for the perpetrator, such as rape, incest or child molestation.

Addictive sexual behaviour patterns can be identified

Addictive patterns include: fantasy sex (an obsessive fantasy life); seductive role sex (seductive behaviour for conquest); voyeuristic sex (visual arousal); exhibitionistic sex (attracting attention to body or sexual parts of the body); anonymous sex (high-risk sex with unknown partners); paying for sex (purchase of sexual services) and trading sex (selling or bartering sex for power) (Carnes 1991, in Schneider, 2004: 204).

Schneider and Irons (2001) point out that these patterns are not in themselves indicative of an addictive disorder. They can be normative or life-enhancing. However, when combined with the addictive components described above, they describe the range of addictive sexual behaviour styles. These levels and the addictive sexual patterns described above would be important to ascertain in a comprehensive sex history.

2.4.4 Sex addiction and the Internet

The Internet sex industry is reportedly gaining ground as a potentially problematic trigger for compulsive sexual behaviour. "The internet is altering patterns of social communications and interpersonal relationships" (Griffiths, 2001: 333). Cooper, Delmonico and Mathy (2004) assert that this is nowhere more true than in the field of sexuality. Cooper and Sportolari (1997, in Cooper, Delmonico, Griffin-Shelley & Mathy, 2004: 131) propose that the Internet has several properties that create a powerful attraction for individuals, which they label 'the triple A engine'. This refers to three characteristics that determine its appeal: accessibility, anonymity and affordability. They go on to say that "the speed and the capabilities of the Internet when combined with sexuality have produced an effect so dramatic that it has been said to catalyse the next 'sexual revolution.' "

Griffiths (2001) maintains that "on-line compulsive use for sexual purposes exhibits all the core elements of addiction, including salience, mood modification, tolerance, withdrawal, conflict and relapse" (2001: 335). Other facets such as "convenience, escape, social acceptability" (Griffiths 2001: 334) and "intoxicating, isolating, inexpensive, imposing and interactive" (Delmonico, Griffin & Moriarty, 2001, in Cooper et al, 2004:131) combine to make this new medium a powerful avenue that facilitates compulsive and other problematic types of behaviour in users. Stein et al. (2001) agree that "cultural factors – the development of the Internet – seems to markedly have contributed to the pathogenesis of the patients' symptoms" (2001: 160). The same deleterious effects seen in other forms of sex addiction are seen to play themselves out in Internet sex addiction.

Clear clinical features have been identified for sexual activity that feels compulsive for the client and has little to do with bonding and intimacy. This sexual life evokes little or no emotional satisfaction on one end of the continuum, to distressing and life-damaging consequences on the other.

2.5 Diverse approaches to conceptualising the phenomenon

There are a number of approaches that do not conceive of compulsive sexuality as an addiction. The first is the social constructivist approach which critically appraises how sexuality is perceived and constructed. The second challenges the premises of addictionology and the third sees compulsive sexuality as an intimacy disorder.

2.5.1 Social constructivist approach

The social constructivist approach holds that what is commonly recognised as objective truth and knowledge is not objectively definable but rather is constructed within a particular social context which determines its own particular meaning.

Within this approach sexuality is seen as a socially constructed phenomenon. Most critical theories of sexuality understand sexual behaviour, in all its forms, as a cultural construct. It is constructed and related to differently in different cultures and differently over time (Giugliano, 2004; Orford, 1985). The notion of 'normal sexuality' is conceptualised in and affected by the broader social context and sexual mores of the time.

Views of what sexual dysfunction is change over time

Giugliano (2004: 43) maintains that "socio-cultural attitudes toward what constitutes 'normal' sexuality have an extensive history that also is reflected in social and psychological theory and in diagnosis over time". He traces the changing psychosocial views of sexuality over time by showing how sexual scripts or codes have changed historically and how the mental health professionals have changed their perceptions as to what defines good sexual health accordingly. Sexual scripts, he explains (2004: 48) "provide the standards that determine erotic control and normalcy".

De Lamter (1985, in Giugliano 2004: 47) outlines three "erotic codes or scripts" that categorise types of sexual relations. The first is *procreative*, which refers to the tradition of sexual interaction being limited to the context of marriage for the purpose of reproduction. The second is *relational,* which regards sexual activity as a means of expressing and receiving emotional and psychological intimacy. The third is *recreational* and refers to mutual pleasure as the chief purpose of sexual activity. Simon and Gagnon (1977, in Giugliano, 2004) emphasize that these three scripts, although wielding differing levels of influence over time, always describe the dominant cultural (white middle-class) definitions of sexual relations.

In the 1950s the procreative code was paramount and entrenched in western social culture. It was reflected in all institutional structures, including family, law, education, religion and medicine (Giugliano, 2004). Sexual pleasure outside of marriage was considered sinful, immoral and dirty. This societal value was reflected in diagnostic categorisation. In 1952 The DSM-1 contained the diagnostic categories of Don Juanism and Nymphomania, and prostitution and abortion were considered to be forms of pathology (Giugliano, 2004). The sexual revolution of the 1960s and 1970s challenged this perspective and liberated sexual behaviour from the strict confines considered acceptable until then. "Within the landscape of technological advances in contraception, legalised abortion, and new antibiotics effective for the treatment of sexually transmitted diseases, the prohibitions against and stigmatisation of the procreative script was weakened" (Edwards, 1986; Morris, 1978, in Giugliano, 2004: 48). Self-fulfillment, sexual experimentation and personal gratification outside of societal dictates defined the newly established norm. While perceptions and values changed, norms were not eliminated – they only changed their form.

Relational sex became the leading sexual script. Sexual expression outside of a committed marriage had been "generally viewed as a pathological avoidance of intimacy, commitment, or incapacity to attach or to love another person" (Kasl, 1990, in Giugliano, 2004: 49). Now as long as the sexual activity took place between mutually interested

consenting parties, and pleasure was mutually enhancing and agreed on, familiarity and commitment was not a priority.

Diagnostic categorisations paralleled the changes. "Mental health professionals were also re-evaluating professional definitions of erotic control and deviance" (Levine & Troiden, 1988: 352). Sexologists began to define past procreative sexual scripts as restrictive, reflecting a "sex-negative culture" and moved towards sex-positive frames of reference. Money and Lamacz (1989, in Giugliano, 2004) refer to sex-negative cultures as ones that pathologise non-marital and non-procreative sex and sex-positive cultures as those that do not pathologise those forms of sexuality.

As professionals again changed their perceptions and guarded against restricting sexual expression, the clinical focus featured an "unconditional acceptance of sexual desire to improve sexual functioning and to empower people sexually" (Giugliano, 2004: 49). New categories of sexual problems emerged out of this cultural climate. Many centered on people struggling with having too little sexual desire or not being able to have pleasurable sex for either physiological or psychological reasons. This was reflected in new diagnostic categories. Classifications included: inhibited sexual desire; sex aversion; anorgasmia, impotence and premature ejaculation (Ibid, 2004: 49).

The sexual revolution, however, created its own set of consequences. "The pendulum of cultural sexual norms again swung, leaving mental health professionals struggling to address problems with indiscriminate or too much sex" (Irvine, 1977 in Giugliano, 2004: 50). New health problems, such as sexually transmitted infections, would be part of this emerging picture (Peck, 1979 in Giugliano, 2004). Following the separation of sex from the injunction of procreation, current trends seem to reflect a separation of sex from intimacy and relationship. Awareness of the phenomenon of sex addiction developed and emerged out of this social and cultural context.

Sex addiction as a cultural concept rather than a clinical condition

Keane (2002, in Birchard, 2004:82) argues that the concept and "other emerging discourses of addiction treat overwhelming erotic desire as a virulent disease". This perspective holds the view that mental health disorders such as sex addiction are essentially social constructions that label behaviour deviant when they do not conform to the culturally dominant sexual standards.

Duffy (1982, in Giugliano, 2004) and Englehardt (1974, in Giugliano, 2004) agree that the classification of sexual addiction as a mental disorder is a codification of sexual mores. Levin and Troiden (1988: 349) affirm this view by stating that "sexual addiction and sexual compulsion represent pseudoscientific codifications of prevailing erotic values rather than bona fide entities and that wider sociohistorical formulations have an impact in generating the meanings that people in society assume about their sexual behaviour". Significantly, the phenomenological experience of patients diagnosed with this 'problem' can be understood as affected by and a construction of these broader social understandings (Orford, 1985).

Jessor and Jessor (1977 in Orford, 1985: 109) concur: "How much our findings are bounded by the period in which they are obtained and are specific to that point in history is interesting to contemplate. Foucault's example, drawn from Krafft-Ebing's writings in the 1880s, illustrates how the definition of sexual deviance changes over time. Krafft-Ebing (2003: 279) claimed that one of the worst sexual aberrations of that time was that of men who cut off the pigtails of young girls in the street with a pair of scissors – not a behaviour that would concern us much today. Foucault asserts that historically there has been a tendency over time to abnormalise, psychiatrise, pathologise and ultimately to control sexuality and sexual norms in society.

The interpretation we have made of particular behaviours, and the very notion of problem behaviour, depend on the social and personal meanings attached to them." Orford concludes that those "who have considered the matter carefully are of the opinion that the problems resulting from excessive sexuality are the result of personal or social reactions

to behaviour itself rather than the result of anything intrinsic to the behaviour" (1985: 99).

Sexual attitudes and mores differ according to socio-cultural context. Anthropological studies show great variation in sexual behaviour and attitudes in different social and cultural groups (Ford & Beach, 1952, in Orford, 1985). This is illustrated by examples where attitudes in non-western cultures towards sexual practices differ substantially from those of western cultures. Amongst the Mangaia in the South Pacific the idea of multiple partners does not carry the same negative moral injunction as it does in western societies (Marshall & Suggs, 1971, in Orford, 1985). Adults in this culture encourage pre-marital sexual intercourse for their young and uphold a belief that prevention of pregnancy is facilitated by abstaining from regular intercourse with only one partner (Ibid, 1971).

Furthermore, this behaviour is seen to fall outside the range of 'normal' sexual activity, yet definitions of what constitutes 'controlled' or 'out-of-control' sexuality "are in themselves culturally determined and reflect the moral values of particular societies at particular times" (Giugliano, 2004: 47). Klein (2002: 4) concurs that powerlessness is "just a metaphor" and that those acting out compulsively are not actually out of control but "*feel* out of control and that controlling their impulses is painful". He asserts that by encouraging people to acknowledge their powerlessness, and making them identify and deal with the addiction as a goal, people are prevented from examining how they came to feel that way in the first place, and avoid exploring personality dynamics and problems. By having the goal of eradicating the 'addiction', people do not "explore the childhood passions at the heart of their sexual guilt – aggression, lust for power, and greedy demands to be pleasured" (Klein 2002: 4). Further, these are all parts of normal sexuality that need to be mediated by adults. People therefore "split or externalise their 'bad' sexuality and work to remove the darkness from their sexuality". (Klein, 2002: 5) According to this argument, the sex addiction concept aims to remove dark and uncomfortable impulses instead of approaching, understanding and working to feel less afraid of it.

2.5.2 Challenges to the premises of addictionology

A second group of theorists asks whether excessive sex, that is, a behaviour, constitutes a "real" addiction, and whether this behaviour can be analogous to an alcohol or drug addiction? Originally addiction was defined by the criterion of physical dependence on a substance (Hagedorn & Juhnke, 2005). Hulbert (1995, in Hagedorn & Juhnke, 2005: 70) asserts that "sex is a form of interaction, not a substance on which the body comes to depend". Supporting this argument, Levin and Troiden (1988: 357) claim that although sexual experiences "may be 'mood altering,' abrupt withdrawal from sexual behaviour does not lead to forms of physiological distress such as diarrhoea, delirium, convulsions, or death".

Lastly, Klein (2002:1) offers what he sees as the false assumptions of the sex addiction model. He claims it assumes that:

- Sex and sexual desire are dangerous
- There is one 'best' way to express your sexuality
- Relationship sex that enhances 'intimacy' is best
- Imagination has no healthy role in sexuality
- People need to be told what kinds of sex are wrong/bad
- If you feel out of control you *are* out of control
- Laws and norms define sexual health.

2.5.3 Compulsive sexuality as an intimacy disorder in contemporary society

Numerous writers contextualise compulsive sexuality as an intimacy disorder (Adams and Robinson, 2001; Schwartz and Southern, 1999).

Functional intimacy

Kaplan and Sadock (2003) maintain that so-called normal functions of sexual behaviour assist in bonding and create mutual pleasure in co-operation with a partner. A person able to give and receive love with a minimum of fear and conflict has the capacity to develop genuine intimate relationships with others, in which each individual strives for the growth and happiness of the other. Sex frequently acts as a catalyst in forming and maintaining

intimate relationships. Solomon (1989) refers to intimacy within a relationship as the ability to feel free to be vulnerable with one's partner and not have to pretend that one is 'invincible'.

May (in Kaplan & Sadock, 2003: 699) describes the value of sexual love as an "expansion of self-awareness, the experience of tenderness, an increase of self-affirmation and pride, and sometimes, at the moment of orgasm, loss of feeling of separateness".

Difficulties with intimacy

It is claimed that non-intimate sexual behaviour within multiple relationships or one-off intimate encounters with strangers, leaving little if any emotional satisfaction, seems to be prevalent in contemporary society and that it seems increasingly difficult for people to enter into and maintain loving relationships (Solomon, 1989). However, the aetiology and manifestations of this problem is multi-determined and multi-faceted. Those who experience this form of sexual contact as ultimately isolating, lonely and empty are presenting in therapy with a variety of problems that can be broadly defined as 'intimacy problems'.

When intra-psychic conflict interferes with engaging with another to the extent that intimacy becomes fraught and unattainable, sexual contact moves into dysfunction. This kind of sexual contact may or may not become part of a pattern of sexual addiction, but can be a defining feature of the kind of hypersexuality. The functional intimacy described above is usually lacking in the sex addicts' sexual experience. The felt experience of the sex addict describes a one-sided sexual engaging and seeing the 'other' in the sexual encounter as purely there for sexual gratification.

Schwartz and Southern (1999: 168) assert: "Availability of self-soothing and self-efficacy determines behavioural manifestations of balancing degrees of closeness and distance. When this balance is dysfunctional, rather than adaptive, intimacy disorders are present". Referring to sex addiction, Adams and Robinson (2001: 23) assert: "Central to this

disorder is the inability of the individual to adequately bond and attach in intimate relationships". In support of this, Leedes (2001) claims that 95% of sex addicts are unable to form close attachments.

Intimacy disorder in an age of narcissism

The concept of sex addiction has emerged from today's particular social and emotional climate. Ellison (2001: 6) refers to contemporary times as "a period marked by profound crisis of sexuality [in which] highly commodified and commercialised images of the body, pervasive patterns of abuse of women, children and marginalised men, a booming pornography industry, an international sex tourism industry, HIV/Aids, and high rates of divorce, teen pregnancy, and sexual illiteracy" are seen. He refers to the beginning of the 21st century as a time of cultural transformation in which social relations, the reordering of power relations between men and women, and the crisis in sexuality, are being structured at every level – not only the economic and political, but also the personal and familial.

Solomon (1989:3) refers to the current 'Culture of Narcissism' as a forerunner of an age of isolation, in which loneliness and emptiness seem pervasive for many. People approach relationships focusing on finding another who will fulfill their needs and wishes, the concept of obligation to others either denied or distorted. Some expect fragile relationships that break easily, and this is accompanied by a cultural injunction to be independent in functioning, without emotional reliance on others. This approach is "flawed by narcissistic expectations" the result being "an inability to invest freely in deep feelings for others" (1989: 4). In the words of a patient of psychoanalyst Otto Kernberg: "The ideal relationship to me would be a two-month relationship. That way there'd be no commitment" (in Solomon, 1989: 4).

Cultural messages can confirm a self-centered approach to living, relationships and sexuality. "People with narcissistic personalities are elevated to positions of eminence and power and idealised celebrities are 'required' to act in ways that reinforce a fantasy of narcissistic success, reflecting our collective wish to be vastly admired uncritically and

without reservation" (Solomon, 1989: 11). Cultural injunctions that emphasize taking care of oneself first and a belief that relationships that have problems should be discarded in the hope of a more 'perfect' love, have had a detrimental impact in that they set people up for inappropriate expectations, and keep people from engaging with the emotional work required for fulfilling intimacy. These cultural myths promote the idea that we must be responsible for ourselves first, that independence is to be strived for and that any dependence is equated with weakness and immaturity. This keeps individuals locked into an emotional regime that leaves them terrified to express vulnerability, resulting in loneliness and isolation within relationships.

The result is that many people who do not have a diagnosed psychiatric disorder but who are relating in culturally reinforced ways of behaving seem to have feelings similar to those with narcissistic pathology. "They feel cut off, empty, drained and unable to develop satisfying relationships with others, while desperately wishing to have someone with whom they can be close" (Solomon, 1989: 11).

Solomon (1989) asserts that intimacy is also hampered in relationships where there is early emotional damage. When both partners have been damaged, both participate in a mutually defensive collusion, leaving each unaware of each others needs and fears and therefore unable to respond empathically and supportively to each other.

In sum, there are numerous ways of conceptualising compulsive sexuality. Shaffer (1997, in Carnes, Murray & Charpentier, 2004) describes the addiction field as reflecting an emerging field of science characterised by "conceptual confusion and blurring of issues" (1997: 34). Carnes, et al (2004) conclude that a range of excessive behaviour understood as addictive disorders share similar features, causes and even cures and that it is the compulsive, relapsing behaviour that is emphasized, rather than tolerance and physical dependence. For Csikszentmihalyi (1990: 62, in Carnes, et al (2004), "almost any activity can become addictive in the sense that instead of it becoming a conscious choice, it becomes a necessity that interferes with other activities ... [we become] ... captive of a certain kind of order".

2.6 Aetiological theories

There are diverse views on the aetiology of 'non-normative' excessive sexual behaviour. Bancroft and Zoran (2004: 226) maintain that literature on sexual compulsivity and sexual addiction has been preoccupied with issues of definition, and little attention has been paid to causal explanations as to why, in such cases, sexual behavior becomes problematic. While there has been a proliferation of *description* of the behavior, less has been written and understood about what predisposes a person to a sexual addiction.

The diverse views include biological and pharmacological theories, deviance theories, the addiction model and the psychodynamic perspective. Although theories conceptualise aetiology differently, most agree on the functions the behaviour serves. Theories cohere on themes of affect control and regulation, and compensation for inadequate psychic structures or internal resources (Adams & Robinson, 2002; Money, 1984; Schwartz & Southern, 1999).

2.6.1 Biological and pharmacological perspectives

These theories focus on the physiological responses experienced and observed during the active phase of the addiction.

Milkman and Sunderworth (1987:166) divide addiction into three categories:

- Satiation: Alcohol, benzodiazepines, opiates and food.
- Arousal: Cocaine, amphetamines, gambling.
- Fantasy: Psychedelic drugs, workaholism, compulsive religious practice.

Satiation is associated with the neurotransmitters gaba-amino butyric acid (GABA) and endorphins; arousal with norepinephrine and dopamine; and fantasy with serotonin. Sex can fit into any of these categories, making it a very powerful mood-altering activity. "Sex addiction, however, is primarily an arousal activity, as satiation and sedation occurs only at the very end of what might be hours of arousal" (Ibid, 1987: 166).

A biological study links the behaviour of sex addicts to high levels of anxiety and depression and other psychiatric disorders such as obsessive-compulsiveness. Bancroft and Zoran (2004: 230) found "high co-morbidity with psychiatric conditions, most notably histories of substance abuse disorders (64%), anxiety disorders (50%) and mood disorders (39%)". The assumption was that a key factor motivating the sexual encounters was anxiety reduction or mood improvement.

Bancroft and Zoran claim further that 45% of research subjects tended to dissociate during the sexual encounter itself. They postulate that this tendency could help establish out-of-control patterns of sexual behaviour, "reducing the self-regulating component that would be expected in most people" (2004: 231).

A paradoxical relationship between mood and sex is seen by Bancroft and Zoran (2004) who claim that the majority of people stay away from sexual contact when depressed or anxious. They explain the link between seeking sex in an addictive way with high levels of co-existing anxiety or depression by suggesting that during childhood or early adolescence, early experiences which combine sexual response with negative mood is later generalised to the adult sexual encounter.

2.6.2 Psychodynamic perspectives

In this perspective, excessive or addictive sexual behaviour is seen "as necessary psychological props for the short-term management of inner distress" (Milkman & Sunderworth, 1987: 196). In this framework the problem is understood in terms of developmental structural issues and draws on depth understandings. Positions discussed below include drive theory, trauma theory, ego psychology, attachment theory, object relations theory, self psychology theory and Jungian theory.

Drive theory sees any psychic conflict as arising out of the conflict between the unconscious drives of the mind. It conceptualises hypersexuality as "libidinal energy that finds no outlet in genital activity" (Giugliano, 2003: 279). Compulsions are seen as automatic but inappropriate attempts to find an outlet for infantile instinctual tensions.

The ego carries out the actions without conscious understanding of its meaning. Sex addiction may be seen as arising out of the pre-oedipal level of development, with "the repeated sexual conquests serving as temporary reassurance against the inadequacy and hopelessness of ever being able to obtain the love of the longed for mother" (2003:280).

Trauma theory exponents note that high frequencies of sexually compulsive adults are found to have been sexually victimised as children (Schwartz, Galpferin & Masters, 1995, in Guiuano, 2003: 277). They view sex addiction as an aspect of post-traumatic stress disorder and dissociative disorders and maintain that "addictive substances and behaviours later become a means to cope with depersonalisation, numbness, emptiness and physical and emotional analgesia" (2003: 277). Coleman (1986, in Bancroft & Zoran, 2004: 232) postulates that a predisposition to use substances or behaviours to alleviate emotional pain may reflect an 'intimacy dysfunction' that could result from child sexual abuse or neglect.

As noted, dissociation can occur at the time of the sexual encounter (Bancroft & Zoran, 2004) and chronic dissociation has been found a common feature of post-traumatic experience. Sensation seeking to provide relief from inner emptiness arising from the dissociated state ensues. Blum (1973, in Giugliano, 2003: 277) and Coen, (1996, in Giugliano, 2003) maintain that the repeated sexual encounter is an attempt to recapitulate the child's original lesson that sex, love and closeness are fused, and that the only way to attain closeness is through sex. Further, repetitive re-enactments of the original trauma are relived in attempts to control what once felt out-of-control and so an addictive cycle is begun through trauma coding (Schwartz, et al, 1995 in Giugliano, 2003: 278).

Ego psychology highlights the adaptive capacity of a dependency on an external drug or behaviour for the individual. These theorists point out that the external addictive substance or behaviour serves to compensate for the ego deficits and regulate painful affective states of the individual. "These individuals will turn to an external source whose pharmacological properties serve to regulate the affect in a way that their psychic

structure cannot" (Graham & Glickauf-Hughes, 1992 in Giugliano, 2003: 280). This has become known as self-medicating.

Attachment theory posits that the early relationship with the primary caregiver has a powerful influence on the child's later way of relating by emotionally and biologically grounding a "working model of self and attachment figure in relationship with each other" within the central nervous system (Bowlby, 1988: 120). Later attachment theorists developed the central idea of the child's first relationship producing a template that serves as a basis for and moulds the individual's capacities to enter into all emotional relationships (Schwartz & Southern, 1999). They emphasise the attunement of mother to child which influences the neurological structure of the brain, claiming that the affective experience between mother and child 'hard-wires' the brain and that the consequences of mis-attunement is structurally written into the personality. Schore (1994, in Schwartz & Southern, 1999) stresses that the *affective*, not the cognitive, exchange in the relationship is the crucial element in this process. Emotions, not events, are remembered, internalised and later acted out.

Money (1986, in Schwartz & Southern, 1999: 166) pioneered the study of affectional systems and contributes to the field of sexual difficulties through his concept of 'vandalised love maps' and their relationship to the affectional system. He defines 'love maps' as "personalised, developmental representations or templates in the mind and in the brain that depict an idealised lover and the idealised program of sexuoerotic activity with the lover as projected in imagery and ideation or actually engaged with that lover".

Early affective experiences impact on the individual's basic integration of self-functions and self-structure and the capacity to bond. Central to this capacity is self-empathy and the capacity for self-care. When caretakers are abandoning or rejecting a caring relationship with self or others cannot be internalised. Negative core schemas or beliefs about self develop. When emerging sexuality is violated in some way, or is fused with traumatic, abusive or neglectful events or environments, the 'love map' becomes vandalised. Because the 'love map' organises relational choices, individuals choose to

interact later in life with people who fit their existing core schemata, replicating core beliefs about self and other that were learnt in their early years. Relationships not fitting that schema are avoided or devalued.

Adams and Robinson (2001) assert that with early caretaking failures, the resulting feelings are loneliness, sadness, anger, fear and shame. "While guilt – 'I have done bad things' – is present, shame (I am bad and unworthy) is the primary feeling that the addict is trying to medicate, rework and compensate for" (Adams & Robinson, 2001: 26). Shame, asserts Money (1986, in Adams & Robinson, 2001:26), "has become merged with arousal in the template or love map" The child is not able to self-soothe and strong affects cannot be regulated. Later, orgasm and other sexual functions provide the means to self-soothe. The discharging and regulating of these feelings motivates the compulsive behaviour. A new layer of shame and distress gets laid down after sexual release and the addictive cycle is entrenched. These feelings underlie the sexual acting out which constitutes a way of re-working earlier biography (Adams & Robinson, 2001; Bergner & Bridges, 2002; Coleman, 1991; Money, 1984; Schwartz & Southern, 1999). The symptomatology ultimately provides a powerful avenue for understanding the original trauma.

Addictive behaviour develops as a way of coping with emotions that have been split off and become unconscious. The sexual acting out reduces tension and defends against the "myriad of dysphoric emotions and lack of internal self-cohesion" (Schwartz & Southern, 1999: 171). Money (1984, in Bergner & Bridges, 2002) and Stoller, (1975, in Bergner & Bridges, 2002) refer to the "preferred sexual scenario where the sexual acting out represents a fantasised world in which early degradations and humiliations can be overcome and whereby a 'personal accreditation' or validation can be achieved". Bergner and Bridges (2002) stress that this fantasised validation, combined with the erotic satisfaction inherent in sexuality, makes for the powerful cocktail seen in sex addiction.

Object Relations holds that sexual addiction can be understood as a failure to achieve 'self' and 'other' object differentiation (Giugliano, 2003: 281). "Without stable

memories and images that are necessary for internal regulation of self-esteem and tolerance of being alone, the individual is left vulnerable to unmanageable depression and intense anxiety when solitary" (2003: 281). Sex is used as a vehicle to establish contact, albeit transient, with another who will meet narcissistic needs and stabilise the individual's internal world.

Parker and Guest (2003: 14) maintain that sex addiction, or the use of any addictive behaviour as the primary method of mood regulation is the result of "the failure to achieve object constancy". As defined by Mahler (1972) this involves the ability to call up the primary love object and use it to self-soothe. The authors assert that developmental deficits occurring specifically in what Mahler (1972) called the autistic phase have bearing on the later development of a sex addiction.

In referring to those showing dysfunctional sexual behaviour, Khan (as cited in Giugliano, 2003) stated that 'perverts' treat human objects as things, as transitional objects to be used, idolised, dirtied, then discarded. He describes "the seeking of an incomplete object/sex partner as similar to a drug fix, used to escape pain, rage, depression or paralysing apathy" (Ibid, 2003: 281). The addict actualises his needs but is unable to involve himself in the sex partner as they are not seen as a 'whole object' as defined by Klein (1986).

Self psychology views sexual addiction as "repeated and unsuccessful attempts at remedying central deficits in an uncohesive psychic structure (Giugliano, 2003: 282)". Kohut (1971) has written mainly on alcohol and drug addiction but his ideas are directly relevant to that of sex addiction. While he maintains that not all addicts have narcissistic personality disorders, he sees narcissistic disturbances as central to the psychopathology of the addict. The core difficulty of those struggling with narcissistic disturbances is the absence of internal structure.

Birchard (2004) agrees that narcissistic damage arising from impairment in formation of the self is the core issue behind all forms of addiction. Kernberg (1986, in Birchard,

2004: 83) describes the clinical picture as "a need for admiration, a tendency towards grandiosity, and/or grandiose fantasies, and at the same time, a tendency to feel inferior". Such people experience boredom, emptiness, and a striving for brilliant achievement. They tend to lack empathy, to experience chronic uncertainty, and dissatisfaction with the self.

Stolorow and Lachman (1980) explain that those who have not had experience of sustained mirroring have not had the reflecting experience of confirming that they exist. A chronic feeling of emptiness or terror is the result. Two different affective states are then implicated, one of 'depletion' and the other of 'fragmentation'. The sex addict uses sex to compensate for deficits in the self's capacity for tension-regulation, self-soothing and self-esteem regulation, as well as the fear of regressive fragmentation. The repetitive activity is about an "impelling need to restore or maintain the intactness of self" and ward off "disintegration anxiety" (Stolorow & Lachman, 1980 in Giugliano, 2003: 283).

Kohut (1977, in Flores, 1988) explains that the narcissistically disturbed individual yearns for praise and approval and/or for a merger with an idealised supportive other because he cannot sufficiently supply himself with self-approval or with a sense of his own inner resources. "The pervert is driven to sexual enactments with figures or symbols that give him the feeling of being wanted, alive, real or powerful" (1988: 143). He describes the addict as craving the drug because the drug seems to him to be capable of curing the central defect in his self. It becomes the substitute for a self-object that failed him traumatically at a time when he should have had the feeling of omnipotently controlling its responses in accordance with his needs as if it were a part of himself. "By ingesting the 'drug' he symbolically compels the mirroring self-object to soothe him, to accept him" (Flores, 1988: 144).

Wolf (1988) posits that a chronically faulty 'selfobject' environment leads to the developmental failures seen in these specific constellations of damage, rather than single traumatic events. He refers to characteristic types of self pathology that stand out and his discussion on the 'understimulated self' is relevant to sexual addiction. He describes this

self pathology in the following way: "Prolonged lack of stimulating responsiveness from the selfobjects of childhood creates this constellation where a person will lack vitality and experience themselves as boring. In order to ward off painful feelings of deadness, they need to create a pseudo-excitement by the use of any available stimulus" (1988: 71).

Intense need combined with expectation of rebuff causes deep shame. Demands may alternate with total suppression of them. "Demands are not derived from the normal, healthy self-assertive narcissism of childhood, but from the fragments of archaic selfobject needs or from the defences against them" (Wolf, 1988: 74). Examples include deviant sexuality, drug and alcohol abuse and frenzied lifestyles. In a damaged self, Wolf maintains, "the joy provided by healthy functioning of the total self is unavailable [and the] ubiquitous empty depression is kept at bay by creating pleasurably stimulating sensations in parts of the body or mind" (1988: 72).

For Solomon (Ibid, 1989: 76) early empathic failure and lack of mirroring results in narcissistic damage that follows an individual into adult life thereby hampering intimacy in relationships. When both partners have been damaged, both participate in a mutually defensive collusion, leaving each unaware of each others needs and fears and therefore unable to respond empathically to each other. The sex addict then looks outside the relationship for what he needs. This is the pattern: the act of 'falling in love' and the emotions evoked "recreate a fantasy of blissful merger of two selves" (Ibid, 1989: 76). This is probably a "wish to return to the pleasures, the safety, the comfort of dependency, or to reenact what was missing in order to find a corrective emotional response reparative of early damaged relationships".

While the heightened emotions for a sex addict are not about the feeling of falling in love, these unconscious dynamics could play a partial role in the relentless pursuit of 'connection'. Solomon adds that "the narcissistic dilemma lies in the paradox of intimacy" (1989: 77). While immersion into an intimate relationship means allowing one's sense of self to merge or fuse with another, an individual for whom early merger

was disappointing, fragmenting or threatening in a variety of ways, develops defensive patterns to ward off that merger. These include splitting and projective identification.

In splitting, love and rage, good and bad become polarised. Much energy goes into keeping these feelings from coming into conscious awareness and finding places to lodge them safely. Projective identification, states Solomon, (1989: 87) is "designed to protect against overwhelming affect", resulting in a need to exert active control over the other in order to avoid feeling danger or hopelessness. Unacceptable negative emotions and affects are projected onto the other, "but then those dangerous and destructive feelings residing in the other are perceived to be in a position to be thrown back in a hostile attack" (1989: 88). This points in part to the experience of the sex addict: the intimate partner is no longer safe and 'safety' must be sought elsewhere.

Jungian theory maintains that the process of projection plays a crucial role in the development of an addiction. For Hollis (1996: 90) an experience or feeling, usually primal, forbidden, terrifying or traumatic remains unassimilated and buried and unowned. What cannot be borne consciously is projected onto a person, a substance, or behaviour. "All addictions are in fact anxiety management techniques [and] the addictive patterns defend against angst whether we know it or not" (1996: 90). As the angst mounts, repetitive behaviour that allows for some kind of 'connection' is indulged in. The anxiety is temporarily held at bay, but the effects are momentary and so the behaviour must be repeated as soon as the material evoking the anxiety is activated again.

In conclusion, some writers' assertion that sex addiction is not about sex, supports the notion that narcissistic damage underlies the experience of sex addicts (Levin, 1999; Ferree, 2001). Levin maintains that what makes sexually addictive behaviour an addiction is "the compulsive use of sex to meeting unconscious emotional needs, primarily for reassurance about one's attractiveness in the face of underlying feelings of worthlessness, to express aggression and dominance; to feel powerful and to maintain or bolster a tenuous sense of self-esteem" (Ibid, 1999: 30).

The aetiology of behaviour commonly called sex addiction is seen in so many different clinical scenarios, it would appear that the root of the behaviour is multi-determined. As such, aetiological factors need to be considered individually for individual clients. According to Schwartz (2004:1) the range of aetiological possibilities in the field is "too vast and complex to integrate reasonably as of yet".

2.7 Treatment

2.7.1 Sex addiction and treatment

Different conceptualisations determine different treatment goals, different treatment and different expectations (Giugliano, 2003). The treatment approaches most comprehensively written about are the addiction model, which includes a cognitive-behavioural perspective, and the psychodynamic model. The addiction model relies heavily on groupwork methodology and self-help structures such as Sex Addicts Anonymous (SAA) for its treatment mode. Treatment using the psychodynamic perspective is more individualised and occurs within the framework of long-term individual psychotherapy. Structural and personality deficits are seen as the site of work. There is a tendency for addiction specialists and psychodynamic therapists to polarise treatment issues and adhere in a purist way to their model. Some practitioners, however, adopt a more eclectic approach.

Within the broader framework of those perspectives it must be remembered that "behaviours that appear similar may have different meanings in different people and therefore may be prompted by different motives and aetiologies and represent varying psychological purposes" (Giugliano, 2003: 275). In this respect Schneider (2004) cautions that before a treatment plan is devised and a diagnosis of sex addiction is made, an explanation for the excessive or inappropriate sexual behaviour presenting must be formulated. It is not always due to sex addiction.

2.7.2 Differential diagnosis

While diagnostic classification was discussed earlier, a differential diagnosis needs to be made in determining whether a sex addiction exists or not. Finlayson et al (2001) propose the following process of differentiating a diagnosis:

- Rule out general medical disorders known to be associated with problematic hypersexuality.
- If behaviour persists after resolution or stabilisation of the medical condition, the next step would be to ascertain whether the behaviour was due to the effect of a substance, medication or a toxin.
- If the behaviour persists beyond the removal of the substance, the possibility of an independent bi-polar or psychotic disorder needs to be investigated.
- If there is no evidence of that level of disorder, the last level of investigation would involve Axis II disorders.

Finlayson, et al (2001: 249) make the point that accurately differentiating personality disorder from problematic hypersexuality will "require considerable knowledge, training, and particularly, clinical experience".

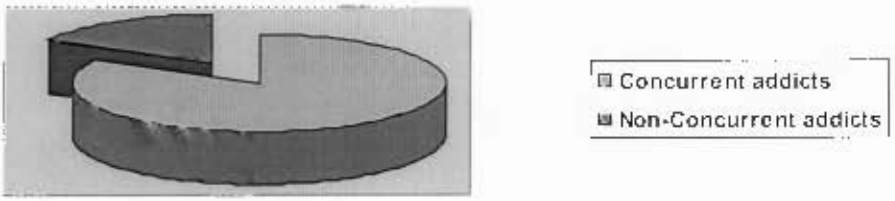
Diagnosis is complicated by two further factors: first, already discussed, is that the psychiatric classification of this behaviour is still under debate and does not stipulate clear, agreed-upon diagnostic criteria; second, that sex addiction often underlies other addictions or psychiatric disorders and may go undetected.

2.7.3 Sex addiction may be hidden

Sex addiction is rarely offered as the presenting problem (Schneider, 2004; Weiss, 2004) as many patients do not bring this area of concern to the therapists' rooms, due to shame or focus on another addiction (Orford, 1985: 94; Schneider, in Coombs, 2004: 8). Eisenstein states that these behaviour patterns were rarely described to clinicians unless the behaviour was known and objected to by the marital partner who insisted on help being sought (Orford, 1985; Hagedorn & Juhnke, 2005).

Co-existing addictions are common as are dual diagnoses (i.e. other co-existing psychiatric disorders). In a survey of 289 patients admitted for treatment for sexual addiction, fewer than 17% reported that sex was their only addiction. This is illustrated below in Figure 1, while Table 2 illustrates the breakdown of the kind of co-existing addictions for the sample.

Figure 1. Concurrent and non-concurrent addictions



(Statistics derived from studies done by Carnes, 1991, in Schneider, 2004: 200)

TABLE 2: Nature of concurrent addictions reported by in-patient sex addicts

Addiction	Percentage
Chemical dependency	42%
Eating disorder	38%
Compulsive working	28%
Compulsive spending	26%
Compulsive gambling	5%

Studies such as these, and others that confirm these findings, suggest that the presence of concurrent drug and sexual dependence, relapse or failure to treat one of the addictions, is likely to lead to relapse to the other addiction (Schneider 2004; Schneider & Irons, 2001).

2.8 Models of treatment

2.8.1 Psychopharmacological approach

Pharmacology is seen to be an effective tool in the treatment of sex addiction. Selective Serotonin Reuptake Blockers (SSRIs) as an adjunct to therapy may facilitate a decrease in the "mind-boggling frequency and often dangerous or dramatic nature of the sexual enactments" engaged in by this client population (Myers, 1995: 480). He claims that the literature is "replete with testimonies as to the efficacy of these medications in the treatment of this disorder" (1995: 480) He points to its important effects in both reducing sexual desire and ameliorating mood, but cautions that the introduction of sexually inhibiting medications may give rise to fantasies about the therapist being punitive, controlling and an indication that the patient's sexual excesses are bad. The patient may also confer a form of magical power onto the therapist, perceiving him/her as able to "regulate the perceived out-of-control aspects of the self" (1995: 480). This may lead to feelings of love and awe for the therapist but also anger around loss of autonomy and a surrender of a sense of self to the therapist. Given the ambivalence that dependency on another evokes in this client population, the wished-for yet feared feelings may lead to temporary intensification of symptoms, despite any chemical effects of the medication taken.

2.8.2 Addiction model approach

Addiction specialists maintain that despite the controversy around labels and definition, the concept of addiction is useful for treating and managing the presenting problem (Carnes, 1991; Carnes & Adams, 2002 in Birchard 2004; 45; Schneider and Irons, 2001).

This model claim is particularly useful when clients have not been able to stop acting out despite insight-oriented treatment; when the behaviour is so risky that stopping the behaviour is a top priority (for example risk of HIV or exploitation of a vulnerable younger person is occurring); immediate risk of job loss is pending; illegal behaviour that runs the risk of arrest is continuing; risk of losing the primary relationship is imminent; and relapse of a chemical dependency is happening or imminent (Schneider, 2004).

The addiction treatment model for sex addicts (Carnes, 2004) delineates a three-phase treatment plan:

- **Intervention in the cyclic compulsive process.** This involves education, referral to 12-step programs and confrontation of denial. The primary goal of treatment is ending the sexual acting out.
- **Attendance at 12-step programmes**. Completion of step one of the programme; preparation of a written abstinence statement; a relapse prevention plan; abstinence period; and sex sobriety plan. As with other addictions, cognitive distortions that support inappropriate sexual behaviour must be probed for. These include "denial, entitlement, negotiable boundaries, minimisation and narcissism" (2004: 229). Clearly there is a strong emphasis in this perspective on tasks and cognitive-behavioural work.
- **Understanding underlying development issues and family of origin issues**.

Assessment for multiple addictions; involvement of family and partner; group therapy and shame reduction all form part of this phase of treatment. Work with the sex addict and his/her partner will need to challenge traditional modes of family therapy or couple counselling. Because the addict is battling with intra-psychic issues within the partnership as opposed to interpersonal issues, the addiction will have to be seen as the 'primary patient' as opposed to the 'partnership', which becomes secondary. A commitment needs to be made to deal with the addiction first (Schneider, 1989). Carnes (1986, in Sprenkle, 1987: 14) points out that the only common denominator to patients suffering relapses was the lack of family participation. The addiction model therefore sees this component as a crucial part of treatment.

Schneider maintains that a vital element in the assessment is the **obtaining of an in-depth sexual history.** Grappling with the concepts of healthy versus addictive sexuality would be part of this process and is an example of cognitive reframing. Schneider (2004: 203) proposes some examples of healthy as opposed to addictive sexuality:

Addictive sexuality		**Healthy sexuality**
Is illicit, exploitative	vs.	Has no victims
Uses conquest or power	vs.	Is mutual and intimate
Is seductive	vs.	Takes responsibility for one's needs
Requires double life	vs.	Integrates authentic parts of self
Is grim and joyless	vs.	Is fun and playful
Re-enacts childhood abuse	vs.	Cultivates sense of being adult
Disconnects one from oneself	vs.	Furthers sense of self

Flores, also working within the addiction treatment model, asserts that some individuals are not able to endure the demands made by a close and intense individual therapy relationship and reports that this kind of therapy usually has little success with addicts (1988: 196). He advocates group therapy for this reason, citing the following advantages of groupwork:

- It diffuses the intensity of feelings which threaten to overwhelm the one-to-one setting. Feelings of severe hostility, fears of closeness and dependence, and ambivalence about relationships are not as directly threatened.
- The group can provide for a transitional object and facilitate the development of a more stable and adequate sense of object constancy as the 12-step group is constantly available and soothingly regular, as is a constant stream of supportive co-group members as well as chosen sponsors.
- The communal and mutual honouring of principles in the 12-step program provide for an experience where idealised self-objects can be found and relied on.

2.8.3 Psychodynamic model approach

An emphasis on developmental and structural deficits

Psychodynamic theory posits that treatment would need to involve revisiting original attachment and separation issues, a process that needs to be built into the treatment plan.

The primary therapy relationship becomes the site where these issues can be redressed (Valenti, 2002). Glaser (2000: 350) maintains that psychodynamic theories are "richer and more complex and perhaps give a better understanding of the character pathology that seems to underlie many sexual addictions". Valenti (2002) maintains that long-term psychotherapy facilitates the availability of a significant self-object who can satisfy the individuals need for nurturance, acceptance, containment and empathic understanding over a period of time. Without the consistent holding environment implicit in one-to-one therapy, sustained and true recovery is limited (Valenti, 2002).

2.8.4 An integrated approach

While some therapists work purely within the psychodynamic model, some recognise that in some circumstances referral to and attendance at a 12-step program is imperative. These theorists propose an integrated model, whereby they might cover the kind of assessments proposed by the cognitive-behaviouralists *and* pay special attention to developmental and structural deficits, personality factors and resulting characterological needs (Glaser, 2000; Parker & Guest 2003). They place strong emphasis on long-term dynamic psychotherapy in conjunction with these programs, as a way of sustaining long-term recovery (Valenti, 2002; Parker & Guest, 2004).

Included in the integrated approach is the technique of working with fantasy and behaviour. Leedes (2001) sees working with the sex addicts' fantasies as crucial. He maintains that for many diagnosed sex addicts, while sexual acting out might not be out of control, obsession with the object of sexual fantasy may be. He argues that the attachment object is closely related to the object of desire and the fantasy becomes a metaphoric surrogate for interpersonal relationships. For the sex addict, he explains, more comfort is derived from their fantasy than the comfort they experience with their partner. He goes on to say fantasies are ideal metaphors that are healing, soothing and create what Bowlby (1988) spoke of as a 'secure base'. Real partners on the other hand continue to disappoint (Leeds, 2001). Without understanding the nature of sex addicts' sexual desire,

and the purposes that the split-off objectified fantasies serve for them, attempts to control and reduce the power of the fantasies will prove useless.

2.8.5 Efficacy of intervention

Schneider's research found that sex addicts felt therapy was problematic and less helpful when insight-oriented therapy was focused on and the halting of self-destructive or illegal sexual behaviours was not prioritised (cited in Weiss, 2004). Another reported deficiency was when counsellors lacked information on the types of activities of the sex addict and their powerful impact. Therapists who tended to underestimate the effects and suggested willpower and simple decision-making as a way of decreasing the behaviours, were found to be insufficient in containing the problem. The last lack identified was that of failing to involve and make transparent the consequences for spouse, partner or others affected by the behaviour. When this occurred, there was no forum for dealing with the issues of trust, betrayal, decreased intimacy and other consequences (Schneider, 1989).

In conclusion, while addictionologists feel that abstinence around sexual acting out must first be established before long-term dynamic therapy is embarked on, for those individuals too vulnerable to adhere to such a behavioural regime, one-on-one safe 'holding' needs to occur first. This can facilitate the development of a cohesive psychic structure. Using the therapy relationship as a transition space, the client may be better able to utilise the cognitive-behavioural treatment offered by the addiction treatment model. It appears that given the complexity of this clinical problem, each treatment model has a significant role in the treatment process, and that awareness of both perspectives is needed for the therapist to offer the most comprehensive treatment plan. If a practitioner is not proficient within one perspective, referral to another practitioner to cover the aspect of treatment needed may be prudent, as opposed to adhering unilaterally to a favoured perspective. Treatment models should be determined by the individual needs of the client.

Myers (1995) recommends that the wisest approach embodies the best of all approaches and that psychotherapy is more likely to succeed with the help of psychopharmacologic agents. Given that sex addiction co-exists with other addictions and conditions such as

post-traumatic disorders, mood and anxiety disorders and personality disorders, it seems imperative that "comprehensive and sophisticated diagnostic assessment" is used when deciding on treatment (Leilblum, 1994: 535). Further, it appears prudent to draw on different treatment modalities as required, given the complex aetiology. Herring (2004: 38) asserts that although "this field was born and raised by the behavioural healthcare community, the concept of out-of-control sexual behaviour is too complex a form of human behaviour to exist within the province of any one paradigm".

2.9 Treatment challenges

Weiss (2004: 257) reports that practitioners need to be particularly alert to *boundary and counter transference* issues when working with this client population.

2.9.1 Boundary issues include limit testing of the therapeutic relationship, confronting sexual slips in the outside world and disclosure issues. Sex addicts may test the limits of the therapeutic frame in order to establish whether the limits set are emotionally safe. Whether or not the therapist upholds the limits determines the level of how containing the boundaries are. This may be in the form of coming late, introducing distracting material or skipping homework assignments. The therapist needs to monitor and confront this behaviour so that therapy can succeed. He or she may have to reframe comments made by clients that can be perceived of as seductive in ways that recognise and reflect the underlying issues.

Sexual slips can be seen as a return to sexual acting out and as a need for more support and accountability. The therapist can respond accordingly by setting up more containing structures, at the same time validating progress that has been made.

Disclosure involves two aspects of the treatment process (Corely & Schneider, 2002). The first is disclosure to the primary partner, if there is a partner, of infidelity and sexual indiscretions. This is a complex process, fraught with therapeutic complications. It demands firm, open, honest holding on the part of the therapist who needs to model

integrity and healthy ways of relating and working through concerns, such as trust and betrayal which are often paramount.

The second aspect, while also about reporting to partners, single or multiple, refers specifically to medical safety. A process needs to be set in place to ensure that those put at risk, due to the addict's unsafe sexual practices, are informed. This is particularly urgent if the client has been found to be HIV-positive. It is a delicate and highly charged matter as emotional, ethical and legal ramifications are being dealt with simultaneously by both therapist and client. Corely and Schneider (2002: 46) claim that "at this time, there is not a uniform legal standard regarding the therapists responsibility when clients are HIV-Positive". While this leaves the onus on individual practitioners to make decisions which can feel onerous, honesty and truthful disclosure have been found to be significant in the recovery both for the individual and for the couple, if there was a primary couple involved (Schneider, 2003). Confrontation and careful disclosure therefore, appears to be an essential component in the treatment process and not to be avoided.

2.9.2 Counter transference challenges

Counter transference challenges include working with a seductive clientele and therapists' attitudes and values towards sexuality. This client population feels more comfortable being seductive and manipulative to get attention than by being vulnerable or openly asking for validation and support. Physical and sexual seduction has been used to meet concealed dependency needs. Counter transference may involve feelings of attraction for the client. This is not unusual for therapists working with this clientele (Pope & Velasquez, 1998, in Herring, 2001; Weiss, 2004). As the clinical problem involves sexuality, it also evokes a host of reactions around the therapist's own values and attitudes to sexuality. Weiss goes on to say: "Not only in physical contact, but also in the more subtle emotional and verbal exchanges, the counselor needs to be aware of his or her own feelings, attitudes, and attractions towards the client, utilising that information to guide his or her words and actions" (2004: 257).

Therapists' values influence their conceptions of health and dysfunction with reference to sexual issues. Hecker et al (1995) point out that value judgments don't appear as strongly in any other area as they do in the area of sexual issues. This affects the treatment process in two areas. The first aspect refers to assessment and diagnosis. Hecker et al (1995) explored how therapists' value judgments and gender stereotypes influenced their perceptions of sexual pathology or health when asked to assess and diagnose clinical vignettes of sex addiction. Values about sex outside of marriage, gender stereotypes regarding sexual activities, sex and level of religiosity of the respondent, were categories found to have a clearly discernible influence in the assessment of whether sex addiction was present or not and how levels of pathology were decided upon.

The second aspect refers to how progress in therapy is evaluated. Hecker, et al (1995) claim that therapists' values often seem to hold more power than client's values. They cite Butler, et al (1983: 262) who found that when client and therapist values converge, the therapist is likely to rate the client as improving, despite other measurements such as a client's self-report or a standardised measure of symptom alleviation showing the contrary.

Herring (2001) has set out ethical guidelines that provide some parameters for the challenging ethical decisions not addressed by a professional code of conduct. He cautions that a counsellor's ethical behaviour is independent of whether it is legally acceptable or therapeutically effective. It is more about a counsellor maintaining rigorous standards of practice and thereby demonstrating a commitment to protect a client's autonomy and dignity. He cites the following core concepts of ethical practice: informed consent, competence, confidentiality, duty to warn/protect, maintaining appropriate boundaries, counsellor self-disclosure, touch, sexual attraction, recovery boundaries, clarity of values and supervision.

2.10 Summary

Extensive debate remains about the way sexual behaviour that may appear excessive and feels out-of-control for the client is defined and understood. Because of this controversy the classification, research, treatment and mutual consultation across disciplines dealing with the problem has been compromised. Further, it is a clinical problem that often remains hidden behind the presenting problem or another more apparent addiction or disorder. Sophisticated and comprehensive assessment is required to ascertain the precise aetiology and nature of the excessive sexual behaviour which is often determined by a wide range of inter-relating factors. These factors combine with current sociocultural notions of acceptable and 'normal' sexuality held by practitioners which are in turn determined by the practioners' unique background and value system. The perceptions, unique understandings and value systems of practitioners ultimately affect the treatment models chosen and the process of treatment itself.

Chapter Three – Methodology

3.1 Introduction

This chapter presents the research design and methodology used in this research. It covers the sampling method; data collection and analysis; ethics; reflexivity and limitations of the study.

3.2 Research design

Qualitative research

The research aim is to explore therapists' perceptions, understandings and constructions of the concept of sex addiction. As this requires in-depth 'thick' description and positions the experience of research participants as primary, the case study research design, which utilises in-depth interviews using an inductive qualitative approach, was chosen.

Qualitative research elicits participants' accounts of meaning, experiences or perceptions. Denzin and Lincoln (1994:2) argue that qualitative research attempts to "make sense of, or interpret, phenomena in terms of the meanings people bring to them". It produces descriptive data in the participant's own written or spoken words. Its task is to identify the participants' beliefs and values that underlie the phenomena. Research is therefore "involved with understanding rather than explaining and explores the subjective insider perspective" (Babbie & Mouton, 2001: 271).

While sex addiction is seen as an illness by the addictionology framework, some theorists grapple with the tension between that limited view and the position that the very notion of sex addiction is just a social construction, as elaborated in Chapter Two. This study is based on the premise that practitioners' perceptions, and the data collected, are made up of their subjective experience and clinical and psychodynamic understanding, which in turn is developed out of and in relation to the broader current socio-cultural context. It

will therefore also draw on social constructionist thinking, which holds that what we take as objective knowledge and truth is the result of our perspective.

Denzin and Lincoln (1994:125) articulate this as follows: "Knowledge and truth are created. We do not so much find or discover knowledge so much as construct or make it. We invent concepts, models, and schemes to make sense of experience and further, we continually modify these constructions in light of new experience." As the literature review showed, the history of the concept of sex addiction and the models used to understand the issue have changed over time and are influenced by current research, cultural context and wider contemporary social mores. Findings will therefore be seen within this context and perceptions interpreted within this framework.

Qualitative research allows a fluid interview process that enables issues to emerge which are salient to participants, but which might not have been predicted by the researcher. As the research is essentially explorative and inductive, the flexible qualitative approach is appropriate. Inductive research is particularly relevant in this study as it is investigating an area that has received little focus in this country. Further, issues of practice protocol are not necessarily transparent in therapeutic communities, and sexuality and sex addiction are areas not openly discussed. The complexity of practitioners' responses and 'the unspoken' can be more effectively explored with a qualitative approach.

3.3 Research Methodology

3.3.1 Sampling

A purposive and snow-balling process was used to choose the sample from a pool of Cape Town practitioners known to be working in the field. The researcher approached practitioners she knew from previous work in the addiction field. These practitioners then recommended others working with the problem and 10 clinicians working with sex addiction were identified. While more than 10 people were approached, the researcher was told by some potential respondents that they were inexperienced and did not know enough about the subject to be interviewed. Out of twelve identified practitioners, one

respondent could not participate due to time constraints, another was away during the research phase, and a third possible respondent was not prepared to be taped. As a result, nine available and suitably experienced respondents were interviewed. It also needs to be noted that as most practitioners interviewed acknowledged that they had not had extensive experience in this field, the minimum criterion for suitable experience comprised of experience with at least one client.

3.3.2 Data collection

The data collection instrument was a researcher designed semi-structured interview schedule. It included identifying practitioner details (see Appendix One). Constructed questions were based on key areas emerging in the literature and were devised bearing in mind the issues of intrusiveness and the sensitivity of the topic. In-depth interviews, conducted with participants to collect qualitative data and lasting between 60 and 90 minutes, were conducted at the practitioners' places of work for their convenience.

The researcher explained to respondents that she was exploring how practitioners working in the field of compulsive sexuality perceived and understood behaviour at times referred to as 'sex addiction.' The practitioners were informed that both theoretical and personal questions would be asked. The sessions were audio-taped with the participants' permission, which enabled accurate interview recording and freed the researcher to engage freely with the participant.

Respondents were informed that they were free to leave the interview at any point and prior to the interview they were given a chance to ask any questions pertaining to the research. Respondents were asked to sign a contract covering the above points before the interview began (see Appendix Two). During the interviews, respondents were given the opportunity to bring up related issues and points of interest they felt were relevant to the discussion. This is in keeping with the inductive and exploratory approach inherent in qualitative research. Appendix Three is a transcription of one of the nine interviews conducted.

3.3.3 Data analysis

In-depth interviewing is less about the content than the process by which the participant came to hold a set of perceptions and understandings (Babbie & Mouton, 2001). In qualitative research data analysis takes place through analytic induction (Collins, 1999), whereby tentative conclusions are drawn between variables observed. The researcher has some intuitive assumptions about the data which deepen as the text emerges. Kelly (1999) maintains that a central goal in interpretation is to discover regular patterns or themes. Thematic development is, Kelly suggests, a kind of pattern-finding process through which aspects of a situation are connected to other situations by virtue of their commonalities. A theme can exist both within and across the situation, and one cannot understand a situation before we look between situations – so the trans-situational character of themes is fundamental to understanding them. Central to the idea of pattern finding is the notion of repetition and "the search for 'repeatable regularities' is central to interpretive enquiry" (1999: 414). Kelly distinguishes between an already formulated interpretative framework and one in which themes can be extracted from within the context itself. In this case the context would refer to the interview transcript. To this end, audio-taped transcripts were transcribed verbatim and a qualitative thematic analysis carried out on the data.

An attempt was made to relate and link themes and categories that emerged through the text in terms of and in relation to the body of theory presented in Chapter Two. Kelly (1999) however, cautions that one should not only find what one is looking for. Bearing this in mind the researcher aimed to find middle ground between using themes derived from the literature (which determines the nature of questions asked) and remaining open to new themes emerging from the interviews. In this way, the research reflects Kelly's perspective on interpretative research which is "as much about asking and refining questions as it is about finding answers" (1999: 411).

The flexibility afforded by qualitative research was exercised in this study. For example, questions 12 to 14 in the semi-structured interview centered on values and attitudes. Early in the interviews many of the respondents indicated they were open to and comfortable

with what they were dealing with. A more important question then emerged which concerned their journey to that place of openness. As the interviews progressed, questions relating to that journey felt more relevant and were asked of respondents.

In the analysis phase Tesch's steps in managing and processing data were applied (De Vos, 2001: 343). These steps are:

- Read through all transcripts getting a sense of the whole; keep record of ideas.
- Select one interview and think about underlying meaning; keep record of thoughts.
- Make list of all ideas and columns of similar ideas that can be clustered together, be aware of unique topics and those that don't fit into categories.
- Return to data. Topics are converted into codes which are then used to delineate parts of text. Ascertain whether new categories and codes emerge.
- Topics are converted into categories. Interrelationships are shown between categories.
- Final decisions regarding codes are made.
- Information is assembled into one place and a preliminary analysis is done.
- Existing data is recoded if necessary.

The qualitative thematic analysis undertaken on the transcripts was informed predominantly by the social constructionist framework underpinning the research project, but where appropriate, a psychodynamic framework was used to understand practitioners' experience.

3.4 Ethics

De Vos (2001:25) poses some ethical issues for the researcher to consider. They are summarised below.

3.4.1 He cautions against research causing **harm to subjects or respondents**. This point does not apply to the respondents in the same way as it would if respondents were a 'patient' population. Care however was taken to be respectful and non-intrusive in exploring practitioners' personal experiences.

3.4.2 The issue of **confidentiality and anonymity** needed to be addressed at initial contact with each research participant. The researcher explained that the exposition of research findings would not jeopardise either their own or their client's confidentiality as they would not be biographically identified in any way. The researcher needed to bear in mind the ethical dilemma that if it transpired that professional boundaries between a therapist and his/her client were reported to have been transgressed, then such a disclosure would need to be held in confidence by the researcher.

3.4.3 Informed consent is important for ensuring an ethical and accountable research process. For this reason the research rationale was explained so participants could be fully informed before making a decision to participate. Questions that explored counter-transference issues might have evoked sensitivity on the part of the practitioner. The fact that an examination of counter-transference would be part of the interview was therefore fully disclosed in the initial contact stages. In this way, the researcher hoped to guard against potential privacy violation as the research explored the experience of both the therapists and their clients. A contract encapsulating all of the above concerns was signed with participants. It promised confidentiality, anonymity and enabled participants to leave the study at any time if they became uncomfortable.

3.4.4 Researchers need to ensure they are **competent in the research methods** chosen. This includes equipping oneself with adequate knowledge of the subject so that pertinent questions can be asked; skill in in-depth interviewing; attempted objectivity and restraint from making value judgments; accountable and unbiased analysis; and accurate data recording. Every attempt was made to ensure these aspects of the research were carried out.

3.4.5 Release of findings. Huysamen (1993, in De Vos, 2001: 33) maintains that "it is desirable to present the findings to subjects as a form of recognition and to maintain good relationships with the community concerned, for the future". Making the research report available in an "accurate, objective, clear, unambiguous manner, containing all essential information" is recommended (De Vos, 2001: 33). A copy of this research project will be

made available to all those interviewed without jeopardising anonymity and confidentiality.

3.5 Reflexivity. As the researcher interviewed practitioners from her own and allied professions, it was considered unlikely that power issues implicit when researching clients – that of 'researcher as expert' – would be there to the same degree. It was however possible that the participants might feel reluctance to share their expertise and/or their own theoretical uncertainties. The researcher needed to be aware of this possibility.

Furthermore, sexuality is a sensitive field, and sex addiction falls traditionally into the realm of sexual dysfunction. The researcher needed to be aware that the interview might impact on interviewees in unexpected ways as practitioners working within this field have been drawn to the field for a variety of reasons. Some questions asked participants to reflect on their attitudes and personal value system and touched on personal histories and experiences. For this reason it was important for the researcher to conduct the interviews with an attitude of open enquiry and non-judgmental interest. It was important to avoid any atmosphere of challenge and critique as this might have evoked defensiveness and distorted responses. Non-intrusiveness around personal struggles felt prudent.

The researcher needed to be aware at all times of her own attitudes to the area of non-intimate, out-of-control sexuality and be careful to avoid bias or prejudice that might flavour or compromise questions asked. Appropriate terminology needed to be strictly defined and adhered to by the researcher if practitioners' attitudes were to be clearly and accurately approbated.

The researcher is aware that her social and gender identity had implications and must impact on this research. Social and biographical markers, in part, determine attitudes and perceptions. As a middle-class white woman she has a specific intellectual, emotional and ideological position which has its inherent biases. All endeavors were made to approach

this research with these biases in mind, taking care to ward against their influence on interpretation or accurate recording of participants' responses.

3.6 Limitations

Qualitative research is challenged on many fronts. Denzin and Lincoln (1994: 4) maintain that positivists consider it to be "unscientific, only exploratory, entirely personal and full of bias" and adds that "empirical methods produced by the softer, interpretative methods are regarded as unreliable, impressionistic and not objective" (1994: 4).

While qualitative researchers have responded to these criticisms by seeking methods that allow them to record their own observations more accurately, the counter-attack on the positivist position from post-structuralists and post-modernists has contributed to the understanding that there is "no clear window into the inner life of an individual" (Denzin & Lincoln, 1994: 12). They go on to say: "Any gaze is filtered through the lenses of language, gender, social class, race and ethnicity. There are no objective observations, only observations situated in the worlds of the observer and the observed. Subjects, or individuals, are seldom able to give full explanations of their actions or intentions: all they offer are accounts, or stories, about what they did and why" (1994:12). Subjectivity then, is seen to be implicit in this kind of research and reflexivity is recognised to be crucial in combating problems that arise due to this.

As the focus is on the practitioner, any findings relating to clients' experiences will be reflected through the perceptual and attitudinal lens of the practitioners. This needs to be acknowledged when considering the experiences and responses of practitioners themselves.

An acknowledged limitation is the small sample size which compromises the study's external validity and ability to be generalised. The study findings therefore cannot be generalised across city in South Africa, culture, class or any other social identities and professional disciplines. In this study, clinicians chosen were selected only from the fields of mental health, addictionology and sexology, so limiting knowledge of how a

wider cross-section of disciplines are approaching the problem. Herring (2004) points out that many interest groups are involved in aspects of the destruction caused by those who cannot regulate their sexual impulses despite negative consequences. He cites, among others, the mental health fields; addiction medicine; sex therapists; sex education communities; medical and public health providers; sexual offender and victim specialists; the business community and the sex industry. "Each brings their own unique expertise, concerns and prejudices to the topic" (2004: 37).

However, it is not the aim of the study to be representative of all or even a particular group of practitioner's experiences. Rather, the study explores in depth some of the meanings that therapists make of the behaviour known as compulsive sexuality.

Another limitation is the length of interviews. It is felt that the complexity of the research problem could not be explored fully within the initial 60 minutes allotted. For five of the nine interviews, due either to the practitioner being available or heightened interest in the discussion, the interview continued for longer. This enabled the researcher to glean more of the personal experience of the respondent.

3.7 Summary

Chapter Three outlined the research design and methodology used in this study. The sampling method, data collection process, reflexivity and research ethics pertaining to this research were discussed. The next chapter will present an analysis of the data collected.

Chapter Four – Analysis of findings and discussion

4.1 Introduction

This chapter discusses the analysis of the data gathered in the interviews and processed using Tesch's eight steps as described in Chapter Three (De Vos, 2001: 343). The chapter describes respondents, who are not identified to avoid breach of confidentiality. Key themes are elaborated and quotes used to unpack meaning.

4.2 Profile of the sample

A total of nine participants – five women and four men – were included in the study (see Table 3). In terms of professional categories, there were four clinical social workers, one psychologist, one psychiatrist, one lay counselor, one marriage counselor, and one occupational therapist. Years in practice ranged from four to 26 years, with an average of 13.5 years. Work contexts included private practice (5) hospitals (3) and psychiatric clinics (2).

Table 3: Demographics of respondents

Professional qualification	Gender	Years in Practice	Work context
Doctor in clinical social work	Female	26	Private practice & psychiatric clinic
Clinical social worker	Female	23	Private practice
Clinical social worker	Male	7	Private practice
Psychologist (sex therapist)	Female	4	Psychiatric clinic
Clinical social worker	Male	13	Hospital social work services
Recoverer, lay counselor	Male	5	In-patient treatment facility
Marriage counselor	Female	13	Private practice
Psychiatrist; Jungian analyst	Male	25	Private practice
Occupational therapist	Female	6	In-patient treatment facility

4.3 Analysis and discussion of key themes

The analysis is structured within six key themes and sub-themes, some of which closely relate to the key research questions, while others are emergent themes and sub-themes. The six themes are: Perception; theoretical understandings; treatment issues; practitioner's subjective responses; knowledge and skills required for the field and social context and sex addiction. Emergent themes include ethical concerns, gender relations and the media. The theoretical lens used to analyse the data drew on psychodynamic and social constructionist understandings.

4.3.1. Perceptions

Sub-themes relate firstly to whether the clinical picture is an addiction, as defined earlier, or not. Secondly, if not an addiction, how can this behaviour be named.

4.3.1.1 Debating the 'addiction model'

Those working within an addiction model (three practitioners) found it easy to utilise the term addiction and conceptualise sex addiction within the traditional model of addiction, with sex constituting the drug of choice. The remaining four who had not adopted this model questioned whether compulsive sexual sex behaviour could be defined in that way. This spectrum of opinion reflects the diverse debates in the literature.

One respondent explained that the main argument against conceptualising the behaviour as an addiction is advanced by sexologists or those in close contact with their perspectives. The core argument here is that sex addiction is a sex negative and pathologising concept that disempowers both client and therapist, and therefore hampers and undermines movement towards change. A clinical psychologist who specialises in sex therapy put it like this:

> When I hear accounts of so-called sex addiction and that the behaviour is out of control that makes *me* feel helpless as a therapist; that I can't do anything about it; that it's a disease and I have no ability to work with it. So I don't know whether it

> doesn't make intuitive sense to me that sex can be an addiction or if it's about my own needs as a therapist to feel like I can do something, but I don't like that term.

However, one participant felt very strongly about the need to view sex addiction as an addiction precisely *because* of the client's powerlessness and lack of control in relation to sexuality. In arguing against the critical sexologist perspective, he insists that it is useful to adopt the term 'sex addiction' where clients exhibit a discourse of uncontrollable sexuality, as powerlessness is a central element in the addiction model:

> To a degree they feel the term is about demonising sexuality. They perceive it as a sex negative term. Their fundamental difficulty is that you then don't have control over your sexuality. They don't see that. They feel you have complete control and as such are responsible for how you utilise your sexuality therefore becoming more mature in your interaction with people and so on. For me it's clear, when a person 'uses' perpetually, despite negative consequences, they don't have control anymore, they're powerless.

In an emotional narrative, another respondent highlights that unmanageability is central in her definition of sex addiction:

> When it gets to the point where that person's life, where it becomes repeatedly chaotic and their lives become unmanageable in their relationships and within themselves, whether it's a secret or not, then to me it's something that is becoming compulsive, its something that they can't stop. For me it falls into the sphere of full-on addiction. It has all those characteristics. Its life threatening, it's progressive, people around that person display the symptoms as well, whether they know about it or not.
>
> When I talk about life threatening I mean emotional and spiritual. That person is so lost, so desperate, at getting that fix. That thought pattern is so pervasive that they're really not in the moment. There is *incredible* anxiety, *incredible* fear, and they start acting on *that*, it's really like demon-possession.

In summary, the three respondents adhering to the addictionology model feel comfortable with the concepts inherent in it and find it a 'user-friendly' model. The rest of the respondents, (four practitioners) who are aware of the addiction framework and utilise some of its ideas on a *conceptual* level, prefer to use more eclectic intervention models in *treatment.* Four of the practitioners adopt an eclectic range of conceptual and treatment

models as an organic response to the work itself, in order for intervention to be effective. These models include: addictionology, self-psychology, object relations, cognitive-behavioural theory, trauma theory, bio-neurological theory, psycho-education, social learning theory, motivational interviewing and transactional analysis. A sex-positive framework was cited as crucial in informing their understanding of the problem in a compassionate way for three of the practitioners.

4.3.1.2 Ambivalence about naming

Respondents reflected ambivalence relating to naming the behaviour, either in or outside the therapy situation. Controversy in the literature is echoed by the practitioner sample, with three feeling strongly about the importance of a definition of sexual addiction, and four arguing that this is a matter of semantics and adopting a pragmatic approach. One practitioner said she preferred to engage with the clients, leaving theoretical debates to academia:

> There are many concepts being thrown around, and I would marry the concepts. I'm very much an eclectic worker, and it's not that important to me to have an absolute clinical, definitive, 'it is'. The people in the field of theory can batter out how they want to name and define it. I read all of it and incorporate and use all of it and so, I haven't bought into either side – it's one of those phenomena in human sexuality which I think doesn't fit into a category in a neat and tidy way.

Three therapists were reluctant to call the behaviour an addiction. One psychodynamic oriented therapist separated out the naming of the behaviour for herself from how she defines it with the client. She maintained that while she saw the behavior as addiction, she felt the definition was not useful either to herself or the client:

> [Neither] me, nor the client has ever used the term. Its not like I've said there's a sex addiction here, it's more that we're talking about him ever only finding aliveness and satisfaction when he's masturbating to porn.

As this respondent described her work with the client as strictly psychodynamic, this stance shows a split between her conceptualisation which draws on the addiction model, while her treatment model uses a psychodynamic therapeutic approach. Although she

understands the behavior as addiction, she will not name it addiction, not does she feel the addiction treatment model is useful for treatment.

A different form of resistance to naming the behavior 'addiction' comes from the conviction that this will 'let people off the hook'. One respondent who works with what Carnes (2001) calls 'Level three' of the addiction, that is, those who have violated legal legislation, emphasised that while there may be an addictive component in the behaviour seen by people in this category, a distinction must be made between those who are addicted (have an illness) and those who violate the law. Her distinction appears to emerge out of concern that psychiatric definitions such as sex addiction may be utilised to ameliorate consequences for sex offenders:

> These are your sex offenders. When there is an interplay between criminality and addiction, I don't think we can talk about the kind of body of knowledge that goes with addiction – the step work, the self-help groups. If we think about it only as sex addiction, that's what will be offered as treatment. There are groups for sex addicts in the city and I know those groups are attracting paedophiles that are hiding behind the fact that there is an addiction, so there are no consequences to the criminal aspects. It is important for there not to be confusion and overlap. I need to make that distinction in the lens that I use and the way that I think about it and also in the way I intervene.

Two respondents pointed out that a distinction needs to be made between sex and love addiction which are frequently conflated. One respondent said the DSM IV criteria for Sexual Disorder Not Otherwise Specified confused the issue and had 'not sorted it out'. One of the respondents pointed out that sex addiction can be seen within a spectrum of other addictive behaviours, and that Axis 1 and Axis 2 diagnoses may be part of the clinical picture. While claiming that the clinical behaviour clearly showed addiction, despite these additional diagnostic factors, the reference to and emphasis of confounding diagnostic factors points to the confusion and complexity around naming.

Three practitioners, however, saw the behaviour as clearly definable as an addiction, conceptualised it within the dominant addiction model and felt strongly about the importance of naming:

> Absolutely, there's no doubt about it, sex addiction exists.
>
> I've thought about it long and hard, and I've had to nail my colours to the wall. I don't see it as compulsive behaviour. I think that's a cop-out for people in the field. I think its sex addiction and I think we should look at it as such. If I take the dynamics that are manifesting in someone with compulsive sexual behaviour, and I transplant them onto addiction, they are virtually a match. The criterion for addiction is applicable to the criterion of compulsive sexual disorder.

4.3.2 Theoretical understandings

All respondents derived their theoretical understanding of the aetiology of 'sex addiction' from a variety of sources. One respondent, who works with the behaviour at an addiction treatment centre, saw the behaviour exclusively within the addiction model, the model used in her place of work. Another one saw the behaviour as an addiction and drew on that model for conceptualising the behaviour, but in the main, she works outside of any theoretical framework, drawing rather on intuition, life experience and learning from self-confessed sex addicts in support groups. One Jungian analyst used insight gained from Jungian theory. One worked primarily within the psychoanalytic framework. Work context, specialised training and preferred mode of working determined these therapists' conceptual framework.

4.3.2.1 Diverse responses to understanding aetiology

Respondents pointed to a wide range of aetiological markers, some of which related to their dominant framework while others were developed in response to specific client needs. All respondents concurred on the highly complex, multi-determined aetiology of this behaviour. While a range of theories are clearly drawn on, as detailed below, there was also a strong sense that therapists found it difficult to provide neat aetiological interpretations. The following comments underline this:

> I think that's an extraordinarily complex question. And I do not believe anyone is going to have a definitive answer to that.

> The context of causality is far more complex than you think it is. I think it differs from person to person. I don't think there are standalone explanations.
>
> As far as aetiology goes, sex addiction is a bit more complex than drug addiction. Because sex is a biological need and is tied up with nurturing and all those type of things kids experience.

One participant locates the sociological dimensions of the addiction within a developmental framework. She expresses the idea that a range of social and cultural conditions facilitate the development of addictive behaviours, and that addiction helps us deal with developmental milestones in the absence of more constructive or facilitative social structures such as rites of passage:

> We have a way in the society that we live, to sexualise a lot of things, and that has to do with that we are a bunch of teenagers emotionally, that we are not grown up. But I think that the demise of the patriarchal society, and that there are no longer rites of passage, with all of that gone, and our communities being so broken and so nuclear, I think we've lost our ability to track our own emotional maturity. Because our mindset is so immature at first, and because we don't have those rites of passage, *we fall into addiction as a way of growing up,* as a way of getting to know ourselves very deeply and evolving spiritually.

Another respondent, drawing on learning theory, saw sex addiction as developing from how intimacy is learned in childhood:

> I would look at how sexuality and intimacy would have been coupled. Theoretically, this behaviour is a way of dealing with anxiety or some other kind of unmanageable emotion, so one would look at what happened to those emotions in childhood, what happened to the learning and how come those pairings were made.

In a similar mode, another comments:

> For one client it was modelling. He grew up knowing his father had multiple partners, cheated on his mother, his father very much sharing that value base with him, so a component of wanting to be like dad and internalising those values.

While the above quote reflects a social learning approach, self-psychology explains, in support of this idea, *how* a child would identify with and internalise that powerful selfobject's values (Elson, 1986). The psychological need to be affirmed and admired determines the merging with the power of an idealised figure and therefore identification takes place.

Other than the use of sociological dimensions as noted earlier, as well as social learning theory, the majority of explanations drew on psychodynamic theory. A broad range of depth theories featured strongly in participants' discussions of aetiology, with most of them utilising notions of early damage and trauma:

> A lot of it, I find, in my own personal reflection, has got to do with the mother. When the child wasn't nurtured enough from the mother and that nurturing relationship didn't manifest itself in a healthy way. The child develops a self-soothing capacity either by masturbating or romantic intrigue. For men it's the act of sex, for girls it's that Mills and Boon kind of obsession because they didn't learn to use another human being, or their mother, to soothe them and make them feel good about themselves.
>
> I'm learning that the more I work with people who are acting out sexually, it seems to go back to some form of very deep intimacy wound or question of their acceptability or their worth. I've heard it said that it's the mother wound.

Trauma theory is utilised by this respondent:

> A common thread does seem to be that a percentage of them eroticise any kind of trauma they have had. It's not necessarily a sexual trauma. Some escaped the realities of their lives as children, so a lot of time is invested in isolating, engaging in the masturbatory act, and also in fantasies of escape, where they re-create a world that's pleasurable, where they are in control, and I think a lot of the pathways are generated from there.

One respondent took an object-relations perspective with a focus on lack and damage in the early relationship with the mother:

> The early relationships are damaged to the extent that the person is unable to relate to people as whole objects, whole people, so he can only relate to parts. So

> if somebody is in that state, they're more in the first stage, which is more sort of a psychotic stage, not psychotic, more imaginary, more visualising, more disengaged, where there's no real relating.

In the above quote the practitioner is referring to Klein's description of the paranoid-schizoid position where primitive fantasies occupy the infant's internal world and external reality is not yet clearly seen for what it is and recognised as outside the psyche (Saltzberger -Wittenberg, 1970: 29).

The respondent goes on to say:

> The interpretations need to be around how much he wants, how little he has, how deprived he feels, how insignificant he feels. I do think all addictions are attempts at self-soothing, and an inability to use relationships or the third, the sense of the other or the self even, the self becomes the only source of satisfaction, and even then not really, so there's a constant longing, constant going on and on, with whatever it is, to the point that in itself its never satisfying but the yearning continues. And that drives the addiction, the longing for attachment.

Several writers agree that addiction is about restoring early emotional damage for the individual (Carnes, 1991; Coleman, 1991 in Bergner & Bridges, 2002; Ferree, 2001). This view is endorsed by Sacks (1985, in Solomon, 1989: 74): "Disease is never merely a loss or excess; there is always a reaction on the part of the affected organism or individual – to restore, to compensate, to preserve and restore identity, however strange the means may appear to be."

Despite the fact that psychodynamic intervention is not seen as the most effective perspective for treatment, and despite some practitioners claiming they did not use depth approaches, at the level of aetiological understandings, psychodynamic 'thinking' seems to have filtered through to even the more devout self-acknowledged cognitive-behavioural adherents. This affirms Glaser's (2000) view that psychodynamic theory provides the richest and most substantial explanations of aetiology.

4.3.2.2 Sex addiction as a symptom

On the issue of why addiction develops around sex as opposed to another symptom, most respondents reiterated that sex addiction is mostly part of a wider addictive spectrum of behaviours and other co-morbid diagnoses, and is therefore difficult to extrapolate from other aetiological aspects. In support of this, no-one interviewed had ever seen any client presenting only with a sex addiction. Despite this, attempts to explain, as detailed below, revealed that some respondents saw the sex addiction as a primary, fundamental response to an early need to defend against a psychic threat.

> The reason an individual will ward towards a sexual dysfunction rather than say drugs and alcohol, is primarily age of onset. Sexual addiction has a foundation and root in early childhood, at a period where they aren't at a stage or not able to find additional mood-altering behaviour. They might have sustained abuse, neglect or trauma and there were no other avenues available to the child to cope.
>
> I think sex addiction is very often the fundamental, underlying addiction. The other addictions are just layers of cover-up.
>
> It seems like the person who ends up with a sex addiction, you could say falls into the same difficult group as eating disorders, because it is such a *primary* instinct. You have to eat and you have to have sex. Because it goes to the core of our relating. It becomes a difficult piece to tease out.

Using a cognitive learning framework, one respondent points to a sex addiction developing in addition to other addictions, but does not address why the core belief around sex develops:

> Through a dysfunctional family there are four core beliefs that the sex addict incorporates into his world view. The one is I'm basically bad. I'm a bad, unworthy person, which means that he was shamed as a kid. The second one is he won't be loved as he is, so if he tells another person what he really feels he's going to get rejected. Thirdly, his needs won't be met if he shows what he needs, and the fourth one which differentiates him from other addicts is that sex is the most important need.

Another view is that a significant contributing factor is confusion between love and sex occurring through developmental experiences with a caregiver/family system. Two examples follow:

> I have got a client who enjoys transvestitic sex – whatever the term for that is, and as a child – if we go back to the primary fantasy, it's about seeking nurturing from a woman. But his mom would remove him emotionally and the only time she gave him care and attention, she would dress him up and then she would care for him. He now dresses up, but he doesn't like that so what he does is he finds sexual release in men that are dressed up as females. That's the distorted process which takes place in childhood, that parental dynamic vandalised the template, the fantasy.
>
> He's able to talk about the bestiality, he's able to link it to, that as a child the only person who ever gave him any sense of reward was his dog, his dog was his best friend. He never had a mother, never had a father, was obviously abused and the dog became the object of his affection. And how best to show someone that you love.

While respondents emphasized that it is virtually impossible to extrapolate sex addiction from the rest of the addictive spectrum, there was consensus that sex addiction has very early developmental beginnings and may be related to fundamental, archaic internal experiences.

4.3.2.3 The link between intimacy and sex addiction

Perceptions were varied around the link between intimacy and sex addiction, and a wide range of thoughts about the role of intimacy in the overall clinical picture and its understandings emerged in the interviews. Some practitioners saw sex addicts as being able to have adequately companionable and comfortable relationships with their partners. The sex addiction was seen to happen outside of and independent of the relationship and certainly not emerging out of, or because of a lack of intimacy in their current relationship. These practitioners felt that the sexual acting out had a limited impact on the sex addict's primary relationship. The following comments illustrate this:

> 'Some partners reportedly did not have a clue! "He was a good father, a good husband, we were still having sex!"

> It did not seem to be an issue for her and in fact was pressing the client to set a marriage date.

Others on the other hand saw intimacy difficulty within the relationship, with the acting out having a powerful impact, marked by alienation between partners:

> Certainly when you look at people addicted to pornography, there are clearly intimacy deficits. Pornography takes them into a wasteland of superficial intimacy. When engaging with pornography, they're in charge, they don't have to connect with anybody, it's very clear, and it's very simple. And the behaviour certainly isolates and alienates the person even more, which makes trying to pursue intimacy that much more difficult. The one feeds into the other. The addiction provides far more satisfaction, and the intimacy deficits expand and expand. There are issues around abandonment, sensitivity to rejection, humiliation. In order to deal with it, the addiction becomes the primary gap filler; it detracts from having to develop the skill, having to develop different values in order to change the behaviour. So the addiction in a way almost offers a companionship that is easy and inviting and that is where the addict reigns supreme. There's no critical feedback, there's no need for sensitivity or vulnerability, that I'm getting found wanting, and in that world there's no difference between fantasy and reality. In relationships there are.
>
> For most people who act out sexually, they feel an incredible shame about it. And they kind of minimise it, so this prevents them from being honest in relationships, or prevents them from being fully available as they could be without their behaviour. And in some way, their partner senses it, especially as the behaviour progresses – either a form of unfaithfulness, or withdrawal or unavailability.

The next two comments reflect that intimacy difficulties are present both on an intra-psychic level (first comment) and an inter-psychic level (second comment):

> What appears difficult is his own sense of his intimacy.

> There's a sense of fear of intimacy, not quite knowing how. Not actually having learnt how. So fear of the dangers, and not knowing how to, and trying ways that are not that appropriate.

Three practitioners felt that the ability to be intimate with their partners emerged after the addiction had been attended to and they entered a process of recovery:

> They recover reality very well, it's very scary for them in the beginning, but they are able to become more direct, to sit in reality and to *actually value* the pains and agonies and the pleasures of being more in reality. But as they start doing the work they begin to see what behaviour is good and safe for them and what behaviour is toxic for them.

For Solomon (1989) early failure, empathic failure, and lack of mirroring results in narcissistic damage and affects the ability to be intimate in later life. Further, a range of defensive mechanisms get set up to maintain distance in relationships, including splitting and projective identification, which occur to ward off disappointment or fear around merger. Splitting is illustrated by the following comment:

> He talks about the split between not wanting to lust for his girlfriend, he wants to have her, he feels he can't look at her in that way, although she also has big breasts, he won't encourage her to satisfy him in the way that she could. He finds it hard to articulate, but I think it's that she would be contaminated by this other world that he thinks is bad and wrong.

For the narcissistically damaged, projective identification protects against threatening internal affect as unacknowledged negative emotions and affects are projected into the other. "Those dangerous and destructive feelings residing in the other are then however, perceived to be in a position to be thrown back in a hostile attack" (1989: 88). This process is resonant with the dynamic described below between the sex addict and the prostitute as a way of defending against what occurs in intimacy with his wife. Safety cannot be felt with one's chosen intimate partner as they hold all the negative projections. The sex addict then looks outside the relationship for what he needs:

> They feel they can be real and honest with a prostitute, where they feel they can't be real and honest with the wife. She's not going to reject you, these people's trust and intimacy was obviously broken at a stage in their lives, and they don't trust an intimate relationship, there was definitely a damage, as far as the intimacy goes, and the sexual act is a pseudo attempt at that connection.

From a different angle, one practitioner's comment reflects the notion that intimacy is relative, and that while much of the behavior seen within compulsive sexuality may be construed as 'non-intimate', for some it provides a heightened sense of intimacy given their history:

> From what I've come across, the child never learned how to form an intimate relationship with anyone, it was almost based on narcissism or a façade but there was never any real sense of intimacy, and if one thinks about that, if you've never experienced a real sense of intimacy, in any non-sexual relationship, then any form of the sexual act will be possibly the most intimate relationship you'll have, because even if it's with a prostitute or not, it's still intimate even though it's shallow. It might be non-meaningful, but I think it's a misguided attempt at real intimacy and that must be quite an intimate, sacred experience for him, relative to his other barren interactions.

Some respondents felt strongly that difficulty with intimacy lay at the heart of the sexual acting out, but that restoring a cohesive self was possible through the process of recovery. Others felt that the sexual acting out was unrelated to problems with intimacy. Consequently, the link between intimacy difficulties and sex addiction in this data remains unclear. While the psychodynamic literature hints at narcissistic damage being a precursor to later impaired intimate relationships, this is not unanimously indicated by interviewee responses.

4.3.3. Treatment issues

Sub-themes emerging under the main theme of treatment included eclecticism versus a purist approach; therapeutic goals; and ethical concerns.

4.3.3.1 Eclecticism versus purist approaches

Models used were drawn from the same perspectives as delineated above, and there was strong congruence for some between the conceptual model used and the intervention model applied. The more experienced respondents, who had been working in the area for many years and with a range of clients, preferred a more eclectic approach. The value of drawing on a wide range of techniques from various therapeutic models was highlighted and a range of reasons elaborated for the importance of utilising a variety of responses.

> My own approach would be an eclectic one. It would be one that borrows and adapts approaches and techniques and models. While the base of my intervention will be clinical, that doesn't offer enough to change behaviour and to necessarily change values and provide people with skills. Your insight-oriented therapies are not always the therapy of choice. It's not the most effective for these people. There needs to be a transfer of skills. There needs to be input that addresses the values that they hold and there needs to be input that targets the beliefs that they hold. So I don't think any particular model gives you all that.

One practitioner maintained that while her training and preferred way of working may have been located within a particular framework, such as a psychodynamic or feminist framework, treatment in this field needs to draw on other models. She explains:

> While my training is clinical social work and the paradigm I work from would lead to a clinical understanding, the work I've done has taken me into other perspectives and models. The feminist framework provides the political analysis about power and control but doesn't offer you anything in terms of intervening and changing the behaviour. Social learning theory offers particular techniques and skills, so do theories of aggression, the drive theory...

Reasons were given for the imperative to draw on a wide variety of techniques and skills related to the specific needs of this client population. This approach appears to have developed in response to the clients.

> You may very well have to sit down and do aversive conditioning with them. You might have to do a relaxation session with them and change the image that he has in his head about the power that wrapping himself around the porno gives him. You might have to look at other techniques such as masturbatory satiation, that changes the sexual impulses after ejaculation, so you're interjecting boredom and you're breaking the attraction to the stimulus and you're actually turning it into something really boring ... that's why you're need an eclectic approach.

The implicit tension between those choosing eclecticism and those who adhere to a more purist model for treatment is hinted at:

> After 25, 26 yrs of practice I say I have a need for eclecticism with a lot of freedom. I think a lot of treatment providers are afraid to say this is not the only treatment approach I use, that there's a reticence, that somehow you'd be found wanting, that you won't be seen in a respectable manner, if you're using different techniques. In the world of academia you take on these labels of specialisation, when in fact we're using tools from a range of modalities. I offer no excuses for shopping around. For my philosophy as a treatment provider, I use certain strategies, and if it works, if it gives me the results that I want, I'm going to do it again.

The literature supports using a range of techniques: "Sexual addiction treatment presents clinicians with unique challenges. This disorder has multiple facets to its aetiology and requires multiple interventions at critical points in the process" (Adams & Robinson, 2001: 42).

4.3.3.2 Diversity of therapeutic goals

A variety of frameworks conceives of the process differently and privilege different treatment goals. This was evident in respondents' prioritising of goals and reflects Giugliano's (2004) assertion that outcome goals set for treatment varied and are determined by the conceptual frameworks used to understand the clinical problem. Those working within an addiction treatment model saw the halting of the acting out as primary. Clients are seen to need input on a behavioural level and structures put in place so they do not find themselves in a position where they can act out. Those working at in-patient treatment facilities saw admission itself as achievement of the first stage goal by virtue of the fact that through admission the opportunity to act out is removed. Practitioners working within an addiction treatment model in an out-patients setting however, saw establishing a sexual contract as important:

> People entering into the recovery process need to develop a sense of their bottom-line behaviour – that is, their boundaries of what is okay for them or not okay. It's not an abstinence, I totally disagree with sexual anorexia, but I motivate for abstinence from behaviour that generates huge shame.

The practitioner working within the framework of facilitating communication between couples saw a central aim of therapy as bringing about a negotiated, workable way of being in the relationship that was acceptable to both parties:

> When two people differ in what they want – say someone's into swinging, or bondage and torture, and the other feels uncomfortable about it, we hold both. We talk about what is preferred, and what feels right or wrong for *them*.

One respondent emphasised that some of the symptomatology has a functional component and is not just dysfunctional. For example, as some clients appreciate the excitement of the acting out, he helps the client incorporate their fantasies into their life in a functional way:

> So we incorporate what they would enjoy in acting out, into fantasy.

One respondent, working within a developmental framework, saw the re-wiring of the early arousal template as a priority:

> The dynamics of that first sexual process needs to be re-established. There needs to be undoing of the vandalisation of the love map. This gives him the opportunity to be responsible for his acting out and to take ownership of it.

The psychoanalytically oriented therapist prioritised the long-term one-on-one relationship that contains the client until such time as change can be entered into:

> My task is to stay with working at his depression emerging and looking at the narcissistic aspects as well, and not getting prescriptive around what he should or shouldn't do. Apparently anti-depressants shift things hugely, but he doesn't want to give up his world. So the challenge for me is to work with these underlying dynamics, untangle them gradually so that his defences don't have to be so rigid and afraid, and that he can slowly get to the point that he can acknowledge what he's feeling before he uses. And get more into his depression and that would be a big win. I wouldn't refer him to a 12-step group. Those groups can be very destructive.

To conclude this section, respondents highlighted the primary importance of '*the relationship*", no matter what techniques or approaches are employed:

> I really do believe that what brings about the healing is the *being* of the therapist. That's really the important thing. Whatever we do, yes, there are helpful things, insight, interpretation, but it's the *being* of the therapist that's going to be the determining factor.

As can be seen, different approaches prioritise different treatment directions, and marked tensions exist between adherents of different models.

4.3.3.3 Ethical concerns

The respondents were of the opinion that any ethical dilemma was in the client's domain and not for them to engage in, with the exception of one practitioner. She works extensively with sex offenders, where the mandates and lines of liability and accountability are clear. This same practitioner is concerned that self-help groups for sex addicts are 'harbouring' paedophiles and other kinds of sex offenders who hide behind their 'addiction' with impunity.

The distance other respondents felt from ethical dilemmas may have had to do with the fact they had not come across glaring violations that required reporting. Management of ethical boundaries differed. One respondent said that when he introduces his way of working to a client he makes it clear that everything is confidential unless there is a legal violation. As yet, he has had no need to break confidentiality.

> I go by the principle of 'clear and present danger' – that if my client's *life* is in danger, or is putting another's *life* in danger, I am bound to report it.

Another saw setting ethical boundaries as a more organic process. As she is not sure what will emerge, she puts up whatever boundaries are required as and when needed.

On the issue of **disclosure**, most respondents had not come across a situation where they knew of a legal violation which they needed to report. For those working with people

who were acting out within legal parameters (as far as they knew), pedophilia was cited as the one violation they would report if it was disclosed. One respondent acknowledged that because sex addicts are highly secretive, he has no doubt that he is hearing only the tip of what people are actually doing; that pedophilia might very well be part of some of his client's repertoire but that no-one has disclosed it yet. No respondent had had to deal with an HIV-positive client who was putting others at risk, nor had any dealt with child pornography in their practice. For this group, prostitution, although illegal, was seen as more of a client choice and did not carry the same injunction for reporting. One practitioner had been told of bestiality occurring, also illegal, and this had not been reported.

The main difficulty around disclosure in an in-patient treatment facility, it was felt, centers on whether or not to disclose certain legal violations to the treatment community because of the possibility that law enforcement officers might be present in the group, as by doing this they may put themselves at risk for prosecution.

Disclosure of infidelities to partners was not seen as the responsibility of the practitioners. Some 'suggest it strongly', while others use the technique of 'soft-confrontation' to move their client to a position where they could consider the impact of their behavior on their partner. One respondent articulated this in the following way:

> My sense is that your ethics of care and the principles underlying that would apply. That you would bring the person to the place where they would take responsibility and your role becomes a supportive one, so you monitor and assist that person in doing what's responsible.

Views in the literature support the position that disclosure is at client discretion; that each case is individual and context is to be borne in mind (Corely & Schneider, 2002). This did evoke ethical difficulties for some respondents, who expressed frustration that at times ad hoc meetings are held with colleagues to liaise on particularly problematic scenarios, but in general ethical decisions are being made in isolation from other professionals in the field. This is highlighted in the literature and cited as problematic.

Herring (2001: 13) maintains that practitioners in this field often encounter challenging ethical decisions that are not fully addressed by a professional code of conduct. Corely and Schneider (2002) emphasise that little has been written about disclosure. "Specifically absent is information about ethical issues for therapists regarding disclosure around infidelity, how to effectively counsel clients about timing or how to actually carry out the steps of disclosure" (2002: 45). Their clinical experience reveals that addicts do get better after disclosure to someone other than their therapist, one of the reasons being that it facilitates reduction of shame. They stress that when a partner is at risk of acquiring or has been exposed to a sexually transmitted disease, there is a significant need for disclosure.

More vociferous opinions are also evident in the literature: some theorists feel strongly that for healing to occur the unfaithful partner must disclose (Pittman, 1989; Brown, 1991, in Corely & Schneider, 2002) and that "secrecy creates insiders and outsiders" (Brown, 1991, in Corely & Schneider, 2002: 45).

An ethical concern raised about the practice of other professionals illustrates that codes of conduct are indeed being forged and managed according to individual perceptions and ideas of what is and is not acceptable. Acting out and inappropriate behaviour among mental health practitioners was seen to be occurring:

> What I find with sex therapists is that they're acting out. Quite a lot of them do not have a model where they differentiate between healthy sexuality ... There's a certain sex therapist that does so much acting out, she's a voyeur, there's something happening there that's really not safe. She spoke about how good and liberating swinging was for her. Swinging is when you meet with one other couple or a number of other couples, that you get naked with and you fuck each other or you fuck the partners, or you all fuck together or you fuck each other in front of them.
>
> A lot of what that woman is saying is not okay. She has not got a clear line, I don't think she's even got *a dotted line* between healthy and unhealthy sex. I heard some tale that she touched somebody to describe something, on their organs. I've also heard her talk, and seen that she touches herself very clearly and very suggestively in her talks.

> I met one person who is very intelligent, very well educated, well versed, well practised in sex addiction, is a raging sex addict himself. And he uses the work that he does to create a playpen for himself to act out. He has deluded thoughts about himself as Dionysus, the messenger from the underground, and the upper world, to specifically help women integrate their sexuality. He *definitely* touches, he *definitely* creates safety so that he can jump in. He thinks it's a very appropriate, okay way to heal people. He's busy training a group of people to be sex therapists, or transformative healers, and their main objective is to fuck their clients to heal them.

Practice in Cape Town echoes the literature in that people working in the field do not have a central code of ethics that they work with. Rather, they follow a general set of professional principles and are guided by their integrity.

4.3.4. Practitioners' subjective experiences

Most respondents were aware, as emphasised in the literature, that reflexivity and awareness of one's subjective experiences when working in this field is imperative so that effective, contained and boundaried work can be carried out. Awareness levels varied however, with some seeing it as an essential tool for working with this client population; others less emphatic, generally less well informed about the area, and not necessarily aware of the special considerations outlined in the literature. Key sub-themes emerging in this section include the emotionally evocative nature of the work; difficulties and challenges; the question of a value-free therapy; and countertransference.

4.3.4.1 Emotionally evocative work

Contrary to the literature which focuses on the challenges and difficulties practitioners experience working with 'sex addicts', these respondents viewed their work with sex addicts positively. This client population offers heightened levels of interest and provokes 'escalated' levels of professional and personal learning.

> I felt quite excited to work with a different kind of addiction. A different constellation of symptoms, so different to most; exciting.

> I enjoy working with them. They're challenging and when they reach levels and they bring about change that's profound and rewarding.

> I like working with them, I think they're fascinating. I'd like my practice to be full of sex addicts! It's not mundane; they're never the same, it's offering something new. It almost invigorates me, I mean the amount of research I've done, I can skip a gym session and come and read articles rather. I wasn't doing that a year ago, when I was going to work begrudgingly. So … its all about change, internally.

Clearly the work evokes a range of heightened emotions. Most of those interviewed felt a strong compassion and could relate beyond the symptomatology to the damaged child:

> They are just very vulnerable people, damaged children.

> I really feel a lot of compassion and helpful energy towards these people.

This client population was seen as being different, especially needy and having complex needs. A number of responses reflect this:

> They have a different level of intrigue.

> What I felt with these guys was, I felt a sense of, there would be very few people who would be prepared to discuss this with them, so I must do as much as I possibly can. It's not that I think I'm a specialist in this area, but being a sex therapist puts me in a position where I am able to speak quite non-judgmentally. Maybe I have a false assumption that other psychologists wouldn't feel comfortable about those areas, but I felt I *had* to give more because this is their one and only chance.

In the same vein, another respondent says:

> It's really hard to watch them deconstruct themselves over behaviour that they think is so degrading. Well, what happens is an overcompensation process, there's a part of me that really wants to rescue them.

A respondent working in an addiction treatment centre referred to the lack of boundaries of this clientele and the hard work of keeping emotional demands at bay:

> The patients have had very little awareness of boundaries, so either they present as very needy, or very over-friendly, or over-familiar, wanting to be in my face all the time – more so than with other addicts. So the neediness is very demanding and sometimes I feel I just want to steer away from them for a little while.

Speaking subjectively, a number of respondents showed that their personal and professional development had been facilitated by this work. While reflecting on this, a number of respondents also made reference to the question of whether full healing ever takes place.

> Of course it's been a struggle, because I, like everyone else in this society, had to go through my own process of coming to terms with my own sexuality, and dealing with all the shame and discomfort and after all the years and years and years of analysis and work, you know, even from time to time now it's not something that doesn't get totally laid to rest

> One of the most interesting things I found, besides for my own analysis, one of the most seminal healing experiences I had was a workshop that was totally experiential. The purpose first of all was dealing with all the shame and detoxifying the shame, and then the experience of eroticising the *entire* body and not just being genitally focused. That experiential kind of thing was what I found, personally, to be more healing than all the years of analysis. (smiles) It doesn't go through the head you see. And for this primary, instinctual piece, you know, you can talk the hind leg off a donkey, you can have all the insights in the world but something about that experiential piece, that was profoundly healing.

> I feel *totally* non-judgmental, you know, just comparing to when I just started out, must be 30 years ago, the first patients, and I was training, and one of the first patients, and she started talking about masturbation, *I nearly died* of embarrassment (laughs) and when I think of where I've gotten to now, you know, where I will talk with *ease* about *any* form of sexuality. I mean, I don't think there's any form of sexuality I don't know about, experienced most of, or versions thereof, you know. It's like, it's fine, whatever you need to talk about, it's fine.

> I started off as very homophobic. Then realising, I had to go and do *a lot* of work and undo *all* the stuff I'd put in place and since then, to where I am now, ja. So my initial orientation has changed as a result of insight I have developed for myself in my own therapy. Where I sit at the moment as a therapist, the other day a man was telling me about how he used to masturbate his dog, and exposed

> himself to people on the street. It absolutely means nothing, it doesn't have an effect on me at all, except for the impact it has on him.
>
> I haven't yet dealt with pedophilia, and I think I would struggle with it, because of my own experience, and not being totally healed. I don't know whether we can ever be totally healed.

4.3.4.2 Counter-transference themes emerging from the data could reflect their client's unconscious dynamics. Firstly, there appears to be **polarisation** between therapists in the debate around definition. Those who adopt the addiction model are seen by the sexologists and professionals in other disciplines as utilising a sex-negative concept, being reductionistic, and not appreciating the complexity of the problem. The addictionologists see other frameworks as obfuscating and 'standing on the theoretical fence'. This professional split can be reflective of their clients split of sexuality into good and bad.

Secondly, practitioners expressed marked **mistrust** of other professionals based on their experience in the field. Some practitioners felt that other therapists cannot or will not 'hold' the issues of the sex addict. Reasons for this view are *inter alia*: either these other therapists do not have the appropriate knowledge base or they have not worked out their own value system around sexuality, or they themselves are acting out. The latter point raises the issue of questionable boundaries and the possibility that risk of abusing therapist/client boundaries is present. These reflections could echo the addict's core issues around trust and mistrust.

Thirdly, a theme of **isolation and marginalisation** emerged. As this work is rejected by many in the helping professions, therapists are working with shadow issues in isolation from the mainstream, much like the addict who lives in shadowy realms on the outskirts of so-called 'normal' sexuality.

Fourthly, a theme of **deprivation** was evident in that practitioners feel behind other countries in terms of resources and knowledge as illustrated by the following comments:

"There's not enough literature, hardly any workshops, and hardly any support groups" and "America is about 50 years ahead of us". Again, this could reflect the addict's experience who feels deprived emotionally and not privy to the emotional riches and internal resources that they perceive to be the property of other more 'whole, mature' people. Addicts often feel developmentally behind peers who are not acting out.

Fifthly, there is the **excitement and allure** of the work. Respondents described their attitude to the work with heightened and escalated affect, reflecting the allure that the intensity of the sexual acting out provides. The energising and enlivening qualities of the chemical endorphin provided by the acting out for the sex addict resonates in practitioners' description of the work. A clear example is that of the therapist who a year ago was going begrudgingly to work and since working with sex addiction is rejuvenated by his occupation.

In conclusion, working in this field promises evocative challenges that require the therapist, like the addict, to reflect closely and with integrity on internal issues and to learn new frontiers of perceiving and being. As one therapist comments:

> I don't think it's possible to be conservative in this field and work. I think it's a natural progression for me to change my attitude, because if I don't, I become judgmental, and I can't be judgmental because I have to be open and that means I have to allow certain things into my thinking.

4.3.4.3 Difficulties and challenges

Most respondents acknowledged that the work involves archaic and often seemingly intractable damage. Resistance to help was also posed as problematic. These factors affect therapists' sense of effectiveness. For those perceiving the problem to be fundamental and chronic, emotions brought up include frustration, being overwhelmed and not feeling confident that one can 'stay the course'.

> We all know that this work is medium to long-term. You don't just rip someone's addiction away from them overnight. Initially there's resistance. The reality is no-one gives up their addiction without a fight. And I don't think we can offer

> anything that is as satisfying as that addiction. The man who cross - dresses in response to his wife's having another depressive episode, what do I offer him as a therapist that's going to be fulfilling? I'm offering him an opportunity to come and speak about how he feels, to practice new skills and learn new tools to deal with that, but I'm not offering him the pleasures of escapism.
>
> In my experience there's *often* relapses. But I know now, you just hope that they get less frequent for shorter duration.
>
> I get impatient. They have, and I'm generalising, a lot of resistence to insights and to having to give up this exceedingly pleasurable but often dangerous, potentially destructive, and all of that. The countertransference is really like – get with the programme! *How long are you going to keep doing this?!* (laughs) I don't say it but I think it.
>
> It seems that the addiction that's more integrated into life is the more difficult to give up. The things that are the most meaningful to life do pose the most complex. And the earlier it begins, the more entrenched it becomes.

Only one respondent expressed difficulty with the material that clients bring. It appears that remaining in the field over time, as discussed above, yields greater comfort with the work. This respondent was new in the field and her feelings reflected the discomfort hinted at or acknowledged by others when first starting out in this work. Keeping and maintaining clear boundaries is a challenge, and she finds she has to work hard and in a sustained way to keep firm boundaries. A lot of support is needed from her team. She also felt challenged by the details of what occurs sexually:

> It's quite an evocative kind of work because you're dealing with morals and values and issues of an intimate nature despite the lack of intimacy that often accompanies it. I struggle to guide someone practically with something that's so innately emotional. I think it needs a huge amount of support to be able to go the length it requires. Because it's very easy to work superficially and to say, we've covered that, lets move on, but really getting down to the nitty-gritty needs a huge amount of support and encouragement.

She sums up her attitude when she says: "Oh my word, at times I wonder what on earth I have gotten myself into!"

The wider network of helping professionals was cited as problematic, specifically with regard to their lack of awareness about and attitudes towards this client population. As Giugliano (2004) points out, therapists are not immune to value judgments and can play a role in perpetuating stereotypical and marginalising attitudes to people struggling with compulsive sexuality. At least two practitioners found other professionals rejecting of the issue and unwilling to become part of a referral network:

> When I started seeing this, I took to the pavements of Cape Town, and of Jo'burg, and I knocked on the doors of psychologists, and they all turned up their noses and said 'there's no such thing'. Or they said, 'I don't know about it and I don't want to work with it, it sounds sordid' I went to them because I wanted to educate myself about it first of all, and secondly I needed to refer people, because I'd come across this phenomena and I had nobody to refer people to. I couldn't come across *one* person who was prepared to do that work. *Not one.* I must have interviewed 12 and phoned a number more.
>
> No-one wants to work with them. No-one wants to get their hands dirty. It's such a long road.

4.3.4.4 The question of a value-free therapy

Most respondents interviewed were acutely aware of the need not to impose value judgments on their clients. While they might not have liked or condoned what they heard, they maintained it was not for them to decide what was right or wrong, and any imposition of their own values would violate their mandate. Most appeared however to have a set of values outside of the therapy context for themselves, and a different one, informed by therapeutic principles, for inside the therapy context. This split is reflected in the following comments:

> They're not the kind of things I personally like to do, or condone in any way but it's not, I won't get offended by it personally, grapple with it, the only thing really I struggle with is the violent stuff. That's just not acceptable. Not that some of the sexual stuff is acceptable but I can empathise with it. The violent sexual acts I can't. Well, I can, I can pretend to, in a therapeutic situation but when I walk away I'm quite disgusted by it. I find it difficult to understand.
>
> I have my own personal set of values but I don't bring them into the room with me. I bring a far more liberal set of values into the room.

> This is what I do, its part of my craft, in my personal life a different set of values apply.

While most therapists strive to avoid value judgments, one therapist claimed 'healthy sexual behaviour' as an important value judgment to bear in mind while doing this work:

> I think a lot about healthy sex. It describes a number of behaviours and communication rituals and effects of connectedness and feeling respected, and safe and playful and daring and intimate and sensual [sharing] between two people.

Only one therapist acknowledged a struggle between her value system and this work. By drawing on therapeutic principles of respect and empathy this practitioner deals with the split felt between therapeutic injunctions on 'how to be' and her internal responses:

> It's especially difficult when there's paedophilia or abuse or rape. Surprisingly enough, in those circumstances those patients always say 'this must be so gross for you to hear, I'm sure that you're absolutely disgusted with me'. I usually say, 'you know what, you're not the first and I'm sure you're not the last', and just reflect it straight back at them and say, 'what are your issues that you feel I'll reject you, what are your fears? What is *your* shame about? This is not really about me, it's about how *you* feel'. But it *is* difficult with my own values, and oh, how can you have done that?

4.3.5 Discerned needs of the field

Respondents described the field as exciting and challenging, but not widely known about or accepted in the professional therapeutic fraternity. Sub-themes in this section include the importance of being theoretically well informed combined with self-knowledge, the neophyte stage of the field; lack of resources; lack of education; limited access to literature and research; no South African research; and limited networking.

Self-awareness and feeling comfortable around one's own sexuality was seen as imperative for therapists. Supervision was seen to be vital to growth of the professional in the field. Attitudes and awareness of sexuality for those in a position to make a difference

to the way in which children are treated and raised was also expressed as an important dimension to address. Lastly, research with an emphasis on South Africa was seen as crucial.

A small group in Cape Town is doing this work and the general feeling is that it is new and they are at the beginning of the process of equipping themselves with knowledge and skills. The comments below reflect this:

> Sex and Love Anonymous was only established in 2003. That's it. Prior to that there was no support group for anyone. The treatment centre, what's the longest running treatment centre, I suppose the DCC, has been going 16, 17 years, but they don't do sex addiction. Kenilworth, Stepping Stones, 5, 6 yrs each, but again, a very recent acquisition in our theoretical thinking in addiction.
>
> So I started reading about it, doing Internet searches, finding chat room support groups, stuff like that, and I realised that in America specifically they're about 50 years ahead of us.

One practitioner turned to the client population itself in order to learn about the problem:

> I then started meeting up with people who had initiated support groups, who were self-confessed love addicts, who spent many hours with me, educating me about how they experienced it, how the 12-step process helped them. That sense of reality gave me a sense of hope, a sense of containabilty, and a sense that there is actually a process that really helps with it.

Others commented on the dearth of training and low levels of professional knowledge in the city and the implications of this:

> I really think it needs to be included in the training at qualification level. When I had my university training I never even heard about it.
>
> There is very little training in psycho-sexuality where one is looking at one's own sexuality or abnormal sexuality or deviant sexuality. Because sex isn't talked about very often, I think people aren't in touch with their own responses or haven't thought them through – so I suppose my concern is that people will react in an unthinking way, or a less than thought-through way.

> My view is that supervision, some kind of peer support, peer networking is invaluable. As well as some kind of research into effectiveness and knowing the facts. Right now it feels as if we're all just carving out our own way and it's very difficult to effectively measure what works.
>
> I think that treatment providers are sitting with a lot of these issues in isolation from one another, and maybe one of the things we need to do is networking and collaborating. Having said that, the folk who work in this area have heavy case loads, or patient loads, and getting together to look and review issues and to incorporate peer review becomes almost impossible.
>
> So a comprehensive knowledge of sexology, with an understanding of the broad spectrum of normal sexuality, whatever normal may mean, and then a good understanding of the *broad* range of sexual problems, dysfunctions, concerns that people experience and are confronted with so that you can situate and understand hypersexuality *within that context.*

In a somewhat different vein, and drawing attention back to the therapeutic relationship, a practitioner highlighted what is needed to be an effective therapist:

> The therapist needs to be comfortable, solid, grounded, able to tolerate, able to stay in touch with, just being present, there. Any therapist who hasn't dealt with their own issues of sexuality, and what their particular proclivities might be, or what they haven't explored, then of course there are problems.

Core issues for Cape Town respondents working with sex addicts, despite enjoying and benefiting from the work, were that the field is under-resourced, marginalised and at a pioneer stage. Most respondents pointed to a dearth of formal training in both sex addiction and human sexuality. Other absences cited include a lack of related literature, poorly resourced self-help groups, little professional back-up and a lack of collegial support for referrals as described above.

4.3.6 Social context and sex addiction

Respondents were undecided about the exact role social culture plays in the apparently widespread compulsive sexuality seen today.

> When you ask a question like that, it immediately exposes the vulnerability of the process. Is it because pornography is now freely available, is it because post '94 there's been a breakthrough in terms of social structure, is it because we've lived a rigid, confined life and in most cases a Victorian approach to sexuality, or is it because now our parents are much more permissive, allow children to go out till such late hours, or is it because of SMS pornography? Who knows? I struggle with answering that question.

Sub-themes did emerge however, and they include: current social mores; nuclear family systems and raising children; taboo around sexuality; the media; the sex industry and gender relations; and economic polarisation.

4.3.6.1 Current social mores

Most felt that sex addiction has existed since the beginning of time but that current permissive social mores have exposed the phenomenon and made it more visible.

> It is primarily because of the so-called sexual revolution and post-apartheid permissive society where rigid social structures have broken down that there is for more openness and acknowledgement of the issue. That has made it more transparent.

> Regarding attitudes to sexuality – we're in a permissive state. Think about how permissive it is – we can publish on the subject; you have a supervisor who is prepared to supervise you; you and I can talk openly on this. I'm a male you're a female, I'm not sure where we're at but I get the feeling were post 60s. That revolution changed things in America and we're playing catch-up to that.

4.3.6.2 Nuclear family systems and the way children are raised

Respondents cited the current construction of the nuclear family and the way in which people's lives are structured as having an impact. Common concerns were the lack of quality time and family time, and ritual having fallen away.

> I do think that in families we are doing less and less of the things that we need to happen to be able to grow up. We don't play with our children. When we're home, we're all incredibly pressurized. Women are working as well now, so that the time when children are held by and adored by their own caregivers gets less and less, and its more maintenance time and the little time we can interact we have dinner in front of the TV.

> I think we're becoming more and more a child un-friendly society. Children are, it's almost like, to have a child today is such an inconvenience. Not sure they get the type of connectedness, the kind of emotional kind of closeness that is such an important part of their developing personalities and selves.

4.3.6.3 Taboo around sexuality

The taboo around sexuality has a powerful impact on this phenomenon. Discomfort with sexuality and difficulty around celebrating one's sexuality creates difficulties around adults experiencing themselves as whole sexual beings and passing this on to their children. The lack of direct, confident and knowledgeable teaching about, and containing of, children's growing sexual identity and needs is highlighted. This, together with a sexually explicit and sex- negative culture, that does not provide healthy ways in which they can integrate what they are exposed to, leaves children confused, alienated and cut off from their sexuality.

> The kind of messages that children take in on a day-to-day basis, about their bodies, about sexuality, is very sex-negative. They're bombarded with information all the time, whether it's books or magazines, or TV and Internet. But there's no place where a healthy adult with a healthy respect and understanding of human sexuality, generally, and child sexual development, specifically, creates a space where a child can integrate this awareness and information in a way that would be to their advantage.
>
> I think we still do not have a healthy respect and acknowledgement of childhood sexuality, so children are not acknowledged as sexual beings until they hit puberty when they have all those raging hormones that we all go on about. By the time they are 12, 13 the development has happened. That is not acknowledged, not well understood, whether that's by parents, teachers, churches, institutions, organisations within the community.
>
> Children see incredibly sexual stuff. They're already conditioned with highly explicit, overt sexual messages. But in their own sexual development they aren't guided, they aren't given safe, proper education and guidance and holding, where they're at, what's appropriate, what's safe, what's okay. We are exposed to it long before we should be and we aren't held in it at all.
>
> It's not being integrated. You're being thrown all this imagery, but there's no chance to work it all through and integrate it, so then it turns nasty, it turns into shadow stuff, and then there's rape, and incest and molestation and abuse and all

> that stuff gets triggered because there's no foundation where this information can be processed and you can deal with it and make choices.

4.3.6.4 The media

One respondent saw the media as perpetuating the struggle pertaining to learning about sexuality in a healthy way. An example was given:

> A television programme called '*The Bold and the Beautiful*'. This programme is on when most family members are having their 'together time'. To me it is the most x-rated, most sexually acting out soapie I've ever seen. I've seen glimpses of it and you'd do well to entertain and horrify yourself to watch it. It actually creates the model of sexual addiction. It's all about entrapment and excitement and being devious and creating intrigue. It's very sexualised, *really* it is. There are no personal victories of a healthy kind.

4.3.6.5 The sex industry

The Internet, while not seen as causative, is perceived by some to trigger already vulnerable individuals.

> I suppose sex is more easily available. There are more opportunities for people to act out, and therefore more difficult to manage. The Internet, you do a search and suddenly you're getting bombarded with quite bizarre web sites, an absolute rabbit warren – they become progressively worse and progressively deviant, and that must be incredibly difficult for people who do struggle to maintain their boundaries and to know where to draw that line. It hasn't created it, I don't know that it's increased the numbers, but perhaps for people who are more vulnerable they might be triggered more easily.

> I think sex addiction has always been there but it's now amplified. An environment also has to be there for an addiction to flourish and something like the internet is being called the crack cocaine of sex addiction, because there is such a turnover rate of visual stimuli, which can really tie into your personal pathology and preoccupations.

4.3.6.6 Gender relations

Gender relations emerge as a significant context in which to explore sex addiction behaviour. One respondent pinpointed cultural aspects of this dynamic, particularly those related to gender and the construction of masculinity, which are being theorised in the

emerging discipline of critical men's studies. Of relevance are cultural injunctions of what it is to be traditionally masculine, particularly the notion that a man has to take charge of sexual conquests. Also relevant are traditional notions of female passivity and submission.

> I think its stereotypes: the way males are being socialised in a macho culture where 'cowboys don't cry', type of attitude, which doesn't allow males to be intimate, it separates sexuality and intimacy. Culturally it enables male promiscuity as a sign of success and virility and strength, which is obviously not a healthy thing. On the female side, I think culturally females aren't allowed to have a voice, and they're supposed to be submissive.
>
> I think, culturally, men growing up fear either having to dominate or being dominated, So for him to be intimate with his partner, means he's going to be in a vulnerable position, which is unsafe, which means his armour is open and he can get hurt.

One respondent (who does not work extensively in the field) asserted that women do not suffer from sex addiction. For the most part, women were not mentioned in the interviews, reflecting that this is seen as a male phenomenon. Certainly it is men who are being seen in therapeutic contexts for this problem. However, two respondents mentioned women, making the assumption that they too have sex addictions, but are not coming forward for help because taboo around the behaviour is more pronounced for women than it is for men. A further point made was that women are more likely to experience relationship or love addiction as opposed to sex addiction. According to Goldberg: "The 'masculine unconscious' is made up of aggression and assertion of ego, is sexual and not sensual and anger is expressed through violence, compulsive competitiveness and treating women as objects or possessions. The 'female unconscious' on the other hand, is "the enraged victim, and seeks romantic fusion with a man as a 'rescue symbol' and 'success object', craving closeness" (1985:32). The situation is further complicated by cultural double standards. Women are expected to be available and sexually provocative yet when they are, they are labeled derogatively and shamed.

The assumption that sex addicts are male is shown to be a myth in the literature (Feree, 2001; Leilblum, 2003). The very real existence of sex addiction among women, despite

their invisibility in treatment, gets sparse mention. This further confirms the lack of research on women in relation to this issue

4.3.6.7 Economic polarisation

Some respondents saw an economically polarised society playing into the behaviour. These findings go beyond the notion that this has always existed and is only now becoming more visible, and instead posit that current economic forces play an active role in exacerbating the problem. Says one respondent:

> I think sex addiction is flourishing today and I think things are really feeding it. I think the big divide between poor and rich, the more wealthy I am, the more means I have, the more virtual my life becomes, the more cut off I am from natural processes, like the start of the day, the end of the day, the more I'm lost in terms of what is really healthy and fine for me. And when I'm poor, the more restricted and trapped and frustrated I am. Their world kind of dichotomises into those people who have everything and those of us who don't and the humiliation and the shame. So therefore, my secret life, my secret addiction provides a lot of fulfillment; it kind of takes me away from my horrible life. So on both sides, the rich and the poor, there's incredible sexual acting out happening at the moment.

Table 4 below shows core research findings.

Table 4: Core research findings

Perception	• Professional tensions between those who define compulsive sexual behaviour as an addiction and emphasise issue of powerlessness and those who maintain compulsive sexual behaviour is too complex to be defined simply as an addiction
Understanding	• Seen to be have diverse aetiology • Respondents struggled to pinpoint aetiological causes • Sex addiction seen to be part of a wider spectrum of addictive behaviours • Perceived to have very early onset • Developmental experiences seen to be eroticised, setting patterns for later sexual compulsivity
Treatment	• More experienced therapists use an eclectic approach • Professional tensions exist between those using addiction model and those who do not • Treatment goals vary according to models used and range from stopping the acting out to re-wiring of the arousal template to working to change psychic structure
Subjective experiences	• The work is emotionally evocative; felt to be exceptionally stimulating professionally and personally • The work is felt to be long-term, fraught with client resistance and intractable problems • Most respondents apply therapeutic principles of empathy and client self-determination allowing them to distance themselves from their personal value systems
Perceived needs in the field with respect to knowledge, skills and resources	• Lack of formal training in sex addiction and human sexuality • Isolation within the wider professional community • Perceived limited access to literature and research • No South African research • Limited networking between those working in the field • On a personal level – self-awareness and comfort with one's own sexuality cited as crucial Practitioners expressed unconscious countertransference feelings that seem to reflect client's emotional struggles

Social context and sex addiction	1. Seen to play a role in facilitating increased recognition of and exacerbating the phenomenon are: • Current permissive sexual mores • Lack of family quality time and ritual • Lack of sexual health in adults and consequently in their children • Taboo around sexuality • The media models of unhealthy sexualised interaction • The sex industry, especially the Internet, is a trigger for already vulnerable individuals 2. This phenomenon is found amongst all classes and across both genders. • Heightened taboo and shame amongst women militates against their receiving help
Emergent finding Ethical concerns	• Most practitioners appeared to feel distant from ethical dilemmas maintaining that that was their clients' concern • Most put client confidentiality before the 'victims' of the sexualisation, e.g. bestiality has not been reported • Paedophilia was cited as the one violation that would be reported • Some practitioners expressed frustration that no singular code of professional practice ethics was available to follow

4.4 Summary

This chapter extrapolated key themes and sub-themes pertaining to the experience of working with sex addiction. It has attempted to provide a sense of how practitioners perceive of and understand the work they do and the behaviour they are seeing, both from a theoretical and an affective point of view. The way they have constructed their working concepts and the meanings they have attributed to their work has been discussed. Conclusions and recommendations will be presented in the following chapter.

Chapter Five – Conclusions and recommendations

5.1 Introduction

This chapter will present the key research objectives and key findings emerging from the data before making recommendations for further research and intervention with respect to the field of sex addiction.

5.2 Conclusions

The research conclusions will be discussed in terms of each of the objectives listed below.

5.2.1 Objectives

This research aimed:

To explore therapists' perceptions of the concept of sex addiction.

To explore therapists' understanding of the aetiology of sex addiction

To ascertain which therapeutic models are being used for treatment and why they are seen to be useful.

To explore the subjective experiences of the therapists working in this field.

To ascertain what specific knowledge, skills and resources are needed for effective work in this field.

To explore therapists' perceptions of the link between sex addiction and the current social context.

5.2.2 Key findings

Objective: To explore therapists' perceptions of the concept of sex addiction

Findings indicate that therapists have constructed their perceptions of the concept of sex addiction in a variety of ways. Some have adopted the theoretical paradigms of their place of work (for example, the addiction treatment centre), while others have drawn on their preferred mode of clinical understanding of emotional and behavioural

symptomatology (for example, psychodynamic understanding). Some have looked to other professionals in the field for answers, or returned to grassroots level to learn from the clients themselves. Most interviewed mediate their perceptions through their own life experience, having gone through profound and sometimes painful self transformation in an attempt to get to grips with the work they are doing with clients. Others have had personal experiences that have challenged their sense of themselves and their sexuality. Some have read the available literature and make the point that no South African research has been done to date.

Those supporting the addiction model see the behaviour as an addiction and are emphatic that cycles of behaviour reflecting powerlessness, unmanageability, and a tendency to continue the behaviour despite negative consequences, together with chemical changes accompanying behaviour denote a clear addiction. Those less accepting of the addiction model are reluctant to call it as such and reasons range from seeing addiction as a sex-negative concept that facilitates helplessness to feeling that the addiction label may obscure the line between those who have the illness and excuse those who are indulging in criminal behaviour.

What has also emerged is that perceptions of compulsive sexuality are inherently value-bound. Practitioners concur that their perceptions of sexually appropriate behaviour are culture bound, and this is particularly significant when working with sexual difficulties.

Objective

To explore therapists' understanding of the aetiology of sex addiction

Findings show that respondents' understanding of the aetiology of sex addition vary. This is related to the struggle to find consensus around diagnosis and definition which is true locally and also found in literature from abroad. This struggle evident in the literature is reviewed in Chapter Two and attested to the complex and often confounding nature of the behaviour referred to as compulsive sexuality. As the theoretical stance and perception influences understanding of aetiology, those working within a psychoanalytic framework

were reluctant to *label* the behaviour as sex addiction while those working within an addictionology framework saw the behaviour as having a clear and identifiable set of indicators that could constitute a sex addiction cycle, as described above.

Despite debate about perception and naming of the behaviour, however, it appears that aetiological understandings draw primarily from depth psychology, which seems to have provided the most substantial basis upon which to understand this behaviour. In this respect, faulty and inadequate bonding and attachments are seen to be the primary reason why addictions develop. Susceptibility to sex addiction is seen to occur when there is a specific sexual trauma, or another form of early childhood abuse or neglect. The child then chooses to eroticise those traumas and draws on his/her 'sexual self' as a mechanism for self-soothing; the caregiver having proven unreliable care or lacking in some way as a source of comfort in times of distress. Some practitioners felt that the phenomenon was a symptom evoked by the unconscious need to restore psychological equilibrium or to evolve spiritually.

A link between sex addiction and intimacy was made in that recovery or treatment was seen to enhance the ability to be intimate; however, there were diverse and inconclusive opinions on the relationship between the two areas, in relation to aetiology. While some saw the link in terms of intimacy problems resulting in sex addiction, others saw intimacy problems as resulting from sex addition.

Objective

To ascertain which therapeutic models are being used for treatment and why they are seen to be useful.

Findings emphasise that treatment needs to be eclectic and to draw from a variety of methodologies. Practitioners understand the clinical dynamics primarily from an eclectic perspective and most treat the problem from an eclectic perspective too, in response to the complexity of the work. Herring (2004: 35) endorses this view: "The concept of out-of-control sexual behaviour is too complex a form of human behaviour to exist within the

province of any one paradigm." It was felt that as experience increases, so does understanding that this is a highly complex area requiring a range of theoretical considerations, techniques and skills. What emerged too was that different therapeutic models determine different priorities around treatment. For example, the addiction model will emphasise the stopping of the acting out, whereas the psychodynamic model will focus on the development of a therapeutic alliance so as that the client's primary attachment can be reworked.

Objective

To examine the subjective experiences of the therapists working in this field.

Findings indicate that therapists experience a range of subjective responses to this work. What emerges is that the work is stimulating and highly evocative, evoking strong counter-transference reactions. This necessitates intense self reflection, which can result in extensive personal and professional transformation. Separating and distinguishing between personal and professional responses to the material becomes more comfortable as practitioners become more experienced. The nature of the work challenges therapeutic boundaries and a high level of vigilance around boundaries is imperative to ensure that these boundaries are not crossed either by practitioners or clients.

The work is seen to be long-term, fraught with a high incidence of relapses. Clients can be overtly resistant, often enduring extensive pain and chaos in their lives before acknowledging the need for treatment. Due to the early onset of difficulties the problems clients face are felt to be of a deeply archaic nature and therefore potentially intractable. This, together with the high relapse rate, can leave practitioners feeling overwhelmed, demoralised and demotivated. Practitioners at intake level or primary rehabilitation programmes report feeling unsupported by other professionals, in that many professional working outside the field were reluctant to take on clients in a long term capacity. Given the dearth of knowledge about the phenomenon and the marginalisation of the field, practitioners also report feeling professionally lonely within the wider therapeutic community.

Objective

To ascertain what is needed in terms of specific knowledge, skills and resources for the therapist to work effectively.

The findings show that the field needs South African research to inform local practitioners, to promote integration into the professional mainstream, to enhance broader professional support, particularly in terms of referral sources, and to highlight awareness of responsible ethical practice. There is a need for debate within local forums around definition and understanding. Findings indicate that practitioners are guided by professional codes of ethics at times and by their personal sense of integrity at other times. This contributes to a lack of clarity about procedure and is open to potential abuse (See recommendations). In terms of ongoing therapy, referral to long-term practitioners is marred by the attitude of other mental health professionals, as well as their lack of awareness and knowledge.

Findings further show that there is a lack of experience and a knowledge base in practitioners. Less than half of the practitioners interviewed reported that they had extensive experience in this work, while the other practitioners felt they had limited experience and spoke from that perspective. A number of potential respondents approached declined participation as they said they did not have experience. This raises questions as to why so few people are working with this problem. Possible answers include the marginalisation of the issue; taboo around acknowledging the problem; a lack of confidence in the helping profession; and questions around epidemiology, that is, whether the problem is as widespread as claimed by proponents of the concept.

Objective

To explore therapists' perceptions of the link between sex addiction and the current social context

The findings indicate that the current social context is seen to play a role both in terms of more easily recognising the phenomenon as well as exacerbating a problem that has been present for longer than previously acknowledged. A pivotal point common across many of the interviews was the paradox in contemporary Western society, that despite unprecedented permissiveness around sex, the sexual taboo is as powerful as ever. While the 'sexual revolution' has brought about a more open, permissive attitude to sex, this transparency also has a sex-negative result. Sex is exploited for commercial and entertainment value in a way that leaves children exposed to media images and scenarios at a vulnerable age.

Emphasis was placed on sex addiction as a cross-gender phenomenon. Practitioners insist that while sex addiction manifests mainly among men, it *is* a cross-gender phenomenon. Some practitioners felt that the stigma surrounding sex addiction in general and the even greater stigma applied to women, maintains the silence and makes it more difficult for women to come forward for help.

It was felt that an imperative is to revisit the concept of a model of sexual health which would promote constructive psycho-sexual development. This is endorsed by Klein's ideas (2002: 6): "We need a model of sexual health that is clinically complex and culturally informed and sex-positive. We need a model that is supportive of adult identity. Being an adult is complicated and scary, and sometimes it's very difficult. A lot of people would like to make their sexuality so simple so as not to be scared. And our job is to help people understand that while it is, in fact, scary to be a grown up, we can provide some tools that can help them deal with their fear. We don't have to strip down their sexuality to take away the darkness, the complexity, the ambiguity, just so people can be more comfortable."

5.3 Recommendations

In the light of the findings of this study, key recommendations include the need for training and education; networking and organising; local research; advocacy; and addressing gender relations and the sexual taboo which has contributed to a sex-negative culture in a milieu of permissiveness.

5.3.1 Training and education

There is a great need for sex education which could take place in a number of forums. Sex education needs to be appropriate in that it needs to cultivate people's ability to make informed decisions and behave in a responsible way, as well as impart information.

Training in human sexuality and compulsive sexuality could be included in:

a) *The curriculum of formal clinical training institutions.* This training could provide a forum for students in order to raise their level of awareness as well as examine their own attitudes around sexuality, thus enabling them to grapple with the often demanding and complex issues that arise in this work.

b) A *post-qualification training for the helping professions.* Because this clinical picture has strong co-morbidity with other illnesses it is likely that a wide range of students and graduated professionals in the helping profession and wider medical fraternity will come across this phenomenon. As discussed earlier, co-morbid illnesses include obsessive-compulsive disorder, affective disorders, attention deficit hyperactivity disorder, brain injury, and hormonal and chemical imbalances. Practitioner knowledge needs to enable early detection, diagnosis and treatment.

c) *At community level.* Training and raising awareness can be done with a variety of service and community organisations. At this level it would be useful for people to be aware of and identify risk factors leading to inappropriate sexual behaviours, so that preventative strategies can be called upon, as opposed to intervention after a problem has developed.

d) *Parents and adults working with children*. There is wide scope for educating parents of young children around healthy sexuality. Work around reducing a shame-based relationship to sex and the taboo around sex seems necessary, so that children can grow up processing their sexuality in a way that is respectful of themselves and others. Sexual health needs enhancing and promoting at all levels of society.

5.3.2 Networking

Networking can be more fully extended. There is a great deal that can be learnt from all sectors working within the field and cross-pollination of ideas and research requires greater co-operation. For example, addictionologists and those with knowledge of cognitive-behavioural techniques can impart knowledge and skills on managing behaviour felt to be problematic by the client. They in turn would benefit from psychodynamic insights into aspects of the problem. Strengthening alliances between interest groups could promote the dissemination of a comprehensive body of knowledge about the phenomenon, as well as draw in funds required to institute educative programmes at local and national level.

5.3.3 Local research

South African research that educates about the extent of the problem locally would be useful. In this respect, if it were found that it is indeed as widespread as it is believed to be in the United States, motivation for funding and intervention programmes could be put in place.

Research to date has neglected women's experiences and failed to determine what support is available and required. Knowledge around women's experiences can reduce stigma and increase available services for women, facilitate transparency and ease difficulties around disclosure.

The relationship between HIV/Aids and sex addiction needs further exploration. If sex addiction is found to be prevalent amongst HIV-positive people, intervention programmes need to be put in place.

The link between sex addiction and molestation/sexual abuse needs attention. If sex addiction is found to be prevalent amongst those perpetuating sexually violent crimes, it

is possible that appropriate measures can be brought to bear on the phenomenon of extensive sexual abuse in this country.

Research into why so few professionals are working with this problem needs to be undertaken. Potential areas to explore include the marginalisation of the issue; taboo around acknowledging the problem; a lack of confidence in the helping profession and therefore a dearth of self-referrals; and questions around epidemiology, that is, whether the problem is as widespread as claimed by proponents of the concept.

Furthermore, if possible given the previous statement, a larger sample which includes different cultural groups of practitioners should be used in further research into this topic.

5.3.4 Advocacy

Given the level of sexual abuse of children in this country, it seems fitting that the strong link between enduring sexual and other forms of abuse in early childhood, and consequent later adult dysfunction, be made apparent to policymakers. This would facilitate accessible funding and support for appropriate programmes to promote and ensure healthy family functioning and early childhood environments.

5.3.5 Addressing gender relations and gender roles

The emotional health of men and women needs continued attention. It seems appropriate for educational programmes to include content that helps men and women challenge conditioning that leaves them vulnerable to emotional depletion, and unable to live out qualities other than those assigned as acceptable for their gender. Programmes that promote emotionally fulfilling lives could enhance the overall emotional and sexual wellbeing of a society.

5.3.6 Addressing a sex-negative culture and the sexual taboo

While work in the field of sex addiction happens primarily in the therapeutic or clinical context, in which sex addiction impacts at the individual, couple, or family level, recommendations can be also be made aimed at the level of community and societal mental health. Attitudes to sexuality, the sexual taboo and the paradox between a sexually permissive society combined with a sex-negative culture, is seen to impact strongly on

the phenomenon of out-of-control sexuality that leaves people emotionally isolated and estranged from themselves and others.

5.4 Conclusion

This study has shown that sex addiction remains contested as a generally accepted and valid concept as depicted by clinicians. It is seen as a complex clinical phenomenon that has a wide aetiological base and cuts across class, race and gender. The field requires that clinicians work within a broad range of theoretical models and with a variety of techniques and skills. It further demands a high level of internal introspection and adaptation from practitioners, if they are to be effective in working with this clientele. There is an element of felt isolation from other mental health practitioners who are perceived to be unaware and/or reluctant to engage with the phenomenon. The societal taboo around sex and a sex-negative culture is felt to be, if not causative, certainly playing a role in complicating the clinical picture. This study also uncovered the paucity of local research in the field and points to the need to develop theory and policy that will result in well informed assessment procedures, integrated referral networks and appropriately funded treatment services.

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Appendix One

Semi-structured interview schedule

Identifying details were gathered regarding:

- Professional qualifications
- Years of being in practice
- Gender

The following semi-structured interview schedule was used as a guideline:

1. In what context do you see the problem of out-of-control sexual behaviour?

2. What do you understand by the term sex addiction?

3. How would you define the problem that you are seeing? Would you call it sex addiction or something else?

4. What do you understand to be the aetiology of sex addiction?

5. What do you see as the reason why the symptom occurs around sexual behaviour, as opposed to another substance or behaviour?

6. We know that sex addiction may co-exist with other addictions; do you see sex addiction presenting without other addictions?

7. Which theoretical paradigms or models have you used to inform you of your understanding of the aetiology?

8. Do you feel there is a relationship with this behaviour and intimacy problems? If so, how would you describe that relationship? How would you see the link?

9. What therapeutic models of intervention have you found useful and that have worked? What about these models have you found useful?

10. What has your subjective experience been in working with this client population?

11. Have you experienced any special challenges around ethical issues?

12. What do you feel is your attitude towards the kind of sexuality you are seeing in relation to this issue?

13. Have you had difficulties reconciling your attitudes with what you are hearing from the client?

14. How do you feel your values and attitudes about sexuality have impacted on your work with these clients?

15. What role do you think the current social culture plays in the development of the problem?

16. What would you say is needed for therapists to work efficiently and in a contained way in this field?

Appendix Two

Consent form

1. I confirm that I understand what this research is about, why it is being undertaken, and what tasks will be expected of me in the process.
2. I understand that I do not have to answer questions if I do not wish to, and that I am free to withdraw from the process at any point in the research process, without having to justify why.
3. I confirm that I am giving my consent to this interview being recorded on tape and that the material will be recorded over after transcription.
4. I understand that the interview material will remain anonymous and confidentiality will be guaranteed at all times. Discussions with the researcher's supervisor will uphold anonymity.
5. I agree that the material, and my words, that are recorded during the interview, can be used, without giving my name, in the presentation of the research. This may include publication.
6. I am willing to briefly comment on any point needing clarification later by e-mail, should this be necessary, at a time that is convenient to me.
7. I have had the chance to ask any questions about the process.

Name of participant: _____

Signature of participant: _____

Date: _____

Researcher: _____

Signature of researcher: _____

Date: _____

Appendix Three

Sample interview

Could you tell me what your qualifications are and how many years you have been practicing? I'm a Psychiatrist and a Jungian analyst. Been in practice for about 30 years. Been in private practice for about 16 of those years.

How would you define what is called out-of-control sex or hypersexuality? Or would you accept the term sex addiction? Absolutely, there's no doubt about it, sex addiction exists. It's very difficult to differentiate, when there's a fine line between simply enjoying sexual, one's own sexuality, or whatever that rhythm or form that may take, and when it becomes, crosses over and becomes what we would define as either a compulsion/addiction. There's no good definition; the best one that I've come up with is probably when the person themselves acknowledges that they've lost control, that they're no longer in control and they find themselves increasingly driven by this desire for various forms of sexuality, whichever form that make take, over which they feel, something takes over and they are no longer in control, similar to any addiction really.

What would you see as the debate around seeing it as other disorders, for example, impulse control disorder, as opposed to an addiction? I think that's semantics. Certainly it's an impulse control disorder, but you can have an impulse control disorder and it not be an addiction. I think if we're defining addiction it is causing problems for self or others, and you can't stop it and you feel out of control, then it becomes an addiction, whether it's substances or sex. Impulse control disorder can be part of ADD. has impulsivity, it could be part of an Axis 2 diagnosis, like borderline PD can be impulsive – a feature rather than a diagnosis.

So while there's an addictive spectrum to consider, there's often underlying depression, anxiety, obsessive-compulsive disorder, and then Axis 2 problems.

And there's this crossover between sex and love addiction, and the two really need to be separated out. This definition puts them together (refers to the DSM criteria for Sexual Dysfunction Not Otherwise Specified): 'Distress about a pattern of repeated sexual *relationships* involving a succession of lovers who are experienced by the individual only as things to be used.' According to the manual, sex addiction involves *compulsive* searching for multiple partners, compulsive fixation on an *unattainable* partner, (that's *love* addiction, not sex addiction), compulsive masturbation, compulsive love relationships, (that's love addiction again) and compulsive sexuality in relationships.
The DSM has not sorted it out.

The National Council says: 'Engaging in persistent and escalating patterns of sexual behaviour acted out despite increasing negative consequences to self and others.' That's a good one. I think that's a good definition.

What do you understand to be the aetiology of sex addiction? I think that's an *extraordinarily* complex question. And I do not believe that *anyone* is going to have a definitive answer to that. Why sex, why not substance. Is there a difference? Well, what we *do* know is that many sex addicts, there's a very frequently, there are other addictions as well going hand in hand. The *actual* aetiology to where it goes back? There's some *very* compelling research, I don't know whether you're aware of Alan Shore's work? Well, it's very interesting. His theory is that what occurs is, what we now know is that following birth of the infant, the brain continues to develop right through into 18 months up to two years. And *very* significant neuronal pathways are still being forged.

And the one's that are specifically important are the ones between the fronto-orbital area of the brain and the limbic system, particularly the amygdale, but the whole of the limbic system and what that whole system is responsible for if all goes well, and if there's adequate parenting, and nurturing etc, those neuronal pathways from the orbito-frontal cortex to the limbic system are going to be responsible for appropriate mediation of affect. If however, during that *crucial* period of 18 months to two years there's either neglect or abuse that occurs in various forms, this process gets interrupted and the

neuronal pathways are not forged adequately, and that leaves the individual, the little child, the adolescent vulnerable to difficulty appropriately mediating powerful affect and then they're inclined to act out the affect – and impulsivity is one of them.

And he's also shown quite compellingly that when this process occurs, what fosters this process is the bonding between caregiver and the infant. If that bonding experience is significantly disrupted, this process doesn't happen and bonding, more appropriate mature kind of relationships in later life, are very problematic. So, he doesn't specifically mention sexual addiction, but he certainly does say that this early neglect or abuse during that crucial period, it does seem to be now compelling psycho-neurobiological back-up, why the individual is then now vulnerable to a whole spectrum of impulse dysregulation disorders, which would include substance addiction, sexual addiction and Axis 2 problems, particularly borderline, narcissistic and so on and so forth. It's still not clear why does person x choose alcohol, person y tik or cocaine, another person downers, and then another person sexual addiction, or various combinations thereof.

It seems like the person who ends up with sexual addiction, you could say it falls into the same difficult group of eating disorders, because it is such a, that is a *primary* instinct. You have to eat and you have to have sex. Human beings, that's just part [of] who we are. So when that gets cross-wired with an impulse control, addictive tendency it's much more difficult to treat and much more problematic than substance abuse disorders. Because it kind of goes to the core of relating, because in relationships sexuality and eroticism forms part of many relationships and if that has gone awry and there has been inadequate, whether its based on inadequate neuronal pathways that have formed, or as yet other poorly understood reasons, it becomes a very difficult piece to have to tease out. From a Jungian perspective, there's another piece I have found that I have found to be quite interesting. It would appear that human beings have a desire for a connection with what Jung called the 'numinous', that is, the transpersonal, the sacred, that which is difficult to define but when you connect with it, whether it's through some beautiful piece of music, or poetry or dance, or a beautiful work of art, or through a very powerful sexual experience, you know it when you experience it, you know that this is profound, it

moves one. We have various ways of saying 'that really touched me', I was moved to tears, etc, etc. Well, the whole sexual experience, not every sexual encounter, but many sexual experiences if it really works well, with the release of the endorphins into the brain, induces a *profound* state of altered consciousness, and as you probably well know, during that state, one loses touch with the environment, you lose track of time, you're not even aware of sounds etc, etc, and it is all focused on this incredible, powerful, numinous experience.

In a part, of course facilitated by the chemistry, the endorphins, but because we live in a desacralised society where we don't have any formalised way of connecting with that energy anymore, churches, formalised religion, for most people that doesn't work anymore. Formalised religion *used* to be a good way of connecting with this energy, if you could *really* believe and you could *really*, if an icon really did it for you, that would be that connection you see, or if your rosary did it for you, for most people it doesn't do it anymore, *but sex does.* That's why it becomes this one, powerful thing that people will often latch onto and are very reluctant to give up because it is the *one* thing that gives them the entrée into this longed-for experience and connection with what we would call the sacred, the divine, the whatever.

What about when it's not experienced as meaningful and is actually quite unsatisfactory? The person engaging in it doesn't understand, you see. They don't realise that this is what is occurring, that this is what they found. There's a catch too. It doesn't work very often with any partner that you get to know, it has to be an anonymous partner on to which you can project all of this powerful, from a Jungian perspective it would be this self energy, this Phallus (in the case of gay men for example) of the other is the G-d, the G-d Dionysus, not that *any* of this is conscious, you see. But there is this worship, this falling on the knees, this feeling of absolutely giving over to this experience, none of which is particularly conscious, and of course none of it lasts because there's no, the dots aren't connected, so the person will keep going back, will keep seeking more and more, and then what happens is a kind of, the person keeps upping the,

often more riskier type of situations to get that adrenalin rush, to get all those chemicals to give the desired effect, you see.

What about when sex happens outside of one's usual social parameters such as prostitutes, public toilets, etc – is that upping the stakes or is that something else? I do think that's something else. Because in our culture, I think this is a piece of it, there might be other pieces, in our culture, sex is very much, *even* in the year 2005, even though it's on the television and movies, really in homes and in our culture, it's still sort of you know, it's swept under the rugs, its something you don't talk about *really*, it's *not out in the open.*

That's the thing, it's not out in the open, so again from a Jungian perspective it gets really easily snuck into the shadow aspect of the person. It gets, you know, because it's shameful, and this is of course *particularly* relevant to gay men, where their sexuality is shamed from the outset, and the form in which their sexuality is shamed, so it has to go underground. So many of the sexual encounters then occur in the dark, in the underground, in the shadowy places, you see, and it then just also happens to increase the excitement as well.

This would be the case then for anyone whose sexuality was shamed at an early stage, I would imagine. Certainly.

How would you describe the link between sex addiction and intimacy?
Intimacy connection, ordinary, vanilla sex. Not sure that there's necessarily an issue with intimacy. I've seen a number of cases of people who have a *perfectly fine partnership relationship*, that has been established over several years maybe, comfortable, supportive, nurturing, but well no, after the first two weeks and months, maybe if you're lucky the first year or two, the sexuality in *any* ongoing relationship peaks right up early and then it gradually declines until you find a sort of equilibrium, but it's certainly not going to be a 4th of July stuff anymore; it just isn't. You know, it's comfortable, it's pleasurable, but it's not that *excitement* that many addicts get attached to, it's the *excitement* affect that

they seek out. That *can't* be experienced with their partner, so it has to be sought elsewhere. The excitement is an attempt to compensate for a lack of connection with one's own real self which with *any* addiction at some level is being avoided. Because we're all reluctant to really face our own inner self, deal with our abandonment issues, the pain of our losses and grief and rage and anger and abuse etc, etc, so it's much easier to try to repress all of that with various addictive behaviours and I think that sex becomes part of that. In that it's an avoidance, an attempt to, it appears as if on the surface it's fulfilling this need for excitement but this excitement is actually an avoidance.

What is the theoretical framework that you have drawn from for your understanding of this issue? Bio-physiological-anatomical aspect that I find fascinating because it does really seem to provide this neurological logical explanation for what might be occurring here.

And your models of intervention? Personally I think it needs to be a multi-pronged approach. Don't think there's just one way in here. When I find that someone really does have a sexual addiction, I will always recommend that they get involved with a 12-step programme. I *absolutely* believe in 12-step programmes and I think that it's very effective if they commit, and if they're willing to work the programme, there's no question.... Do you know that Jung actually helped formulate the 12-step programme? It's like a mini process of individuation, all those steps. It's like a summary of his whole concept of what would be required to bring about transformation of the psyche. And I think that's why its kept going all these years. Partly because it does work, if people are willing to involve, however its of course very difficult for people to commit and get through the door and actually to working the programme in a support group.

But I recommend that they do. And if they do, that's obviously going to be beneficial. The other mainstay of the treatment is the relationship. Because fortunately, what Shore and others have shown now, is that, if it wasn't for this reason we could stop doing the work that we do – the brain *does* maintain its plasticity throughout life. It *can* sprout new neuronal pathways, those damaged neuronal pathways *can* be forged through the

interpersonal work in the individual therapy. And I don't think it matters particularly what kind of therapy approach you're doing. It's the *relationship* which is ultimately going to bring about healing. The integrity and the quality of the relationship.

Also I make use of CBT type of interventions, you know, identifying triggers, peoples, places and things, thought patterns, looking at what occurs with loneliness when you're alone, what starts coming up, utilising tools like writing, trying to identify the emotions, naming the emotions, placing the emotions in the body (psychoeducational). Many of these people have to be taught emotional processing 101, and that's very helpful. And then identifying what Jung call complexes, when something gets really triggered that starts an obsessive complex, to identify that, to use some tools to stop that, which would be more CBT –- bringing down a boom with a stop sign. I often will go over a whole set of alternatives for people – you know, call your sponsor, call a friend, call your therapist. Write, do some deep breathing, go to the gym, put on some music, etc, etc. I'll often help formulate a whole list of tools that can, because what we are attempting to do is find alternatives to this addictive pattern of behaviour.

And at the same time I also utilise insight-oriented therapy and working with dreams, just basic therapy.

Moving on to your subjective experience in working with this client population, do you find that this work brings up any special ethical challenges around for example safe sex perhaps, or other issues? I have no qualms about raising issues of safer sex, talking about what are you, what exactly do you do, which I find is actually very helpful, because people have so much shame around these issues, that it's very *hard* initially to *talk* about and just discuss these things, but through the years there's not much that I haven't heard in this world, so I'm very comfortable, and once they perceive that I'm very comfortable with whatever, and I'm not going to be judgmental, then it helps to decrease the shame around the discussion, and I always make a pitch for *especially* when there's other substances involved, you know, are you aware that that is going to impair your judgment? And you're going to have to make sure you're taking precautions ahead

of time etc, but I've never been in that unenviable position of finding out that a spouse or a partner is having unsafe sex and putting the other partner at risk and what do you do about that. If that were to occur, I would treat it as a therapeutic issue, I would *never* contact the other partner without this partner's permission, but I would certainly not let it slip under the rug.

Any particular difficulties? I think the greatest difficulty is that it *is* such a primary drive, it's like eating disorders. Eating disorders are *notoriously* difficult to work with, because it's such a primary impulse, desire, and in my experience there's *often* relapses; people will do well for a while and then just, and it's usually precipitated by, I find as people get stronger, developing ego strengths to tolerate the discomfort of the affects that get triggered, then things start going better. But I know now, the chances of relapses, you just hope that they get less frequent for shorter duration.

Can you describe your emotional response to the work, any specific countertransference? I would think, if I had to generalise, I have particularly with sex addicts, it's hard, because I get impatient. They have, and I'm generalising, a lot of resistance to insights and to having to give up this exceedingly pleasurable but often dangerous, potentially destructive, and all of that, but it's the pleasurable aspect that they're very reluctant to give up, the countertransference is really like – get with the programme! How long are you going to keep doing this?! I don't say it but I think it.

One of the things, I'm thinking of one particular person who had these relapses and then not show up for sessions, I find that quite problematic. I get worried, concerned, is this something serious, it's probably a relapse, why hasn't he called, and then one has to wait until he finally emerges again and calls, that's hard. Even when we have an agreement that he will call and let me know what's going on when he would go into – a combination of drug, weekend binge, he would do crack and sex, that he'd be so exhausted when he came out of that that he couldn't even pick up the phone and say I can't make it and whatever.

Regarding your values and this work. You mention being very comfortable with what you see and hear. Can you describe the process to get to the place where you are now? Of course it's been a struggle, because I, like everyone else in this society, had to go through my own process of coming to terms with my own sexuality, and dealing with all the shame and discomfort and after all the years and years and years of analysis and work, you know, even from time to time now it's not something that doesn't get totally laid to rest. I'm much better, but, I had to go through a whole *healing* process, myself. One of the most interesting things I found, besides for my own analysis, which went on for many years, one of the most seminal healing experiences I had was through a group in the States called 'Body Electric'. What they did was they put together a workshop that was totally experiential.

They researched Taoist massage techniques, the workshops were primarily done in the nude, and you were taught to give and receive a Taoist erotic massage. With the purpose first of all, dealing with all the shame and detoxifying the shame, and then the experience of eroticising the *entire* body and not just being genitally focused. The way they set up the workshop, most of it was done blind-folded, the massages, so you couldn't use the usual visual cues that you use, and all that you could experience was your own sensuality, your own eroticism, throughout your body. And they would switch every 10 minutes so you couldn't get attached to one pair of hands. And I did several of those workshops, various forms of them. That experiential kind of thing was what I found, personally, to be more healing than all the years of analysis. (smiles)

Yes, Body work circumvents the brain. Exactly. It doesn't go through the head you see. And for this primary, instinctual piece, you know, that is my experience, it's interesting.

You can talk the hind leg off a donkey, you can have all the insights in the world but something about that experiential piece, that was profoundly healing. I've actually thought about bringing these guys out here to do a workshop, they were delighted at the thought. I think it would be fantastic.

So after a lot of your own work, how do you feel hearing the material? Totally non-judgmental, you know, just comparing to when I just started out, must be 30 years ago, the first patients, and I was training, and one of the first patients, and she started talking about masturbation, *I nearly died* of embarrassment (laughs) and when I think of where I've gotten to now, you know, where I will talk with *ease* about *any* form of sexuality. I mean, I don't think there's any form of sexuality I don't know about, experienced most of, or versions thereof, you know, it's like, it's fine, whatever you need to talk about, it's fine.

And they must feel it. That's a very important issue that you raise there, because I really do believe that what brings about the healing is the *being* of the therapist. That's really the important thing. Whatever we do, yes, there are helpful things, insight, interpretation, but it's the *being* of the therapist that's going to be the determining factor.

Would you say anything is needed particularly for this work beyond general therapeutic presence? The therapist needs to be comfortable, solid, grounded, able to tolerate, able to stay with and be in touch with, just being really present, there. Any therapist who hasn't dealt with their own issues of sexuality, and what their particular proclivities might be, or what they haven't explored, then of course, there are problems. Because they can start vicariously living out through the practice member – we like to call it practice member these days. (smiles) Can't call them patients, you can't call them clients!

Research does show there are professionals who are involved with that. *And not to mention acting out!* I dealt with several cases in New York where there'd been sexual acting out. It's unspeakable. The damage that gets done, the rewounding that occurs. When there's any sexual acting out within the therapeutic relationship. That I think is really, really, really bad.

I'm thinking of one particular case, it was so pernicious, because, we've got to be so careful as therapists, because he fell into the trap. She, the practice member, was saying

to him, what I need, the healing will be if you love me in a way that I've never been loved before. And so, instead of *interpreting* that and staying in an analytical mode, he started saying, of *course* I love you, look I'll *show* you, see, look, I have an erection, see, you *are* lovable, you *are* sexy. And of course, this became fascinating to her, but this was the little girl who was wanting the parent, this was all the wrong way round.

How did this get found out? I was seeing her for medication, and she was seeing this therapist for therapy, and at some point when it got to the point just stopped short of actual sexual intercourse where he in one session embraced her, rubbed his penis up against her, and started kissing her, she left almost in a psychotic state, called one of her friends, who happened to also know this friend, who knew she was seeing me, and the friend called me and said, this is what's happened, you've got to do something.

And what did you do? Well, I called her, and she finally told me this had happened. I called the therapist who actually confessed, he said, you're right, I did. In this particular instance she stopped seeing him and because she had the connection with me, she started working with me. But she then laid ethical charges against him and it was the most extraordinary thing. I mean it was *extraordinarily* difficult. You know what they did? The organisation? They *absolutely* closed ranks. They pathologised *her*, they pathologised *me* as her new therapist. They said that this had all been made up, that this was fantasy. Because she had an eating disorder, and didn't we know that people with eating disorders often had sexual fantasies with their…

So there was no recourse there. No recourse. He did pay out whatever his malpractice insurance, it was like 20 thousand dollars or something, that he paid out to avoid a court case, but she never got the satisfaction of having her experience validated by the professional body or having him kicked out, and he continues on his way. That so frequently happens.

In the course of my interviewing I have heard of things happening here; what does one do with these collegial issues? I don't know what the law says, one has to go and

see what the law says, because you see, if it was child abuse, you'd have to report it. Recently, at Valkenberg, one of the social workers did a wonderful presentation on elder abuse, and I wasn't aware, but the law says, if you become aware of an elder either abusing themselves, like taking drugs or drinking and neglecting themselves, and you don't report it you can be had up, or, if you know of some family member abusing an elder, you're obliged to report it. But in this particular instance, I don't know what you do.

And the issue of bestiality is another area that throws up ethical dilemmas... You see, that's very interesting, I'd have a very strong countertransference there, I would not tolerate that, I'd say, you know what, if you were going to continue doing this, I can't work with you. Sorry. This is not possible, I'll help you find a new therapist but this is not possible. I have too much of a feeling for animals, no matter what your needs are and this is part of your process, no, I could not do that.

What do you feel is needed in order to help therapists working in this field be effective and supported in their work? It's very new here, not much networking etc, People are not working with it.*Not at all*! It's very interesting, when I did this talk at the triangle project most people, the person whose running the triangle project is coming across this more and more; he wants to get people referred, and therapists are, oh, no, no, no, I can't treat that, no I can't touch that, I'm not going to do sex addiction. So it's sort of really new! Newish. (laughs) People feel they're inexperienced, they're out of their depth.

What role do you think the current social culture plays in this issue?

Well, our social culture is so complex, but just for example with the HIV thing, it's so clear the stigma, sex, everybody's having sex but we don't really, you know, we don't talk about it and we pretend that we're not really having sex. It's so absolutely ludicrous. But that's part of the oppressive, religious, cultural discomfort.

There's that, but then there's also the explosion of sex images all over... Yes! Yes! But it's almost as if it's out there, you know, it's done vicariously, yes, and you're presented with all these images of very erotic sexual images but it hasn't made it more comfortable for people to just talk about. Doesn't seem like it. With Pieter Dirk Uys, he's doing HIV prevention work and he goes to schools and in his very funny way he'll have condoms out, and he's very in your face, the kids and the teachers, they almost can't deal with it, they're tittering and laughing, blushing, eventually they sort of settle down, but, we don't talk about these things, we don't name them...

Do you think the out-there-ness of sexuality is a way of people moving towards a way of expressing their sexuality, or not? I'm not sure that this is a movement towards greater comfort with sexuality, I think this is purely about that the powers that be have found that this is a great way to make money and its not about educating, its not about getting people more comforting, it's got shock value, and it sells their movies, and it pushes up their ratings.

And I think it means is, you see, it's not being integrated. You're being thrown all this imagery, but there's no chance to work it all through and integrate it, so then it turns nasty, it turns into shadow stuff, and then there's rape, and incest, and abuse and molestation and all that stuff gets triggered because there's no foundation where this information can be processed and you can deal with it and you can make choices.

So it seems like it's a different form of shadow – in Victorian times the shadow was totally repressed, happening behind closed doors... Ja, now it's more in your face but still not integrated.