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# **Sexual Addiction: A Psychotherapeutic Approach**

**A project submitted to the Middlesex University in collaboration with  
Metanoia Institute in partial fulfilment of the requirement for the degree  
of Doctor in Psychotherapy by Professional Studies**

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## **Abstract**

This research project contains a first proposal, a second proposal, and an examination of the decision to change from the first to the second, and four products of the research. This was an aborted interview-intensive qualitative research initiative with paedophile sexual offenders. The second was the development of a treatment and training programme for sexual addiction. The change from the first to the second was caused by the secondary trauma that followed exposure to the primary trauma of others. The four products principally cover the following subjects: 1] narcissistic damage, sexual addiction and religious behaviour 2] causation issues in sexual abuse in the church 3] researching sensitive and distressing topics 4] treatment and training issues in sexual addiction. The fourth product was preceded by a quantitative research project. The whole of the above is anchored in the story of a personal journey and includes an analysis of the theory of sexual addiction.

***This work is dedicated to***  
***Julie Norman***  
***Friend, benefactor and fellow traveller***

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## Introduction

The *Review of Previous Learning*, the first stage of this doctoral project, was submitted in the winter of 2000. It finished with these penultimate words,

The project that I plan ahead, and the academic work that I propose to do, is clearly a combination of personal history, academic work and application; cross-referenced, synthesised and brought forward in tandem.

This project, which is now completed, has been that combination: a synthesis of personal history, academic work and application. It is the outworking of the original academic, professional and clinical intention.

This project began with the intention of researching the relationship between sexual and religious behaviour especially as it contributes to offender behaviour. I found this research so distressing that I applied for, and was given, permission to change my proposal to the creation of a sexual addiction treatment and training programme for psychotherapists and other health care professionals. The following document relates to the first and second proposal and the decision to change from one proposal to another.

It contains the following material:

**The Journey to the Doctorate**— sets forth a personal narrative, 'a *narrative of the self*' [Richardson, 1994, p521]. It begins with the reasons for the journey, describes the journey up to and during the doctoral project, evaluates the programme of specialist seminars, comments on some of the Level Five

Descriptors and lists some of the contributions to the profession of psychotherapy made by the doctoral project.

**The Theory of Sexual Addiction**—This chapter is concerned with the theory of sexual addiction and concepts related to the theory of sexual addiction. It is divided into eight sections: sources of conceptual data, components of the theory sexual addiction, locating the theory of sexual addiction in a wider context, treatment and methodology, a discussion of nomenclature, case studies and reflections on the limitations of the theoretical material. Treatment and methodology are considered in this section because of their close association with the development of theory. In addition to definitions and descriptions, at the core of the chapter, there are the principal conceptual components of a theory of sexual addiction, among them:

- Narcissistic Damage
- Sexualization
- Shame: the Principal Driver
- Addiction and the Regulation of Affect

Also in this chapter there has been an emphasis on demonstrating in the text and by diagram all the interconnections between the theoretical components. The overall aim of this chapter is to explain the theoretical and conceptual basis that lies behind the project and the products of the project.

**Literature Review / Sexual Addiction** —This is a review of the sexual addiction literature and limits itself only to that literature. This chapter is dominated by the work of Patrick Carnes, Aviel Goodman, and Charlotte Kasl. The latter part of the chapter concentrates on the literature on Internet sexual

addiction and the chapter ends with the personal comments on the theoretical content of the literature drawn from clinical practice.

**Literature Review / Critical of Sexual Addiction**—This chapter contains a review of the literature critical of the concept of sexual addiction and which challenges the usefulness of the proliferation of ‘addiction discourse’.

**Quantitative Research Project**— Prior to the preparation of the fourth product, a quantitative research project was undertaken to ascertain the need and usefulness of the product. This quantitative research has been given its own chapter and the research is explained in a standard research format.

**An Introduction to the Products**—This chapter introduces and explains the four products created by the research with particular reference to methodology, the contents of each product, the processes involved, and where appropriate, the limitations associated with each product. It makes reference to two additional products that have also grown out of this project but lie outside the time frame of the research.

**Overview and Conclusion**—This chapter contains an overview of the four-year process that lies behind this doctoral project and the role and function of the process itself during that four-year time frame. The chapter continues with a reference to the general limitations of the project but goes on to highlight and list the learning outcomes and conclusions of the work.

**The Appendix**—contains background material relevant to the whole of the project as well as the products of the project. It also contains a revision of the first product and information about the sexual addiction treatment programme that is still a 'work in progress'.

The first product, the journal article, **Narcissistic Damage, Religious Behaviour, and Sexual Addiction**, explores the relationship between religious behaviour and sexual addiction and locates the relationship in the common source of narcissistic damage. The motivation for this article was to understand the aetiology of sexual misconduct in religious organisations.

The second product, **Time for Action**, is a report to the member churches of Churches Together in Britain and Ireland, and for sale to the public, of the problem of sexual abuse in the church. This book focuses in particular on the sexual abuse of adults by religious officials. My contribution was Chapter 9, the chapter on causation, and part of Chapter 3, on definitions and the parameters of the research. The contents of the product contain only the material for the chapter on causation. When it was launched on the 3<sup>rd</sup> December 2002 there was considerable media interest.

The United Kingdom Council for Psychotherapy [UKCP] Conference Paper, **Researching Sensitive and Distressing Topics**, was written to explore the decision made in the spring of 2002 to change the focus of research away from sexual and religious behaviour and to focus instead on the development of a 'sexual addiction' treatment and training programme for psychotherapists

and other professional health care workers. This paper was particularly interested in the traumatic and contaminating impact of distressing research on the well being of the researcher. The ideas in this paper are referred to in the chapter titled 'The Journey to the Doctorate' and draw especially on the specialist seminars. This paper has been submitted to Kamac for publication in a book, **What Is Psychotherapy Research?**

The final product of the research is a teaching programme to train psychotherapists and other health care professionals to work with sexual addiction and compulsivity. This is designed to be a stand-alone programme, or for continuing professional education, or to be inserted into an existing modular structure.

I wrote in the *Review of Previous Learning*,

The project that lies ahead, and these studies which are connected with it, are appropriate, sequential, interconnected, successive, integrative, and finally culminating. It is the culmination and application of a life story, scripts, imperatives, roles and acquired knowledge, with its outcome directed towards self-actualisation and the delivery of service to people in need.

The start of this project reflected the desire for a process of integration. The end of this project represents the achievement of culmination and application.

## **Chapter 1**

### **Journey to the Doctorate**

#### **Introduction**

##### **Reasons for the Journey**

I decided to undertake the doctoral programme for a number of reasons both professional and personal. The professional reasons include an opportunity for systematic learning, involvement with a community of researchers and practitioners, time and motivation to reflect on the application of knowledge to practice, to strengthen professional credibility, and to better equip the quality, professionalism, and excellence of clinical practice. It is a natural way to round off previous academic work and previous professional training. The personal reasons include a desire to understand and to make sense of my personal history, to amalgamate and synthesize all that has gone before, and to take and use the past to make sense of the present and to inform and shape the future. This doctorate is the pursuit of an interest in understanding narcissistic damage and the effects of narcissistic damage, especially shame, on adult functioning, sexuality, relationships, and in the causation of addictive compulsive processes. This is a story with academic, clinical, and personal components, consequences and outcomes.

#### **Section 1**

##### **Describing the Journey:**

###### **The Journey Leading Up to the Doctoral Programme**

I was educated in a church school, studied sociology and anthropology at university, and then did a diploma in theology and the general ordination

exams. Ordained in 1970, I worked in parish life until 2001, most of which was in central London. During my time in parish ministry I engaged in three major areas of study, two privately managed: cosmology and social structure, organisational development and addiction studies. Having completed an MSc in Psychosexual Therapy and accreditation with the British Association for Sexual and Relationship Therapy [BASRT] and registration with the United Kingdom Council for Psychotherapy [UKCP], I left full-time parish ministry to develop a third age career as a psychotherapist and psychosexual therapist. I intend to do this for the next 10 to 15 years.

Behind the story there is another story. The 'set up' for that journey begins long ago in my family of origin. I was the child of an unhappy, narcissistically damaged and emotionally needy mother, who was addicted to nicotine, alcohol and prescription drugs, and who, was eventually arrested for prostitution. She was emotionally seductive towards me in childhood and physically sexually seductive towards me in adolescence.

By contrast, my father avoided me. The family was divided but stayed together. I belonged to my mother and my brother belonged to my father, thus depriving me of a father and depriving him of a mother. He became a medical doctor and then a psychiatrist. He was eventually diagnosed with a bi-polar disorder, has been in and out of trouble with the police for shoplifting and drug offences, and has lost his license to practice medicine. I write about him to give an indication of the level of disturbance in the family and the severity of the consequences.

I grew up an un-coordinated fat child in a slim athletic male culture, poor in a place of competitive affluence, and gay in a violent society that hated and despised gay people. I experienced life as painful, fearful and dangerous. I felt myself to be contaminating and loathsome.

In contrast to the violence of my culture, the self-hatred created by my own internalised homophobia, and the insanity of family life, I found in the church a refuge and a place of acceptance meaning, safety, respect, and joyful celebration. A vocation to priesthood offered me a way out of shame and other consequences of narcissistic damage and deprivation. At the same time, before I knew what addiction was, I became an addict. I used ecstatic religious experience, nicotine, alcohol, sexual fantasy, work, and food to anaesthetize loneliness and self-contempt. Looking back, I can see other symptoms of narcissistic damage: a need to control, fear of exposure, a marked tendency to split and compartmentalise, chronic low-self worth masked by grandiosity, difficulty in setting functional boundaries or respecting the boundaries of others, cyclical depression, sexual shame, seductiveness, a need for admiration that could not be requited, and the capacity to manipulate and cajole. I had never been in a relationship with anyone and I had little capacity for intimacy. I became, in the words of a colleague, 'a man more driven than called'.

In 1987 at a conference on healing addictive compulsive disorders, my vocation was challenged and my addictions confronted and there began a process that brings me to today. Shortly after the conference, I read **Healing**



**the Shame that Binds You** [Bradshaw, 1988] and for the first time I began to understand what had happened to me. The book gave me a language and an introduction to a set of concepts to describe what had gone on in my life. The book is divided into two sections: the problem and the solution. The problem, in effect, describes the origins of narcissistic damage and its outworking in shame. The solution proposes Twelve Step recovery and one-to-one psychotherapy. I began both immediately. The following years were given over to that process. This included regular therapy, hundreds of hours of twelve step meetings, two periods in residential treatment, and constant reading and reflection. Two things seemed to happen in this process, I largely withdrew from addictive behaviours and I began to repair the inner damage that had been both masked and medicated. In addition to addiction recovery there have been a number of beneficial side effects. I lost my fear of flying, fear of public speaking, my hypochondria, anorexic / bulimic eating patterns, cyclical depressions and indebtedness. Perhaps most indicative of all, I developed some capacity for relatedness, evidenced by the establishment and maintenance of a 'first and only' committed relationship. I take these things as the fruits of recovery, not only from addiction, but also from the effects of narcissistic damage. This is an on going process.

My decision to move out of parish work and move into full time psychotherapy has not been about the loss of a religious vocation but rather the fulfilment of a vocation, unifying, harnessing, and gathering together all that has gone before. It feels as though the purpose of this part of my life is to draw upon and utilise my experience of narcissistic wounding, addiction, addiction

equivalents, pastoral background, academic experience, and my experience of recovery and the refining processes of change to unify these into one single endeavour. This doctorate is, therefore, a double act. It harnesses my experience to further the well being of others, while the service of others furthers my experience of well-being.

In the *Review of Previous Learning*, this doctoral work is described as ‘the culmination and application of a life story, scripts, imperatives, roles, and acquired knowledge, with its outcome directed towards self-actualisation and the delivery of service to people in need’. It was in this sense, among others, that I described the decision in the *Review of Previous Learning* and in the introduction to this document to undertake the doctoral programme as ‘culminating’.

The twelfth step of all the twelve step addiction recovery programmes carries the requirement to take the programme ‘to the still suffering addict’, in other words, to exercise a service function on behalf of other people with similar problems and similar needs. The wisdom is that we are ourselves best served in the service of others. My goal in embarking on this doctoral programme has been to draw upon my personal experience, strengthen it with academic research and reflection, and to create a better quality of clinical practice and, at the same time, to make a contribution to the field of psychotherapy.

## **Describing the Journey:**

### **The Journey During the Doctoral Project**

I joined the doctoral programme in 1999 and having submitted Level Four and Level Five applications, submitted a *Learning Agreement* in 2001 and a revised agreement in 2002. The first proposal was to research the relationship between sexual and religious behaviour with particular reference to sexual offending; the second proposal was to develop a 'sexual addiction' treatment and training programme for psychotherapists and other health care professionals.

***The goal has since been to become an expert in the psychotherapeutic treatment of addictive and compulsive sexual behaviours and an expert on the impact of addiction on sexuality and relationships.*** The shift from the first to the second proposal better fits my interests, better serves my professional goals and more closely fits the requirements of this doctoral programme. On another level, the decision to change was to remove myself from a traumatic and damaging research experience and at the same time to continue with a congruent project that would make a contribution to the field of psychotherapy.

### **The First Research Proposal—Working with Offenders**

The first proposal was designed to explore the relationship between religious behaviour, sexual behaviour and offender behaviour. To further describe the context of this work: I interviewed elderly incarcerated Irish Roman Catholic paedophile priests. This involved a repeated exposure to stories of abuse and

experiences of shame, repeated exposure to men who were vulnerable and broken in their own right, profoundly shamed and traumatised. It involved frequent visits to secure facilities, a confrontation with vigilantes, constant exposure to a hostile media and the shaming asides and imputations of colleagues and friends [contamination by association]. The vigilante experience multiplied the shame and created an atmosphere of fear in both incarcerated residents and resident workers. It created in me a heightened sense of fear and contamination.

During this time I was serving on the Churches Together in Britain and Ireland Working Party on Sexual Abuse in the Church. On this working party, which took evidence, I was exposed, session after session, to the testimonies of those who had been abused. Half of the members of the working party were survivors of sexual abuse and/or domestic violence and the atmosphere on the working party was frequently acrimonious, vindictive, and emotional. Some members of the working party attacked my interest in understanding and describing causation and took it to be an attempt to justify rather than understand the abuser. I felt further attacked and found myself becoming addictive, I began to drink too much and I experienced sleeplessness, depression, paranoia, bad dreams, chronic fear and uncertainty and a sense of contamination and despair.

In the first research proposal, on sexuality and religious behaviour, I was preparing to analyse a data set of semi-structured interviews [Appendix A], ten with sexual offenders and five with those who work with offenders. Making

contact and setting up the interviews took a long time and careful planning. There were many problems with security and as an unknown novice researcher I was treated with suspicion and mistrust. The process of identifying and targeting the gatekeepers, persuaders and other appropriate professionals was, in fact, a process of 'grooming', although different, but as in abuse, the deliberate cultivation of another for one's own purposes. It made me feel uneasy. Although eventually very cordial and helpful, the organisations I visited [The Portman Clinic, The Wolvercote Clinic, and Our Lady of Victories, Stroud] met me with wariness and suspicion. People did not ring back, phone numbers were unlisted, and incoming callers were questioned and screened for motive and purpose. Having read the tabloid press and experienced the work of vigilantes first hand, I fully understand the reasons for the high levels of security but its effect on my inner life was to trigger my own inner scripts of unacceptability and to make me feel amateur on the one hand and ghoulish on the other.

During the pursuit of my first research proposal the only time my symptoms of distress disappeared was when I went to a professional conference on the treatment of offenders. This was a good-humoured affair, addressed by Tony Ward, Professor of Forensic Psychology at Melbourne University, in an atmosphere of purposeful and convivial collegiality. Here I was not alone and the work was in the context of professional normality. Attendance at this conference was the only time in the first research process that I felt inspired and affirmed rather than stressed and contaminated. Clarke and Roger in doing work on secondary trauma in offender treatment programmes [2002]

note that, across the literature, it is reported that between 20% and 25% of those who work with offenders show the symptoms that they and I have outlined and the symptoms that I experienced.

I was engaging in a process of narrative based qualitative research with people who been raised in circumstances of trauma, who had traumatised vulnerable others and who had themselves been traumatised by arrest and incarceration, in an atmosphere of trauma and recrimination. I had to bring to this process, 'immersion' and all the other heuristic and reflexive qualities required of the qualitative research. By the time I finally decided to change the direction of my research I had interviewed three professionals working with offenders and I had completed ten 90-minute interviews with elderly Roman Catholic priests who were gross paedophile offenders. McLeod's [2001] challenge to the researcher 'to become a knower' turned out, in its own way, to be an invitation to post-traumatic stress disorder.

### **The Second Research Proposal–**

#### **Sexual Addiction: A Psychotherapeutic Approach**

I had begun to interview offenders and treatment providers at the end of 2001 and the beginning of 2002. The symptoms of secondary trauma set in almost immediately and intensified with the intensity of the research. After consultation with my clinical supervisor and my own therapist I made the decision to change the nature of my work from its focus on religious and sexual behaviour to the development of a treatment and training programme for psychotherapists and other health care workers to work with sexual

addiction. I chose this alternative plan because the concept of sexual addiction has been present before and during the doctoral programme. It has an important role to play in my personal story and in my family of origin. It was an implicit component in my MSc research. It was clear from the work I had already done with offenders that sexual addiction underlies many types of sexual offending and that offender treatment programmes have many features in common with addiction treatment programmes. The theme of sexual addiction runs through all my previous doctoral submissions. It has increasingly come to dominate my invitations to speak and the nature and character of the referrals that I receive. I had intended, in any event, to begin a treatment programme for sexual addiction and compulsivity in the autumn of 2003. That programme has now begun and is in the process of evaluation with a view to the publication of the outcome of that work.

I was aware from my own psychosexual professional training [1995–1998] that sexual addiction was little thought about and little understood even in the field of psychosexual psychotherapy. I was also aware that there was no specialised treatment or training available in the United Kingdom to target specifically this type of behaviour and little or no academic work done on this subject in the United Kingdom. I was becoming aware, at the same time, of the growing impact of the Internet on sexual addiction and compulsivity. All in all, it seemed that I was correctly placed and equipped to make a contribution, on this subject in particular, to the field of psychotherapy. My choice of action was to develop a treatment and training programme for psychotherapists and

other health care workers to understand and respond appropriately to these behaviours when presented in clinical practice.

This decision meant a change from a well progressed and highly qualitative proposal, exploring data from extended interviews, seeking to identify themes, categories, typologies, to a much more quantitative and constructional proposal. The methodology behind the creation of the treatment programme is a combination of personal experience, experience from clinical practice, combined with an analysis of sexual recovery literature and offender treatment literature, with the inclusion of psychosexual, psychoanalytic and psychotherapeutic insights. This was a process of construction. The methodology that was used to evaluate the need and desirability of such a project was quantitative rather than qualitative. The decision to change has given rise to the development of a training programme, a practical contribution to the field of psychotherapy [Appendix I], along side a number of other contributions represented by the other products of the doctoral programme [Appendix, F,G, H].

### **The Doctoral Programme as Recovery**

Cames [1991, p260] notes that in the 'repair and growth' stage of the recovery process that 'we were able to measure dramatic improvements in career, status, financial stability, friendship, ability to cope with stress, spirituality and self-image'. The pursuit of this doctoral programme is not only an academic exercise but is another stage in an on-going process of repair and growth.



Stephen Pattison, senior research fellow in practical theology at Cardiff, writes about his vocation and its relationship to shame [2000, p113], 'In my own case, I think I became a clergyman partly to avoid a sense of inner chaos and worthlessness and to become an acceptable 'somebody'. I would say the same: ministry as an exercise in the management of shame, and thus in becoming an acceptable somebody. This doctoral programme is also an exercise in becoming an 'acceptable somebody'.

## **Section 2**

### **Specialist Seminars**

I began the specialist seminars with no expectation of their usefulness. My attitude began gradually to change and, towards the end of the project, the seminars began to make more and more sense. The seminars were chosen [Appendix B] for the value of their application to the following subject areas:

- Psychotherapy Research
- Clinical Practice
- Project Content

All three subject-areas were present, to some extent, in each seminar. Additionally there were unexpected overall learning benefits that came not from the individual seminars but from the seminars taken together.

#### **Psychotherapy Research: Shapiro, Parry, Mair and Hart**

The seminars on 'psychotherapy research' led by Shapiro and Parry drew attention to the nature of research, and to the importance of consistent,

reliable, accurate and dependable methodology. The seminars summarised some of the key themes in psychotherapy research: process and outcome, the recognition of the need to distinguish between specific and non-specific factors predicted to produce therapeutic change, the distinction between efficacy and effectiveness, the argument for randomisation, and an outline of different types of evidence. The distinction between change and 'clinically significant change' was quite new to me and I found Parry's graphs to illustrate this distinction interesting and persuasive. The overview [Parry, 2002] presented, in summary, the case against evidence-based psychotherapy and this added depth and breadth to the seminar.

Included in the handouts for the seminar led by David Shapiro was his address [2002a], given in memory of his father, Monte Shapiro, to the Centenary Conference of the British Psychological Society on the 'scientist-practitioner model'. This model, which grew out of the Boulder Conference of Graduate Education in Clinical Psychology in 1949, called for clinical psychologists to be trained both as scientists and practitioners [Shapiro, 2002a]. It is this inspiration, the 'clinician working scientifically' [Shapiro, 2002a, p232], that Shapiro put before the Centenary Conference in Edinburgh, emphasizing 'more strongly than before the value of applying the findings and methods of psychology to understanding clinical problems' [Shapiro, 2002a, p232]. This seems to me, in whatever variant it is to be found, an essential core conceptual insight and philosophical underpinning to the concept of 'the excellent practitioner'. It also puts the psychotherapist, or

any other practitioner of a psychological therapy, competitively involved in the realities of healthcare provision.

The seminar led by Mair and Hart was the last taken of the eight required seminars. It was described in the promotional literature as seeking 'to explore the interface between research, evaluation and psychotherapy practice—how to make research projects personal, meaningful, and useful to the profession'. It was chosen because [Richardson, 1994, p516], 'writing is a way of knowing—a method of discovery and analysis'. I thought it might be able to inform and facilitate the 'writing up' process.

For reasons that are obvious from the earlier part of this chapter, Mair's reflections on the connection between 'quest' and 'question' in the research and the researcher were very attractive [Mair, 2002, p4],

*I am a question which is struggling to know itself. I am a question searching for ways to give itself form....Psychological enquiry is what life is about. It is a 'calling' or a 'need' or a 'journey' which involves who I am as well as what I do.*

This '*psychology of questions*' [Mair, 2002, p4] summarises, at least in part, my own motivation and the purpose of my decision to undertake a doctoral programme. As I have written about my personal journey, I have become increasingly aware of the importance of the role and usefulness of the self in the research process—the quest and the question. I enjoyed this workshop but I would like to have seen more done to explore the role of language in identity and brain function [Cozolino, 2002] and more done to develop the

notion of 'narrative making' as part of the 'formulation of a plausible story' [Butler, 1999].

**Clinical Practice: Barkham and Butler**

This seminar, led by Michael Barkham, was taken at the very beginning of the doctoral programme before anything else had been done. I had no research questions or intended products. His explanation of the four generations of research [Barkham et al, 1999] put the subject of psychological therapies research into an historical perspective. This is summarised as follows [Barkham et al, 1999],

- 1<sup>st</sup> Generation: Is therapy better than no therapy?
- 2<sup>nd</sup> Generation: Which modality is the most effective?
- 3<sup>rd</sup> Generation: Which modalities are cost effective?
- 4<sup>th</sup> Generation: What is clinical meaningfulness?

I found his analysis and practical emphasis on the importance of evidenced based practice a call to private practice [Barkham et al, 1999], 'everyone is here: researchers, money and blue chip journals'.

This workshop had an important impact on the practicalities of clinical practice. The most important was the introduction of *Clinical Outcomes in Routine Evaluation* [CORE] and an opportunity to begin to reflect on the appropriateness of CORE in the evaluation of psychosexual work. CORE outcomes were integrated into my private practice at the beginning May 2003. They are also being used, with supplementary questions, to evaluate the group sexual addiction treatment programme begun in September 2003. To my knowledge CORE has not been used as a measure in psychosexual psychotherapy and it will be interesting to see its effectiveness and to explore

what ancillary devices might need to be designed to measure effective therapy and successful outcomes in working with sexual addiction and compulsivity.

This seminar also raised questions for me about the nature of the 'excellent practitioner'. Is it possible to describe someone as 'excellent practitioner' if he or she ignores the implementation of outcome studies or the relevance of evidence based practice in the overall content of a therapeutic practice?

Gillian Butler's seminar, described as a 'practical seminar', was chosen for its application to the realities of clinical practice, for its potential contributions to the improvement of practice and for the application of its theoretical content to the development of a programme of treatment and training for sexual addiction. This was a well-prepared and well-presented specialist seminar.

The main aim of the seminar was to focus on 'formulation' as a clinical tool and formulation as a way of relating theory to practice, so that it allows the emergence of hypotheses. The seminar was indeed useful for this and for the enunciation of the three main principals that lies behind formulation [1998, p4]

- (i) A formulation should be based on a theory, reflecting an attempt to put the theory into practice
- (ii) A formulation should be hypothetical in nature, so that it can be modified by information gained during the course of treatment
- (iii) A formulation should be as parsimonious as possible

The distinction between conceptual model; formulation and diagnosis was helpful and has informed subsequent clinical correspondence with medical

referrers. Butler [1998, p7] defines a model as a way of conceptualising a particular disorder; and a formulation as a way of conceptualising the application of the model to the case, '...thus the formulation illustrates, in ways that are clinically relevant, how the model applies, and does not apply, to the case'. The function of the formulation is to look for patterns that assist in understanding and that help to provide insights into the achievement of change [Butler, 1998].

Not only has the emphasis on formulation and the focus on the application of theory to problem been particularly relevant, but so too has been the concept of the 'plausible story'. Butler [1998, p1] quotes Frank [1986],

Patients come to psychotherapy because they are demoralised by the menacing meanings of their symptoms. The psychotherapist collaborates with the patient in formulating with the patient a plausible story that makes the meanings of the symptoms more benign and provides procedures for combating them, thereby enabling the patient to regain his morale.

Butler's work has been integrated into the treatment and training programme for sexual addiction in the sequencing of tasks and in the emphasis given to 'family of origin' and the use of the 'time line', 'trauma egg', 'tree of life' and in other experiential exercises contained in the treatment programme.

**Project Content: Valerie Batts, Gillian Straker, Valerie Sinason**

Valerie Batt's seminar was chosen for three reasons. It was relevant to my personal experience as an American from the deep South, it suggested that there might be an opportunity to explore the relationship between addiction

and excluded status and it provided an opportunity to reflect upon the incorporation of anti-discrimination awareness into routine clinical practice. In an excellent practice, measures should be taken to avoid discrimination. This seminar had a direct outcome in the highlighting of anti-discrimination policies to various aspects of private practice and to the development of the treatment programme for sexual addiction and compulsivity [Appendix I].

I chose the seminars given by Gillian Straker and Valerie Sinason because it seemed to me that both of these, the first with its emphasis upon trauma and the second with its exploration of dissociative conditions, could contribute to my understanding of sexual addiction and compulsivity. Straker's work [1993], like the work of Clarke and Roger [2002], explores the impact of trauma on human functioning and explores the phenomenon of secondary trauma on health care workers and other professionals [1993]. She suggests [1993] a symptom-set similar to Clarke and Roger [2002]:

- Depression
- Anxiety
- Psychosomatic Ailments
- Chronic Fatigue
- Sleep Disturbances
- Survivor Guilt
- Memory Impairment
- Concentration Difficulties
- Heightened Emotionality
- Feelings of Helpless or a Denial of Such Feelings

Straker [1993, p32] writes,

Workers entering the world of trauma survivors are profoundly affected by them, often finding new depth within themselves. They also, run the risk of early burnout and even secondary traumatisation. Indeed, interacting with trauma, even vicariously, has potentially serious repercussions for psychological well-being.

Her seminar helped me to make sense of the internal process that lay behind my unwillingness to continue with the first proposal and the decision to focus instead on the second.

Straker's seminar explored the impact of trauma on human functioning and especially looked at the impact of secondary trauma on health care professionals. She notes that the people entering helping professions often do so, on an unconscious level, because they identify with the 'woundedness' of the other and have a desire to make reparation [Straker, 1993, p35]. Straker emphasises the impact of repetitive trauma on cognition and the capacity of trauma to become encoded in the sensory system outside of language. She writes with reference to other researchers that [Straker, 2000, p8] 'traumatic experiences remain imprinted as sensations or feeling states which are not immediately translated into narratives'.

This seminar made a contribution to my understanding of trauma, narcissistic damage and sexual addiction. If traumatic memories are encoded in the sensory system outside of language, this supports the view that traumatic memories could be encoded in sexual fantasy and sexual re-enactments. Stoller [1975] takes just such a view. He proposes that 'perverse' behaviours and fantasies are victorious re-enactments, reversals of humiliation.



Sinason suggests something similar in her seminar on attachment, trauma and multiplicity.

There are other insights in Straker's work that suggest that trauma studies will yield a harvest of insights into the aetiology and the mechanism of sexual addiction. For example, according to Straker, cognition and values change in response to trauma [2000, p4], impediments are created in the thinking process, and there is a tendency towards dissociation [2000; p7]. My clinical experience supports this view.

Straker's seminar alerted me, by inference, to the possibility of secondary traumatisation for psychosexual therapists and other health care workers in working with sexually addicted clients. She writes that the [1993, p43] 'first step towards ameliorating these problems is, of course, to recognise them'. She suggests that the symptoms of vicarious trauma are clearly identified for workers and that there should be regular review meetings and involvements in outside conferences and workshops.

Her seminar helped me understand some of the problems that I faced in the process of interviewing paedophile clergy. It became clear to me that the distress I experienced in interviewing paedophile Roman Catholic priests was secondary traumatisation. Part of the traumatisation was caused by being in the presence of stories of acts of sexual abuse and part of it was spending hour after hour with people who themselves had been grievously traumatised. These were men had been 'found out', arrested, publicly exposed,

imprisoned, bullied in prison, found repulsive, universally hated, and sentenced to a living death. This was exacerbated, at the same time, by the Churches Together in Britain and Ireland Working Party on Sexual Abuse in the Church. The professional challenge of this workshop has been to resolve to spend more time and attention on trauma studies for crossover insights into a greater understanding of sexual addiction and compulsivity.

Of the eight seminars, I found Valerie Sinason's the least productive. This is probably because I went into this seminar hostile to the presenter. Some years ago she attacked, in the press, something that I had written. Through no fault of her own, her manner triggered deeply embedded issues of abuse from my past. From a psychotherapeutic perspective, it was interesting to sit in a workshop that I did not enjoy and try and comb through my responses to determine whether my hostility to the presentation was grounded in a process of re-traumatisation and projection or whether it grew out of proper academic objections to the substance of the material and the content of the seminar. I now think that the high level of hostility that I felt during the seminar is probably explained by the fact that it was an intersection of both of the above. Also, looking back, I see that this workshop took place at the peak of the traumatic fall-out that I was experiencing from the paedophile interviews and from the Church working party on abuse. Did that not affect or even determine my response to Valerie Sinason and to her seminar?

The seminars that had the greatest impact on me [Batts and Straker] were the one's in which the research and the researcher were one. In other words,

these were the seminars in which it was clear that not only were these women practitioners and researchers, but that they were, in their own way, women who had themselves experienced the subject of their study. In Batts' case this was racial oppression; in Straker's case this was primary and secondary trauma in working with the effects of apartheid. These were the two presenters who experienced the subject, taught the subject, knew the subject, and engaged with the subject in clinical practice.

### **An Overall Contribution from the Specialist Seminars**

In addition to the benefits from individual seminars, there were other unexpected benefits that came not so much from one specialist seminar as from the seminars taken as a whole. These were to highlight for me the concepts of evidence-based practice, patient-based evidence and practitioner research.

### **Evidence Based Practice**

Although I first came across an emphasis on outcome studies at the Promis addiction counselling centre in 1992, this research gave me my first serious recognition of the importance of evidenced based practice. This began with the Barkham seminar and is set to play a growing part in the development of clinical practice. The importance of evidence-based practice is stressed in Wilson and Barkham [1994, p50],

However the climate of increasing accountability has heightened the need for individual practitioners to monitor and evaluate the outcome of their own clinical work, a situation that is likely to become more urgent if renewable licenses to practice are introduced.

The role that evidence-based practice played in this research project was to follow all workshops and public speaking engagements during the life of the project with my own evaluation forms and to follow the pilot treatment and training programme with the provision of a process of evaluation [Appendix C], and to introduce CORE outcome studies into my practice and into the Sexual Addiction Treatment Programme.

### **Patient Based Evidence**

I come to this research as patient as well as practitioner and have therefore the capacity to bring insights from both experiences. The usefulness of this is suggested in an article on evidenced-based practice. Peter Tyrer [2000], Professor of Public Mental Health at Imperial College School Medicine, writes about the importance what he calls 'patient-based evidence'. Tyrer [2000, p254] challenges colleagues,

'I would like to see formal acknowledgement that evidence-based practice should take into account information from all sources, including that of the patient before coming to a judgement'.

My work on addiction and compulsivity brings together a commitment to evidence based practice and, at the same time, grows out of patient based evidence. Denzin and Lincoln [1994, p 12] write, that 'there are no objective observations, only observations socially situated in the worlds of the observer and the observed'. It seemed to me that Straker and Batts experienced themselves as both observer and observed. They modelled what it means to be patient, practitioner, and researcher and this gave to their presentations

grace and authenticity. I would seek those qualities for my own research, my clinical practice, and for the future of my work.

### **Practitioner Research**

My experience as a recovering addict adds an *in vivo* dimension to my clinical practice. In common with other professionals [Robson, 1993], I have found that my research has drawn from my practice and my practice has been stimulated by my research.

McLeod [1999] has characterised practitioner research as

- For the advancement of knowledge
- As 'knowledge in context'
- To make a difference to practice

Integrative of traditional methodology, practitioner research draws on ways of knowing that counsellors already possess [McLeod, 1999, p20]: 'reflexivity, collaborate sense-making, finding meaning in feeling'. In line with Tyrer [2000], but less tentative and more definite, McLeod [1999, p11] writes

It seems to me that one of the crucial understandings which has emerged as the magic spell cast by positivism has gradually dissipated, is the recognition that a reductionist, hypothesis testing model is fundamentally flawed as an approach to constructing *practical* [italics author] knowledge of persons. To carry out research that is relevant to practice, it is necessary that investigations are placed in the context of practice.

My work has been, in part, to understand addiction and compulsivity and to do that as researcher, practitioner, and patient. McLeod [1999] looks for an advancement of practice through practitioner-researcher research. I see my practice as advancing and benefiting from the reciprocal interplay between

practice and research measured against the subjective experience of the self of the researcher.

### **Concluding the Seminars**

The combined effect of the schedule of seminars has been to create a 'matrix', in both senses of the meaning of that word, 'a place in which a thing is developed' and, at the same time, 'the substance between cells' [Concise Oxford Dictionary of Current English, 1964]. The internal seminar programme created units of work and reflection that have been both generative and inter-connective to the development of the research.

### **Section 3**

#### **Level Five Learning**

Of 17 possible descriptors given in the *Programme and Modules Handbook 1999/2000* I choose four for further comment:

- Excellent Practitioner
- Knowledge
- Communication / Presentation
- Ethical Awareness

Excellent Practitioner— I have had a goal to be an excellent practitioner. My movement out of parish life into full time psychotherapy and psychosexual therapy and my involvement in this doctoral programme over the past five years gives evidence of intention. Material from the specialist seminars has

been incorporated into clinical practice. The practice has grown from part-time to full time. As well as a small number of medical doctors and psychiatrists most of my referrals tend to come from other psychotherapists who have heard me speak or know of my work on sexual addiction from this doctoral programme. These referrals increasingly reflect my areas of academic and clinical speciality and now make up about 40% of my practice. As a commitment to excellence in clinical practice I introduced CORE outcome evaluations into my practice and have used it with the sexual addiction treatment programme.

**Knowledge**—I believe that I demonstrate that I have acquired an in-depth knowledge of sexual addiction and a number of other associated subjects. This is the first work in the United Kingdom on the subject of sexual addiction and I believe that this gives evidence of knowledge at Level 5. I am also persuaded that my knowledge and understanding of the causation of sexual misconduct among the clergy, summarised in **Time for Action** is, from a look at the literature, unique and distinctive. There has been nothing published in the United Kingdom on Internet sexual addiction and nothing yet on the impact of Internet and sexual and relationship functioning and so this puts this part of the work very much on the cutting edge.

**Communication / Presentation**—I have enclosed in the appendix a list of speaking engagements that cover most of the time of this research project [Appendix D]. The decision to move from the proposal on offender behaviour and develop and design a training programme for the treatment of sexual

addiction was also motivated by a desire to continue public speaking, teaching and presentation. I have done this in previous work and it would seem sensible to capitalise on that background and experience. Presentations to critical communities have included, among others, two presentations on sexual addiction to my professional association, BASRT, and two to the British Association for Supervision, Research and Practice, one to the UKCP and four regional day conferences on abuse of power in the church to the Churches Counselling Ministry to the Clergy.

**Ethical Issues—** The most sensitive and complex ethical issues cluster around the earlier research proposal with sexual offenders, and although there have been ethical issues and considerations in the preparation of the training manual, these have been less complex and less sensitive in their implication.

Most of the earlier ethical considerations have are connected to the collection of data from human subjects. I have been guided by the ethical guidelines given in Barker et al [1994] and by the Ethical Principles for Conducting Research with Human Participants [British Psychological Society] [Robson, 1993]. These ethical reflections and requirements have been strengthened by the addition of special texts on working with incarcerated participants, with sensitive subjects and in working in areas that might potentially harm the participants [Davison and Stuart, 1975, Kimmel, 1988, Renzetti and Lee, 1993, Ringheim, 1995, Seiber and Stanley, 1988]. These can be outlined as follows:



Informed consent  
Full information and full explanation  
Freedom to withdraw [at any time]  
Freedom from deception  
Freedom from coercion  
Opportunities for feedback and de-briefing  
Privacy and confidentiality  
Harm risk benefit analysis

I have written about these in the UKCP Conference Paper [Appendix H] and I attach copies of the research documents [Appendix A]. I was in the process of considering ethically how best to close down the first project when the Wolvercote Clinic was itself closed and the residents dispersed to unknown locations. As I had deliberately avoided knowing surnames or other traceable information, I have come to the conclusion that the most appropriate thing to do, in this instance, is probably to take no further action.

The greatest ethical weakness, to my mind, in the doctoral project is the absence of attention that is given to ethical difficulties in the training programme for working with sexually addicted clients [Appendix I]. As it stands, it is assumed that this material would be covered in an over-all training programme or in some other form of continuing professional education. The treatment of sexual addiction raises a number of ethical issues associated with the problems of disclosure, for example, disclosure of patterns of sexual behaviour to partners and family members or disclosure of HIV status when a client persists in having unprotected sex. These ethical issues include guidance on note taking and the requirements for disclosure of illegal behaviours as required by law or as required by professional

organisations. In this regard there remain areas of uncertainty and ambiguity and it seems to me little clarity has yet emerged under the legislation.

While I recognise the weakness of the training manual to provide sufficient teaching on the ethical issues raised by working in this field, that is a factor of time availability and, where required, an additional unit could be created and added to the programme. All in all, I think that I have grappled with the complexity of the ethical issues involved in research of this type and at this level.

#### **Section 4**

##### **Contributing to the Profession of Psychotherapy**

One of the first criticisms levelled at the first proposal on offender behaviour was that it could equally well have been a social science investigation and was not, except as it might have appertained to treatment issues, centrally psychotherapeutic. The creation of a treatment and training programme for psychotherapeutic work with addictive compulsive sexual behaviours fixes this project in the mainstream of a programme in psychotherapy.

Through the creation of its products, this doctoral project has benefited the profession with contributions in the following areas:

- Research methodology
- Psychosexual psychotherapy
- Understanding sexual abuse in the church
- Sexual addiction treatment and training

While the heuristic nature of qualitative research, especially counselling and psychotherapy research is widely supported in the literature [Karp, 1996, McLeod, 2001, Meier, 2002, West, 1998, Barker et al, 1994] there is little emphasis on the possible negative impact on the researcher of working with sensitive and distressing topics. During this project, the traumatic experience of the first research proposal, that caused the move to the second, gave rise to a contribution in the field of psychotherapy research [Appendix G].

My professional association BASRT is a member organisation of UKCP. Our organisation has just over 600 members of which about 160 are accredited. I believe that the work done, and the work to be done as a result of this doctoral programme, has made an influential contribution to the professional and research component of our organisation. This is illustrated by an invitation to organise and to speak at the 2000 BASRT Conference on sexual addiction and to speak at the 2002 BASRT Conference on sexual addiction and the Internet.

An understanding of the connection between sexuality and religious behaviour is crucial to understanding and applying an adequate strategy for the treatment of people who present with both behaviours experienced problematically. This project has created a contribution from the profession of psychotherapy to the sociology and psychology of causation and of use to religious organisations as they work for prevention and treatment. It has done this through a two-year participation in the Churches Together in Britain and Ireland Working Party on Sexual Abuse in the Church and in the writing of

Chapter 9 in the book published [Appendix H] as the report of this working party.

The training manual contains and collates information to inform clinical practice on the effective treatment of the phenomena of 'sexual addiction'. This treatment strategy is especially designed to take into account the working culture and needs of United Kingdom psychotherapists especially those in private practice. The quantitative research project described in chapter five and the pilot project evaluation forms [Appendix C] confirm the needed and singular nature of this research contribution to the profession. This project has produced a training programme devised in the United Kingdom to train psychotherapists and other health care professionals to work with sexual addiction and compulsivity. This contribution has been extended in 2003 by the creation of the non-residential treatment programme, located at the Psychotherapy and Counselling Consultation Centre at Regents College, London [Appendix K].

## **Conclusion**

### **The Journey Forward**

Even before I had completed the writing up process of the final drafts of this document, I had already begun to look ahead to the things of the future.

I have found myself considering many things. I have found myself considering the best way practically to integrate and expand clinical and academic interests. Reflecting on the fact that there is no psychosexual training programme in London or the South East, I have speculated whether the development of such a programme would be opportune and viable. Having begun an outpatient programme for the treatment of sexual addiction and compulsivity, I have also found myself speculating about the development of a research project within that to explore Goodman's [1998] theory of the 'seductive mother' as the defining feature in the aetiology of sexual addiction.

The doctoral project, and in particular the first research proposal, has sparked an interest in qualitative methodology in general and I have wondered about applying qualitative research techniques to other areas of interest. For example, when I was a student at the Whittington Hospital my first client had Peyronie's disease. Ever since then I have wanted to research the aetiology of Peyronie's disease and to think about the development of appropriate psychotherapeutic treatment strategies for managing the effects of the disease.

Having accepted the post of Associate Priest at St Marylebone Parish Church, with its Centre for Counselling and Healing, I am also aware that there is work to do done to integrate the theoretical and clinical implications of this doctoral project into a place of wider theological reflection.

The outpatient treatment programme for men with addictive compulsive sexual behaviours [Appendix K] will be evaluated with CORE outcome studies in combination with an analysis of interview material using an appropriate qualitative methodology.

Quite apart from other particular projects, or future publications that may or may not be specific future outcomes of this doctoral work, the most important developments are more intangible: an on-going interplay between scholarship, research, and clinical practice. In all of this it is clear to me that this doctoral project is a work in progress.

In the Review of Previous Learning, I used a quote from T.S. Eliot [1962] about the self and the nature of time taken from *East Coker*, the first of the *Four Quartets*, 'Time present and time past are both contained in time future' [1962, p189] and from the second quartet, 'In my beginning is my end' [1962, p196]. The finishing point of the present is the starting point of the future.

## **Chapter 2**

### **The Theory of Sexual Addiction**

#### **Introduction and Overview**

The theoretical position that underpins this project and its primary product, the treatment and training programme for psychotherapists and other health care workers [Appendix I], is that a pattern of sexual behaviour exists, that it is appropriate to name 'sexual addiction', which is directly related to narcissistic damage and to the consequences of narcissistic damage, especially shame. This interconnected sequence of concepts can be outlined and summarised as follows:

Sexual Addiction is the name given to—

- A pattern of sexual behaviour
- That is compulsive and preoccupies the individual
- Which brings with it harmful consequences
- Which is difficult for the individual reliably to stop and stay stopped
- Which is used to anaesthetize and manage the effects of narcissistic damage
- Of which shame is a principal characteristic
- All of which is set up in the family of origin

This chapter will identify the sources that have contributed to this theoretical construction, elucidate step-by-step the components of the theoretical position outlined above, locate the concept of sexual addiction within a wider context,

summarise the two major objectives of treatment, and discuss the contentious question of nomenclature. Treatment will be considered in this chapter alongside theory because, in general, the theory of sexual addiction has emerged from addiction treatment rather than addiction treatment emerging from a theory of addiction. Similarly, because of the heuristic nature of sexual addiction research, this chapter will include observations on sexual addiction and research methodology. It will include two case studies to illustrate theoretical concepts with concrete examples of practice. It will close with critical reflection on the strengths and weaknesses of using the language of addiction and applying addiction theory, in clinical practice, to sexual behaviour.

Given the powerful, intense and repeated nature of addictive compulsive sexual behaviour, acted out and often rehearsed thousands of times in masturbatory fantasy, this behaviour can have a power, potency and tenacity more intense than any substance. It has a far reaching potential for chemical, hormonal, and behavioural changes of a greatly mood altering nature [Butts, 1992] Additionally, unlike chemical dependencies in which the body eventually makes adjustments for the absence of the chemical, the sex addict, in effect, carries the chemistry within the body. It is not only part of his/her addictive cycle it is also part of a natural biological cycle and it is connected to an individual's reproductive mission.

### **Sources for a Theory of Sexual Addiction**

The conceptual material that makes up the theory of sexual addiction, the products of this doctoral project [Appendix F, G, H, I] as well as the other parts of this chapter are drawn from the following sources:



- Heuristic Experience—a personal journey
- Clinical practice—as a psychotherapist working on a one-to-one basis with people who see themselves as having addictive compulsive sexual behaviours
- Clinical practice—the experience of running an outpatient treatment programme for people with addictive compulsive sexual behaviours
- Review of the literature and the research— prior to, as well as the during, this project
- Observation— of men and women in programmes of addiction recovery

Heuristic experience refers to my own experience of addiction and my journey of addiction recovery. Much of that journey has been outlined in the previous chapter. Heuristic experience includes my reflections on causation, on my family of origin, on the developmental and progressive course of addictive behaviours and the use of addictive substances, as well as my experience of the processes of recovery. Clinical practice refers to my work with individuals who either self-refer or who are referred to me who manifest sexual behaviours that, in their view, are compulsive, harmful and seemingly unstoppable. This also includes material drawn from my experience of running a group treatment programme. For reasons of space, the review of the literature in the next chapter has been limited only to the literature on sexual addiction although a wider reading of the relevant literature has actually contributed to the development of the theoretical framework. This wider process of reading and

reflection has extended over a period of fifteen years; only the last five have been in the formal context of this doctoral programme. Observation, the fifth category of theoretical source, covers a similar period of time. I have known and have closely watched many men, and a smaller number of women, in different stages of addiction recovery. This has allowed me to see examples and varieties of addictive compulsive sexual behaviour, hear many first hand accounts of family of origin experiences, and to have an opportunity to observe different individuals pursue programmes of addiction recovery.

### **Principal Components of a Theory of Sexual Addiction**

This explanation and elucidation of a theory of sexual addiction is divided into seven major components:

- Definitions of Sexual Addiction
- Descriptions of Sexual Addiction
- Narcissistic Damage and the Aetiology of Addiction
- Narcissistic Damage and Sexualization
- Shame: The Major Driver of Addiction
- Sexual Addiction and the Regulation of Affect
- Diagramming the Interconnections

Each of these is drawn from and elucidated by heuristic reflection, academic material and clinical experience as well as observations from addiction recovery programmes, although not always all or in that order.

### **Definitions of Sexual Addiction—**

The concept of addiction provides us with a way of thinking about and describing age-old patterns of behaviour that we have always known about but

have not always framed as addictive / compulsive [Butts, 1992]. Over a century ago, Krafft-Ebing [1886, p70] described this condition:

Sexual appetite is abnormally increased to such an extent that it permeates all his thoughts and feelings, allowing of no other aims in life, tumultuous and in a rut-like fashion demanding gratification without granting the possibility of moral or righteous counter-presentations, and resolving itself into an impulsive insatiable succession of sexual enjoyments...This pathological sexuality is a dreadful scourge for its victim, for he is in constant danger of violating the laws of the state and of morality, of losing his honour, his freedom, and even his life.

According to Goodman [1998, p12], 'most clinicians agree that what Krafft-Ebing described as pathological sexuality does exist, in the form of paraphilias and syndromes of similarly driven nonparaphilic sexual behaviour'. Sexual addiction is another name for what Krafft-Ebing calls 'this dreadful scourge'.

Goodman [1998, p9] gives the following, more up to date, definition for sexual addiction,

A condition exists in which the subject engages in some form of sexual behaviour in a pattern that is characterised by two key features: recurrent failure to control the behaviour and the continuation of the behaviour despite significant harmful consequences.

This definition summarises and makes more parsimonious the definition given by Krafft-Ebing.

Carnes and Wilson [2002, p5] propose that 'a process would be considered to be an addiction' when the behaviours fulfil the following three criteria:

1. Loss of control
2. Continuation in spite of harmful consequences
3. Obsession or preoccupation with obtaining, using or recovering from the behaviours

Carnes [1996] expands this definition by drawing up what he calls 'the ten signs of sexual addiction', which are outlined in the next chapter, and by placing behaviours into eleven descriptive categories. The definitions for sexual addiction given by Carnes, Goodman and Wilson have been foundational to the development of the theory of sexual addiction but they are limited in two aspects. They include, but fail to emphasize, the subjective nature of the criteria used in the definitions and they fail to include 'function' as a core element within the list of definitional criteria.

In my clinical work with clients who come for assessment with such patterns of behaviour I use the phrase 'it is only a problem if it is a problem'. This phrase tries to put into words and emphasize the subjective nature of the definitional criteria. For example, what is loss of control? Who decides? Why is it a bad thing? We celebrate the loss of control in ecstatic religious experience and in heterosexual monogamous marriage as sublime. What are harmful consequences? Who decides? I have a client who has spent £50,000 on escorts over the past four years. Is that out of control? He is rich and has spare time. He could be spending the money on first class travel and five star hotels. He is in treatment because his wife finds his behaviour unacceptable and, for him, the potential harmful consequences are the loss of a 30-year marriage. What is preoccupation? How does it differ from interest, involvement and absorption? Why might it be defined as 'industriousness' to spend eight hours in the British Library absorbed in writing a paper and as an 'addiction' to spend eight hours at a computer absorbed in Internet pornography? All the answers to the questions above are subjective and involve judgements of value.

All the components of the definitions of sexual addiction have this subjective character. This subjectivity should be made plainer in the definitions themselves and in the application of the definitions to clinical practice. It is for the individual patient to decide whether these criteria apply to their own behavioural style and to decide whether the consequences are harmful or sufficiently harmful to warrant a process of change. The importance of this subjective decision-making is understood and formalized in the sexual recovery programmes but not emphasised in these professional definitional formulae.

These definitions also omit to highlight what I believe to be the chief definitional characteristic of the phenomena, namely the notion of function— sexual addiction is a pattern of behaviour that is used to anaesthetize shame and other negative affects rather than to heal and change the cause of that negative affect. ***Consequently, I define sexual addiction as follows: a preoccupative pattern of sexual behaviour that is experienced as 'out of control', that brings with it harmful consequences and which is used to anaesthetize negative affect rather than to heal the cause of that negative affect.***

According to Carnes [1998, p21] 'sexual preoccupation becomes an analgesic fix for the sex addict' and 'obsession and fantasy become a primary coping strategy'. He continues [Carnes, 1998, p23] 'sex addicts use their sexuality as a medication for sleep, anxiety, pain and family and life problems'. This 'self-medication' view of addiction has also been proposed in other forms by many researchers from different perspectives [Weiss and Mirin, 1997] and has been

come out in my clinical experience. In my treatment programme for sexual addiction, participants specifically identified anger, anxiety, boredom and loneliness, as well as shame, as affects that they anaesthetised by their addictive compulsive patterns of sexual behaviour.

### **Descriptive Examples of Sexual Addiction—**

I list here a number of descriptive examples of the behaviours of clients that I have worked with, in which, the client and I have come to a view that the behaviour fits the description for sexual addiction and should be treated as such. These examples come from one-to-one clinical work. Similar examples are given throughout the literature on sexual addiction.

- A young heterosexual male with a female partner and three children from that union whose 'addictive behaviours' involved exhibitionist homoerotic masturbation in showers and changing rooms and other public places
- A middle aged married heterosexual male who had little control over his use of Internet pornography. He would go online for half an hour and then compulsively masturbate much of the night while on the Internet. Sometimes this would go on sporadically for two or three days.
- A self-employed young gay man who spent four to five hours, four to five days a week, using the telephone and the Internet in pursuit of semi-anonymous sexual encounters against a background of mounting debt and decreasing employment opportunity

- An extremely able young male doctor deeply conflicted about his sexual orientation who would have ritualised telephone sex about once a week while talking through a fantasy of innocence and seduction
- A divorced woman in her mid-fifties with four adult daughters but who lives alone whose sexual patterns involve regularly going out to pick up men who are unknown to her and bringing them back to her flat for sex. She is concerned about the compulsive nature of the behaviour and the danger that this behaviour creates.

Each of these patients reported some or all of the following harmful consequences: powerlessness, self-contempt, personal danger, health risks, the loss of creative time and career opportunities, financial loss, and an impaired capacity for intimate relations with a domestic partner.

The issue is not the type of behaviour, or the amount of time, but the experience, function and consequences of that behaviour in the life of the individual. It is not about heterosexual, homosexual or solitary behaviours. Within my group treatment programme for sexual addiction and compulsivity, participants manifest the following behaviours: one man has anonymous sex with men in public places, one masturbates to pornography of women being beaten, another masturbates over a more mixed repertory of images of bondage and domination, two men use escorts and prostitutes in spite of being committed to fidelity in long-term relationships, and two others compulsively

masturbate over heterosexual Internet pornography. In all but one case these men have problems with emotional intimacy and in being sexual with significant others. Additional material, in the form of two case studies, is provided at the end of this chapter to illustrate further the concept of sexual addiction.

In the course of clinical practice, I have observed a number of miscellaneous characteristics and features that characterise and accompany sexual addiction. Frequently clients report a fixing of the behaviour during adolescence but an on-set long before puberty. Sexual addiction usually appears in combination with substance use or some other addictive compulsive behaviour. It often goes along with addiction to, or a use of, high adrenalin substances and behaviours. I often come across sexual addiction in combination with cocaine and a professional life that thrives on excitement and risk. Alcohol is sometimes used as a gateway drug to other recreational drugs and to periods of sexual acting out. Sometimes sexual addiction presents in combination with other behaviours to create an anorexic-bulimic cycle of behaviour. In these cases sexual behaviour forms the binge side to the cycle and some other behaviour [often work or religion] forms the other side of the cycle. This alternating pattern of behaviour, as it applies to sexual behaviour in combination with religious behaviour, is described in the revised first product of this project [Appendix J].

Addictive behaviour is persistent and tenacious. Even after long recovery it reemerges in times of stress or in later re-enactments of the original narcissistic wounding. This explains my own heightened levels of compulsivity immediately after the examiners rejected an earlier submission of this document.



## **Narcissistic Damage—**

Narcissistic damage is the term that I use to describe a configuration of the self, set up in the family of origin, that results in two major consequences: the self is experienced painfully and the self is experienced as unacceptable. By painful, I mean a chronic, or pervasive state of negative affect. This includes such things as depression, chronic anger, core loneliness, and unremitting shame. By unacceptable, I mean that the self of the person is experienced as intrinsically flawed in the sight of others and, consequently, the reality of the self seeks to be hidden and masked.

In 1988, when my addictive patterns were challenged and some understanding began to develop, I was told about a book entitled **I Always Knew There Was Something Wrong But I Never Knew What It Was**. The title of the book seemed to sum up my own experience of life. It described my inner sense of self and my inner world. Eventually, as I moved into addiction recovery, I began to realise that my history and the inner experience that lay behind my addictive behaviour, as I have defined it above, was narcissistic damage.

I have written more extensively about my family of origin elsewhere so I will only summarise here: unwelcome pregnancy, born by caesarean section, not breast fed, addicted needy mother, abandoning father, intrusive mother, maternal sexual abuse, and from that a gathering sense of defectiveness. This was exacerbated by the problems of being ridiculed as a fat child and recognising that, as a gay person, I had an unacceptable and abhorrent sexual

orientation. I can see, looking back, all the symptoms and characteristic outcomes of the narcissistic damage that I describe in this chapter.

Based on the **Diagnostic and Statistical Manual of Mental Disorders IV** [American Psychiatric Association, 1994] [DSM IV], definitions of character and pathology, narcissistic damage can also be defined as 'enduring affect, cognitive, behavioural, relational patterns, laid down in the formation of the self and carried into adult functioning that are inflexible, maladaptive, and cause either significant impairment or subjective distress' [adapted from Goodman, 1998, p298]. Goodman [1998] further describes narcissistic damage as an impairment in the individual's system for self-regulation.

Miller [1987] describes narcissistic damage in the following way: a sense of self created in the family or origin as an accommodation to parental needs, which brings with it a sense of emptiness, loneliness and anomie, as well as, a compulsion to control and a propensity to grandiosity. In a similar vein, Kernberg [1986] suggests that the following symptom set is associated with narcissistic damage:

- Grandiose fantasies
- Feeling inferior
- Over-dependence on admiration
- Boredom
- Emptiness
- Striving for wealth, brilliance, or power
- Lack of a capacity for empathetic understanding
- Chronic uncertainty
- Dissatisfaction with self
- Exploitation and ruthlessness
- Chronic intense envy
- Defences against chronic intense envy

In my observations of women and men in programmes of addiction recovery, I have witnessed many 'first step' presentations. These 'first step' presentations are personal stories given in public meetings that, in effect, connect narcissistic damage and addictive compulsive patterns of behaviour. I have seen all of consequences of narcissistic damage described above by Kernberg in these first step presentations, and at work, not only in my own life, but also in different proportions in the life of all my sexually addicted clients.

In addition to my own description of narcissistic damage, I use Goodman's [1998] definition because it avoids the obscure language of object relations and self psychology. It is comprehensive—covering affect, cognition, behaviour and the capacity for relatedness— and emphasises the subjective nature of impairment and distress.

The origin of narcissistic damage lies in the origin of the self [Kohut and Wolf, 1986] and emerges from a 'faulty interaction between the child and his selfobjects' [Kohut and Wolf, 1986, p177]. Prototypically, in ego psychology and the psychoanalytic tradition, this is located in a disturbance in the mother-child relationship. These disturbances of attachment are variously described but are always located in a disturbance or damage in the relationship between the child and the principal caregiver that creates the characteristic configuration of the self of the child. Goodman notes [1998] that the literature indicates that affect regulation, self-care, and self-governance functions are internalised from our relationship with our primary caregivers. The psychoanalytic tradition similarly locates the aetiology of perversion in such disturbances. The relationship

between sexual addiction and perversion will be considered later. New research in brain science and developmental psychology, made possible by new measurement and imaging techniques, is increasingly providing neurological evidence to substantiate the understanding of narcissistic damage and its consequences that is described in this chapter [Stern 1998, Schore, 2003].

What is the connection between addiction and narcissistic damage? Addictions, whether they involve substances or processes, are mechanisms for anaesthetizing the negative affect and other consequences of narcissistic damage— ‘the self experienced painfully’ and ‘the self experienced as unacceptable’. While this provides a theory that addiction is a response to the consequences of narcissistic damage it does not however explain why some people adopt sexual behaviour as their principal anaesthetizing strategy. An additional question of aetiology remains. Why do some people come to use sexual behaviours for this function?

#### **Narcissistic Damage and Sexualization—**

The consequences of narcissistic damage can explain the use of substances and processes to manage the self but this does not explain why some people specifically choose sexual behaviours to fulfil this anaesthetizing function. The explanation for this can be summarised as follows:

- Intergenerational Sequencing of Addictive Compulsive Behaviours
- Overt or Covert Sexualization in the Family of Origin

The specificity of sexual addiction is primarily attributed to high levels of sexualization in the family of origin and to the intergenerational sequencing of substance use and/or other addictive compulsive behaviours. In my experience, both of these can play a part and either of them can make a decisive contribution to the development of sexual addiction. I think there is also a random quality to it, much depending on accidents of time and personal history. Carnes [1996] takes the view that sexual addiction and all addictions are inter-generational. Many of my own patients report that the pomographic imagery they use with masturbation began with the discovery of pomographic material that belonged to their father or stepfather, who presumably used it for the same purpose. One patient of mine, in treatment for sexual addiction, was able to identify sexual addiction through three generations of his family. He was quite clear that both he and his brother were sexually compulsive and that his nephew was sexually addicted. The fact that his nephew was sexually addicted was suggested by the fact that the nephew had made five girls pregnant before he had reached the age of 21, the first when he was just 13. In my own observations of addiction recovery, I have regularly come across those who were 'addicted' to unprotected sex. This phenomenon is suggested here. This patient told me that he had spent time with a great nephew who was then 13 [the son of the same nephew] and that he had been astonished how it had already become clear that the boy was not just attracted to women, normal and appropriate to 13 year old heterosexual boys, but that he had already begun compulsively to cruise women on the street. The point of such a detailed account of this one family is to illustrate the inter-generational nature of sexual addiction and other addictive compulsive behaviours.

I have also observed that sexual addiction sometimes ricochets down the generations. In other words there is an intergenerational alternation between control behaviours and release behaviours. So, between the generations, sexual addiction will sometimes alternate with abstinent behaviour. In effect both behaviours are responses to narcissistic damage and are driven by sexual preoccupation. This pattern is suggested in the 'figure eight' cycle of addiction diagrammed in the article on sexuality and religious behaviour [Appendix J]. I have also noticed the frequency of alcoholism and other forms of substance dependency in the families of those who are sexually compulsive and that strongly suggests to me that sexual addiction often alternates with other addictive compulsive processes. This also explains why it is not always seen directly repeating itself from generation to generation.

Goodman [1998] suggests that an atmosphere of sexualization, including high levels of 'covert sexuality' and/or 'maternal seductiveness' accompanies narcissistic damage in the family of origin of the emerging sex addict. According to Goodman [1998, p136]

In other words, the functions that sexual behaviour serves in perversions can conceivably be served by other kinds of behaviour, such as taking alcohol or some other drug, or eating, or gambling. What leads the pervert to select sexual behaviour to fulfill these functions? The critical factor seems to be the relative influence of sexualization in the individual's psychic life.

It is difficult to explore and assess the realities of covert sexualization in the family of origin, partly because this material is buried in the client's distant past and partly because incest taboos make any suggestion of sexualization in the

family of origin, especially from parents, sometimes too difficult for many clients to contemplate.

I have a client whose addictive compulsive sexual patterns include regular masturbation while viewing hardcore heterosexual pornography and the regular use of escorts and call girls. The thing that stands out about his history is that his mother required him to pass a solid bowel movement every day and forced him to sit on the toilet until this had happened. She would insist on monitoring the results. This went on until he was 10 or 11 and she frequently inserted suppositories in him. I have no evidence that any of this behaviour falls into the category of 'covert sexualization' but it strikes me, and I think that this would be true of most psychotherapists, that there was more going on in this particularly invasive and rigid mother-child transaction than digestion and evacuation.

In my experience of covert sexualization in my own family of origin, when I was 15 years, my mother would tell me that her dressing gown had 'accidentally slipped' or that I was a 'prude' because I objected to her genital nakedness in my presence. Covert sexualization is very hard to assess precisely because it is covert. It is particularly pernicious because it creates a world of many confusions.

Sexual addiction, like any addiction, serves the purpose of anaesthetizing rather than correcting the consequences of narcissistic damage. The principal component of narcissistic damage is an endogenous shame made more acute by the shameful consequences of addictive compulsive sexual behaviour. Ideas

about the specificity of sexual addiction as a response to narcissistic damage that is accompanied by sexualization are under-developed in the literature, deserve further reflection and will be explored in writing up the issues and outcomes of the outpatient sexual addiction treatment programme [Appendix I]. Goodman [1998] concludes that the equation of sexual addiction looks like this:

Sexual Addiction = Narcissistic Damage + Sexualization.

### **Shame: The Principal Driver—**

Earlier in this chapter, in my explanation of narcissistic damage, I wrote that narcissistic damage had the following consequences: the self is experienced painfully and as unacceptable. Shame is the painful feeling of being unacceptable. I highlight shame here for three reasons. It is the core affect of narcissistic damage, it is the principal driver of the addictive cycle and high levels of shame are particularly associated with addictive compulsive sexual behaviour.

One psychologist [Wurmser, 1987, p67] described shame as the 'veiled companion of narcissism' and like many other investigators, he attributed shame to be an outcome of impairments in the mother-child relationship. Lewis [1987, p 95] links shame with narcissistic damage and describes it as a 'negative experience of the self', a feeling that involves 'an implosion or a momentary destruction of the self in acute self denigration'. Kaufman [1989, p5] writes that shame is the 'affect of inferiority' and describes it as 'a wound made



from the inside by an unseen hand'. Here is Sartre's [1956, p xx] classic description of shame:

Moved by jealousy curiosity or vice I have just glued my ear to the door and looked through the keyhole, but all of a sudden I hear footsteps in the hall. Someone is looking at me.

Sartre [1956, p xx] goes on to say 'I am ashamed of what I am'. This suggests that shame is an ontological condition intrinsically bound more to being than to doing.

Shame is the primary feeling state of the narcissistically damaged self. It is the feeling state that is connected to unwanted and distressing exposure. It is an affect that warns us that a behaviour, or way of being, has the potential to cause us to be disgraced and excluded. Exclusion, particularly in the primal horde, has the potential to destroy the one who is shamed. This 'unto death' nature of shame is demonstrated in the way people use images of death in popular language to talk about shame. People sometimes say that they were so embarrassed that 'wanted the ground to open and swallow them up' or they could have 'died of embarrassment'.

Shame is a powerful mechanism of socialization and social control. In my own experience, the most powerful experience of shame involved an incident that took place when I was three. My mother interrupted sexual play with another child and told me that this was a very bad thing. The level of shame that was placed upon me was so great that I could barely bring myself to remember the event. 35 years were to pass before I could tell anyone what had happened.

From this, and for the many reasons already described, shame became the underlying experience of my self. I experienced myself as unacceptable and my inner world was filled with unrest, confusion and distress. Shame was my emotional 'default' setting— shame about being insufficiently male identified, uninvolved with traditional male pursuits, unable to catch a ball. Multiple addictions were learned in the family of origin and used to anaesthetize the all-pervasive and overwhelming nature of so much negative affect. In writing about shame and addiction, I write with long personal experience.

Kaufman writes that [1989, p5] 'shame disrupts the natural functioning of the self.' Shame has an important social control function, but it can also cripple and distress. One client of mine reported that as a child he had experienced so much shame from his mother in the kitchen that he cannot even now, as a middle aged adult, load a dishwasher without feeling incompetent and becoming physically uncoordinated.

In the literature on addiction, shame and narcissistic damage are inter-related. I am persuaded that shame is the principal outcome of such damage. In my view shame is the self, experienced as unacceptable. It is the nature of the experience of the self as unacceptable that requires the masking as well as the anaesthetic. As I have argued in the article 'The Snake and the Seraph' [Appendix K] this combination explains the relationship between sexual addiction and religious behaviour. I have heard shame described as the oxygen of the addictive fire. I have watched in addiction recovery programmes, and in my own treatment programme for sexual addiction, a direct relationship

between a reduction in the levels of shame and an increase in the capacity for honesty, and the reduction in acting out behaviours.

If addiction is about, among other things, the management of internal feeling states, then shame is the primary feeling state that is medicated by addiction. The problem is that addiction, and sexual addiction in particular, creates a catch-22. While it temporarily creates a tunnel of pleasurable oblivion, it normally contributes to higher levels of pain-filled shame. Carnes writes [1991, p94],

Shame emerges from addiction. Shame causes addiction. Whichever way the shame is flowing, whether consequences or cause, it rests on one key personal assumption: somehow I am not measuring up.

Butts [1992, p128] writes in much the same way, 'They [sex addicts] continue to feel driven and worthless, even upon completion of the very sex acts which they originally felt compelled to accomplish'. The conceptual relationship between shame and the addictive cycle is shown in Fig. 1.

Why so much shame about sexual behaviour? In my clinical experience, high levels of shame almost always accompany addictive compulsive behaviour. My own view is derived from thinking about shame and masturbation. The levels of shame experienced around masturbation are thought by some to be useful in that they contribute to the socialisation of sexuality. Shame helps move sexual behaviour out of the autoerotic and into the wider domains of marriage and family life. If the function of shame, as an affect, is to tell us that we are doing something wrong and therefore we risk social approbation then there are

## Shame Driven Cycle of Addiction

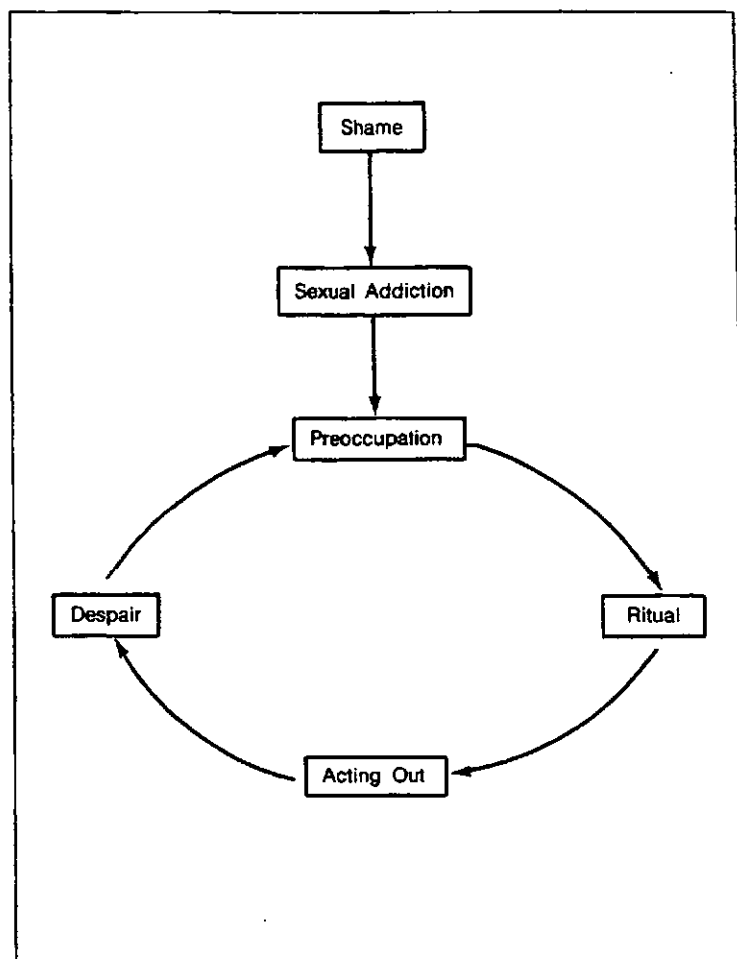


Fig. 1

important social and reproductive benefits to the shaming of behaviours that did not optimally contribute to the survival of the species. In other words, high levels of shame tend to accompany behaviours that take place outside of committed relationships because, in evolutionary terms, these behaviours do not maximally ensure protected childrearing and therefore do not contribute to the well-being and continuation of the species. While socially, cognitively and technologically we have moved beyond the needs of the primal horde, to a place where reproductive function is no longer a pressing priority, our affect states still operate out of an earlier place of human evolutionary need.

### **Sexual Addiction and the Regulation of Affect**

Goodman [1996] suggests that addiction grows out of impairment in the self-regulatory mechanism of the self and that it becomes the function of the addiction to manage, monitor and modulate the experience of painful affect. This would be as true of sexual addiction as any other addictive substance or addictive process. Rosen [1997] takes the view that perversion has much the same function in the regulation and maintenance of the esteem functions of the self. These overlapping and parallel perceptions between sexual addiction and perversion add weight to the argument that addiction, or possibly perverse behaviour manifested addictively, function to regulate negative affect and the experience of the self. Bays and Freeman-Longo [1989] take a similar view in their explanation of the dynamics of sexual offending.

In my own experience as a recovering addict, I find that I am now able almost always to assign a cause to addictive craving. In the early stages of my own

addiction recovery, I noted that every time I saw someone off at the bus stop that I would crave sugar and buy and eat at least two bars of chocolate. It was plain to me that the bus stop scenario activated a loss of attachment script that I then medicated with sugar. As a child, sugar usually in combination with butter and white flour, had been the primary sign of attachment. I have noted elsewhere in this project that I experienced unusually high levels of addictive distress when interviewing offenders. I attributed this to secondary trauma and the activation of shame. I similarly note that in the requirement to re-draft an earlier doctoral submission I experienced a similar increase in addictive preoccupation. I attribute this to the re-opening of earlier narcissistic wounding in the experience of 'not good enough'. This addictive preoccupation disappeared the moment I began running my addiction treatment programme. My co-facilitator, also a recovering addict noted, after our first session, that he wasn't sure 'what it was doing for them but he certainly felt less compulsive'. In working with this group of recovering men, all self-identified as sexually addictive and compulsive, the group identified a range of feelings that they anaesthetized with sexual behaviour. One of the participants became vividly aware that he would watch pornographic videos whenever his wife made him angry. He could see that he was using sexual behaviour to manage his anger at her, and at women in general, through this process of sexual acting out.

The characteristic nature of addictive processes and therefore sexual addiction, to manage painful or unruly affect, is further supported, not only Comes [1998] but methodically and more comprehensively by Goodman

[1998, p197], 'the addictive process originates in a disorder of self-regulation'.

Goodman continues [1998, p197]

A survey of the relevant literature indicates that all aspects of the self-regulatory system, including affect regulation, self-care, and self-governance functions, develop through the gradual internalisation of self-care functions and their assimilation into unfolding, constitutionally determined infrastructures.

Goodman [1998] attributes such disturbance to narcissistic damage that he locates and attributes [citing a range of psychotherapeutic terms all describing the same thing] in the failure of maternal responsiveness, traumatic disappointments, insufficient maternal availability, faulty patterns of affective interchange, and a mismatch between the infantile emerging psychobiological need and the available environmental provision. This linkage further connects narcissistic damage and its outcomes to addiction and therefore to sexual addiction. This linkage has been systematically confirmed in reflections on my own personal journey, in my clinical work, and especially as I have scrutinized the experiences of the men who are currently enrolled in my treatment programme [Appendix K]. To describe sexual addiction, as affect regulation is another more psychobiological way of saying that addiction anaesthetizes this twin condition: the self experienced painfully and the self experienced as unacceptable.

### **The Conceptual Interconnections: A Diagrammatic Outline**

A comprehensive theory of sexual addiction is built upon a combination of interconnected and interdependent concepts. This is diagrammatically summarised in Fig. 2.

# A Theory of Sexual Addiction

## Conceptual Interconnections: A Diagrammatic Outline

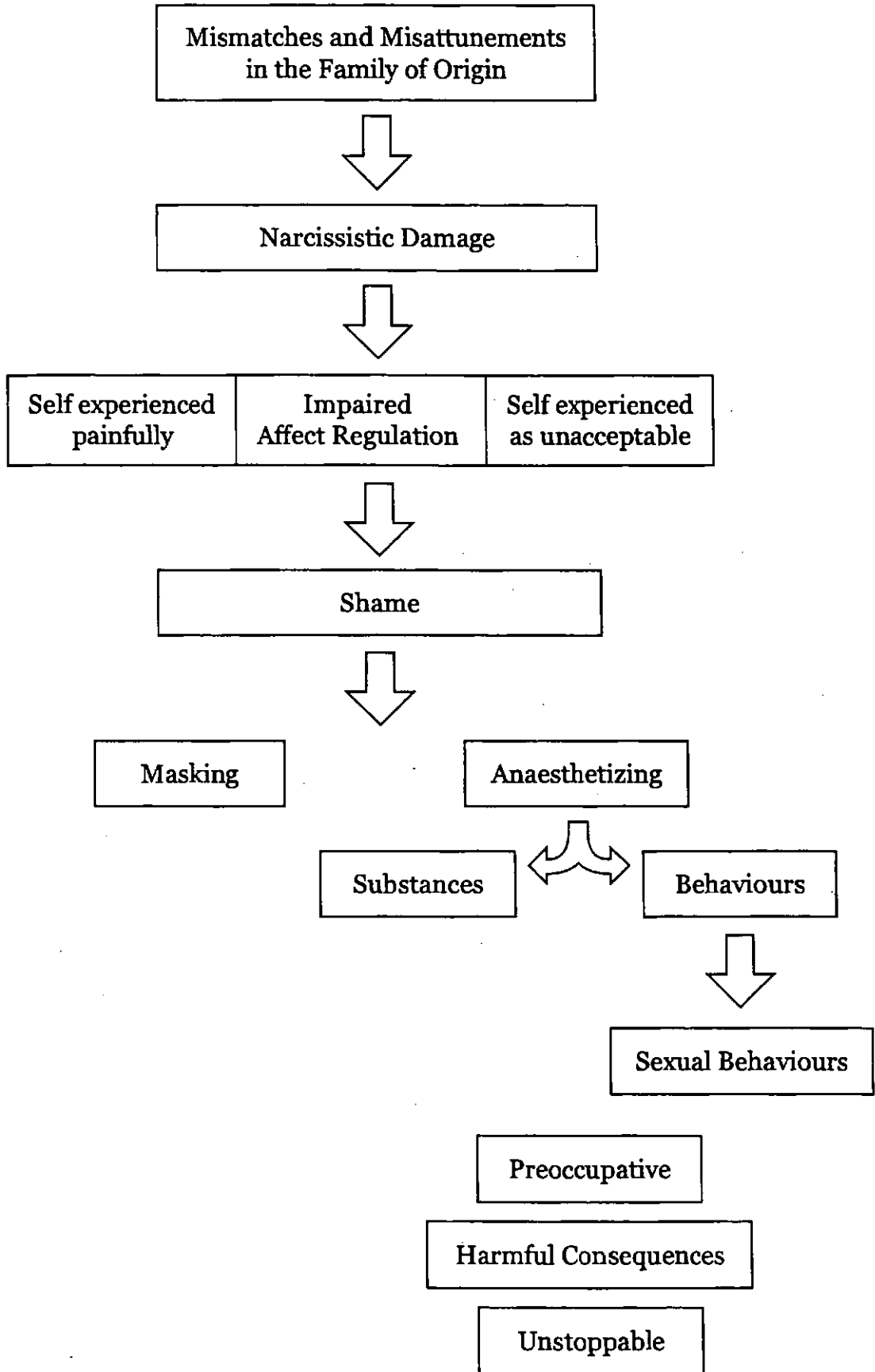


Fig. 2



Interactive patterns between the developing self of the child and the principal caregiver give rise to adult patterns of behaviour that are maladaptive, inflexible and dysfunctional. The three principal characteristics of this 'narcissistic damage' are: an impaired affect regulation, the self is experienced painfully and the self is experienced as unacceptable. The principal negative affect is shame. The response to this is the taking on of masking behaviours and anaesthetizing behaviours to regulate and modulate negative affect. These anaesthetizing behaviours may involve substances and/or processes. Sexual behaviours may be one of these anaesthetizing behaviours. When this is subjectively experienced as 'out of control', preoccupative, and when it brings with it real or potential harmful consequences, and it is seemingly unstoppable, this behaviour is given the name sexual addiction or addictive compulsive sexual disorder.

### **Locating the Theory of Sexual Addiction**

The following section identifies the location of the theory of sexual addiction in relationship to a variety of different contexts. It starts with the personal and professional context. It goes on to consider other addictions, the medical context, existing psychoanalytic and psychotherapeutic categories as well as methodology and treatment strategies.

### **In a Personal Context—**

The theory of sexual addiction that is presented in this chapter has grown out of the reflections of a personal journey. It was not, in the first place, the fruit of clinical training or an academic programme. I 'discovered' this conceptual model quite by chance on my own journey. It helped me to make sense of my

own destructive multiply addicted compulsive patterns of behaviour and to find a way to leave them behind and to learn a new way of being, feeling, thinking, acting and relating. The identification, acquisition, commitment to and further development of these concepts are part of the journey to the doctorate that lies prior to, underneath and along side the creation of the individual products.

As I have indicated in the first chapter, the decision in 1998 to begin this doctoral research programme was motivated by a desire to have an opportunity to consolidate and systematise these reflections and to employ them in a way that would contribute to the profession of psychotherapy. It was also motivated by a personal desire to understand and synthesize all that gone before and to bring clarity and good out of the confusion and adversity that had gone before.

#### **In a Professional Context—**

BASRT is member of the family and systemic section of UKCP. Psychotherapists who are registered with UKCP within this section are designated by UKCP as 'psychosexual psychotherapists'. Within BASRT there is an extended process of accreditation that involves a programme of supervision that is adjusted to combine with academic programmes, as they are available. Although there have been important training programmes at St George's Hospital, Tooting and the Whittington Hospital, Archway, both of which are now closed, formal academic training in psychosexual psychotherapy has been limited. Current availability includes programmes at Lancaster University and Sheffield University as well as the 'in house' programme offered by the marriage and relationship charity, Relate.

The function and purpose of psychosexual psychotherapy is to understand human sexual behaviour and to be able to respond with appropriate and effective treatment strategies to problems that are presented in clinical practice that have a major psychogenic sexual component. In many areas of sexual dysfunction there is a fine line between biogenic and psychogenic causation and psychosexual psychotherapists constantly need to refer to medical as well as psychological factors in assessment and treatment. Psychosexual psychotherapy as practiced within BASRT is also heavily orientated to marriage and relationships, offering to help couples who are experiencing problematic and painful relationships.

Psychosexual psychotherapy as it is practiced within BASRT has had the following characteristics:

- Close connections to sexual medicine, sexual physiology and sexual pharmacology and product development
- A conceptual context that assumes a family systems approach
- A substantial educational and cognitive behavioural composition
- Informed by other psychotherapeutic and psychoanalytic modalities

The utilisation of addiction theory to understand and work with sexual behaviour is a new, but related and growing, dimension within these traditional streams of influence. An addiction model for understanding and treating patterns of compulsive sexual behaviour is concordant with all four streams of influence and fits naturally into the historic context of psychosexual treatment and

training. Evidence of the growing impact of addiction theory within the profession is suggested by the BASRT programme of recent and future conferences. There have been two national conferences on sexual addiction in the past three years. There will be a conference in the Manchester area on sexual addiction next year [Appendix D], largely for medical practitioners. The material for this conference will come entirely from the treatment and training manual on sexual addiction [Appendix I]. Within our professional community a growing application of addiction theory to sexual behaviour is an outcome of this project. This will be referred to again in the closing chapter.

### **Sexual Addiction and Other Addictions—**

The World Health Organisation in 1964 defined drug dependence as,

...a state, psychic and sometimes physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. [Brickman,1997].

From this definition it is possible to see how the 'state resulting' could be just as easily be derived from a mood altering behaviour as a mood altering substance. This definition also blurs the distinction between addiction and compulsion. This definition, with its reference of tolerance, also suggests that escalation and withdrawal are not essential components in a definition of addiction. I make this point because the absence of physical withdrawal symptoms has sometimes been sited to me as a reason for not applying the term addiction to this sexual behaviour. Comes [1991] includes escalation and withdrawal in his ten signs of

sexual addiction. In my work with sexual addiction my clients always report withdrawal symptoms but do not always report escalation. While many clients do escalate their behaviour, others seem to settle on a long term and chronic pattern of behaviour with little or no escalation.

The standard **Medical Dictionary** defines addiction as 'the state of being given up to some habit, especially strong dependence on a drug' [Jacobs, 1997, p170]. This definition more specifically includes habit, as well as substance, in such a way as to suggest that the definition of addiction is not limited to the introduction of substances into the body of the addict. Griffin-Shelley writes [1991, px]

'As we become more and more familiar with addictive disorders, we are better able to see the similarities between drug addicts and alcoholics, heroin addicts and smokers, sex and love addicts and food addicts, over-workers and the over religious.'

This is one of the basic tenets that underlies this doctoral project. The concept of addiction need not be limited to the introduction of substances into the body but equally includes the use, pursuit and/or dependence on certain behaviours that have similar mood altering capacities. 'Similarities among different kinds of addicts have long been common knowledge' [Jacobs, 1997] Ultimately it seems to me that the addict is addicted to the experience rather than to the substance. Why would someone do it or take it if it did not make any difference?

Another basic tenet that underlies this doctoral project is that sexual addiction, like all addictions, is associated with the regulation of painful affect. Coleman

[1992] states that 'compulsive sexuality can be a coping mechanism similar to drugs and alcohol'. This is expressed, at its most extreme in existential psychotherapy, in the work of Firman and Gila [1997]

'Addictions are not simply habits casually gathered over the course of living, they are desperate strategies by which we avoid the unimaginable terror of non-being.'

This assertion points the theoretical position back to the subject of shame, an affect state associated with exclusion and abandonment and, thus to death itself and the 'unimaginable terror of non-being' [Firman and Gila, 1997].

### **In a Medical Context—**

Although there is much debate [Kutchins and Kirk, 1997] about the usefulness of the DSM, I write about DSM IV here because of its importance and influence in the medical profession and the professions allied to medicine. The location of sexual addiction within this wider system of classification has important potential consequences for psychotherapists working with sexual addiction and compulsivity, especially those working alongside medical and other health practitioners. This makes it especially important for psychosexual psychotherapists. Understanding DSM IV, and understanding sexual addiction in relationship to DSM IV, is important for psychotherapy practitioners to be able to effectively communicate across the medical and psychological disciplines. Schneider and Irons [1996] argue that sexual addiction is subsumed within DSM IV categories and point out that the use of differing vocabularies and conceptual models causes a difficulty in communication that 'has fuelled scepticism among some psychiatrists and other mental health

professionals regarding the case for including sexual addiction as a mental disorder' [1996, p76].

I have limited this discussion to DSM IV and have deliberately not included a similar discussion of the location of a theory of sexual addiction in ICD 10 because all of the currently available literature on sexual addiction is American and this literature only makes reference to DSM classifications. In any event DSM IV is widely used.

The term sexual addiction is not used in DSM IV. It did get a side mention as an example in DSM III R but this was dropped from DSM IV. The status of sexual addiction in relationship to the preparation of DSM V is not known. However, there are two categories of classification within DSM IV that are relevant to a discussion of sexual addiction:

- *Sexual Disorders*
- *Substance Dependency*

DSM IV groups mental disorders into 16 major diagnostic categories one of which is *Sexual and Gender Identity Disorders*. This is further divided into the following three categories: *Sexual Dysfunctions*, *Paraphilias*, and *Gender Identity Disorders*. Sexual dysfunctions are characterised by problems of arousal and problems in the sexual response cycle. Within sexual dysfunction there is a residual category *Sexual Disorder Not Otherwise Specified*. This includes three examples, one of which is 'distress about a pattern of sexual relationships involving a succession of lovers who are experienced by the

individual as things to be used'. This category has been most used to code the behaviours that fit the definition for sexual addiction [Schneider and Irons, 1996].

The category *paraphilias* can also be relevant to diagnoses and conversations about sexual addiction. This category is commonly associated with increases in sexual activity with compulsive and impulsive features [Schneider and Irons, 1996]. DSM IV defines paraphilias in the following way,

Recurrent intense sexual urges, fantasies or behaviours that involve unusual objects, activities, situations, that occur over six months and cause significant distress or impairment of social, occupational, or other important areas of functioning. [Schneider and Irons, 1996, p78]

This definition is similar to sexual addiction but also different in a significant way. It includes the concept of intensity, and harmful consequences, but says nothing about not being able to stop. There is a focus on 'unusual objects, activities, or situations' rather than on the function of the behaviour in the life of the patient. Sexual addiction can, but does not necessarily or even normally, involve unusual objects, activities or situations. It may manifest itself entirely in masturbation or coital intercourse. It is defined subjectively, not so much by what is done, but the effect it has and the role it plays, by preoccupation, harmful consequences and the difficulty of staying stopped.

Schneider and Irons [1996, p75] also suggest that



addictive sexual disorders that do not fit into standard DSM IV categories can best be diagnosed using an adaptation of the DSM IV criteria for substance dependence.

Based on his work and research into compulsive gambling and substance addiction Goodman [1998] proposes the following criteria for sexual addiction drawn from DSM IV criteria for substance dependence simply replacing the words *substance* and *substance use* with the words *sexual behaviour* [1998, p233] as in the format quoted below:

### *Sexual Addiction*

A maladaptive pattern of sexual behaviour, *leading to clinically significant impairment or distress*, [italics in the original] as manifested by three [or more] of the following, occurring at any time in the same 12-month period:

[1] tolerance, as defined by either of the following:

- (a) a need for markedly increased amount or intensity of the sexual behaviour to achieve the desired effect
- (b) markedly diminished effect with continued involvement in the sexual behaviour at the same level of intensity

[2] withdrawal, as manifested by either of the following:

- (a) characteristic psychophysiological withdrawal syndrome or physiologically described changes and / or psychologically described changes upon discontinuation of the sexual behaviour
- (b) the same [or closely related] sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

[3] the sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

[4] there is a persistent desire of unsuccessful efforts to cut down or control the sexual behaviour

[5] a great deal of time is spent in activities necessary to prepare for the sexual behaviour, to engage in the behaviour, or to recover from its effects

[6] important social, occupational, or recreational activities are given up or reduced because of the sexual behaviour

[7] the sexual behaviour continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated the behaviour

Using this definition, any behaviour that is used for gratification and to medicate internal negative affect can be compulsive and can constitute an addictive disorder [Schneider and Irons, 1996]. Goodman [1998] is at pains to point out that these are provisional criteria and that the term *substance dependence* appears in DSM IV but not the term *addiction* or *sexual addiction*.

What does this look like in application? Using the specific behaviours of the members of my treatment programme, their behaviours would be located in DSM IV in the following way. Two of the men might be assigned the category *paraphilias* for sexual behaviour involving the Internet and a preference for corporal punishment and one member of the group for having sex with men in public places. In each of these cases there is clinically significant distress and impairment of social and occupational functioning. Other members of the group who regularly have affairs and frequently use prostitutes would clearly fit into the category *Sexual Disorder Not Otherwise Specified*. Each member of the group would fit, for diagnostic purposes, the criteria for substance dependence adapted as above for sexual behaviour.

When I am writing to medical referrers I usually include in my letter some reference linking my assessment and treatment plan to the categories in DSM IV as they have been discussed above. This is done with reference to differential diagnoses also as listed and outlined in DSM IV.

### **In a Psychotherapeutic and Psychoanalytic Context—**

Just as it is important to locate sexual addiction in relationship to DSM IV nosology for a clearer understanding of the concept of sexual addiction and for the ease of communication across the disciplines, so it is also important, for the same reason, to locate sexual addiction in relationship to the traditional and technical language of psychoanalysis and psychotherapy. Because of a lack of systematisation and an agreed nomenclature this is a much more difficult process and so extensive as to be beyond the scope of this project.

Since the language and conceptualisation within psychotherapeutic modalities is very diverse and not as systematic as DSM IV, I will confine myself to one theoretical concept, the concept of perversion, discussed here largely as an example of a relevant, but not identical, usage in the literature.

Theorists focusing on the diversion of sexual desire away from 'normal' stimuli coined the term *perversion* [Brockman and Bluglass, 1996]. In psychoanalytic usage *perversion* has been defined in the following ways,

1] 'A deviation from the normal sexual act when this is defined as coitus with a person of the opposite sex directed towards the achievement of orgasm by means of genital penetration' [Laplanche and Pontalis, 1967, p306]

2] 'A variety of sexual practices that deviate in aim or object choice from the accepted norm of heterosexual genital union' [Moore and Fine, 1968, p72]

There are commonalities between the two concepts *perversion* and *sexual addiction*. For example Stoller [1995] associates perversion with anger and aggression, describing perversion as an erotic form of hatred. Anger and aggression are associated with sexual addiction in the literature on sexual addiction and in the literature on sexual offending. It was very clearly identified among participants of my treatment programme as a principal trigger for addictive compulsive sexual behaviour. In the same way that Goodman [1998] associates sexualization with the aetiology of sexual addiction, Glasser [1995] emphasises the importance of sexualization in the formation of perverse behaviour. Rosen [1995, p76] argues that the 'regulation of self esteem is a major function of the perversion'. These commonalities suggest to me that these clinicians are able to see some of the characteristic of the behaviour of sexual addiction but without the coherent and systematic framework provided by addiction theory.

Although the literature on perversion is relevant to an understanding of the narcissistic damage and thus the aetiology and nature of sexual addiction, especially in terms of the self psychologists, nevertheless, as we have defined it, sexual addiction is not about the gender of the participants or the nature of the sexual activity but about the role and function of the behaviour in the life of the individual. It might, or it might not, overlap with one of the definitions of perversion provided by classical theory, ego psychology, or object relations. However, keeping an awareness of the relationship of the concept of sexual addiction to the various concepts of perversion and other relevant nomenclature is professionally important when in dialogue with the wider

psychotherapeutic community and with psychoanalytic psychotherapists in particular.

It should also be noted that the use of terms like *deviant* and *perversion*, that have been used to socially disenfranchise and marginalize sexual minorities, and the continuation of the use of such terms by some therapeutic treatment providers, contributes to stereotyping and discrimination. As such this runs against the spirit of the ethical guidelines of most academic and professional associations. The specialist seminar on discrimination and stereotyping, referred to in the last chapter, professionally alerts us to the harm and injustice that can be done by classifying groups of people as sick and well, medically validated categories equivalent to bad and good.

### **Sexual Addiction and Treatment Strategies**

This chapter has been dedicated to outlining and explaining the principal conceptual components that make up the theory of sexual addiction. I have added this section on treatment strategies because, in most cases, the theory of sexual addiction grows out of an experience of treatment. In my experience, people who work in field of addiction treatment are themselves almost always recovering addicts. From a review of the literature on sexual addiction it has become clear that most, if not all the theorists, are both recovering addicts and treatment providers. In the realities of the personal journey, theory has grown out of remedy. The result of this doctoral programme is to take the theoretical material, to make it ever more coherent, and to use it to influence the

development of practice. This sets up a circular process: practice affecting theory and theory affecting practice.

Although concepts relevant to sexual addiction lie behind all the products of this doctoral project, the main thrust has been, through the revised proposal, to produce a sexual addiction treatment strategy [Appendix I]. An adequate treatment strategy requires the completion of various therapeutic tasks. Drawing from the literature [Cames and Adams, 2002], from my own research [Birchard, 2000], from the work done by the Churches Together in Britain and Ireland Working Party on Sexual Abuse in the Church, from clinical practice, these therapeutic tasks divided into two main areas of work: the first using a cognitive behavioural approach; the second using a much more supportive and exploratory psychotherapy. These two conjoint approaches can be characterised as:

- Recovery Facilitation
- Psychotherapeutic Restructuring

These two approaches are explored and explained in greater detail in the article 'The Snake and the Seraph' [Appendix J] and so will only be summarised in this section.

The first approach largely involves cognitive behavioural therapy; the second involves a much more psychodynamic insight-orientated therapeutic approach. Keller [2003] recommends, for the treatment of substance abuse, a similar combined approach. In my view, recovery facilitation is a therapeutic psycho-

educational process in which the therapist offers the client challenge, support and education. A range of tailor-made cognitive behavioural techniques is provided to facilitate recovery. The chief of these is to encourage the client into a group process that is specifically targeted to the treatment of addictive compulsive behaviours. This might be a twelve step sexual addiction recovery programme or some other similar treatment programme. Whatever the theoretical orientation of the treatment provider, there are a number of cognitive behavioural tasks that are relevant to a successful outcome. The therapist must provide a place for the client to learn about sexual addiction. This can be done by providing a mini-course at the beginning of the therapeutic process or by weaving material into the unfolding of the process. Included in the education programme, is direct teaching about the importance of group work and a priority for the client to commit and participate in a sexual addiction recovery programme.

Nowinski [2003] has evolved a treatment regime that has as its primary goal to bond the patient to a twelve step programme,

The primary goal of TSF [Twelve Step Facilitation] is to help the patient to begin the process of bonding to a 12-step fellowship by understanding its key concepts and learning how to utilize its resources for support and advice.

Cames [1991] suggests, from his research, that as many as 87% of recovering sex addicts relapse unless there is an involvement in a culture of recovery. For most clients this will, in effect, mean that they will access and have to make a commitment to a twelve step sexual addiction recovery programme. Most of these in the United Kingdom are London based, but not entirely, and new

opening up all the time. Sexual recovery meetings are also available online. One of the recovery programmes, Sex Addicts Anonymous, has a provision for 'boundary meetings'. These are meetings specially set up to provide a programme of recovery for the clergy, medical doctors, psychotherapists, and others who need to attend meetings separate from clients, parishioners, and patients.

In addition to the educational and behavioural tasks proposed above, there are two additional priorities, more usually associated with conventional psychodynamic and person-centred approaches. I describe these as 'restructuring' because they are processes that are reparative on the original narcissistic damage. If the cognitive behavioural tasks are to change the behaviour, these next two tasks are set to change and repair the sense of self, experienced painfully and as unacceptable, that generates the addictive compulsive but unwanted behaviour. The first task is an exploration into the family of origin and the creation of a narrative that explains and makes sense of the client's experience. The narrative helps the client to make sense of the present. The construction of the narrative helps form and strengthen a sense of self [Butler, 1999]. The second task is the use of the therapeutic relationship to repair the damage of broken relationships. Cooper [2002] goes so far as to write that sexual addiction is a disease of broken and relationships. His treatment programme is therefore very centred on the restoration of 'relatedness'. This also is to help the client bring into his or her life activities and processes that fill 'the hole' that lies at the heart of narcissistic damage. This is to use the self of the therapist to effect changes in the self of the client and to



use the therapeutic relationship to create new and changed relationship templates. Furthermore, this is to help the client construct and bring into place the components of a rich and meaningful life to replace the anaesthetizing functions of the addiction with enduring structures and sources of solace. Just stopping the addiction is not enough. A more detailed programme of treatment can be found in the forth product of this doctoral project [Appendix I].

The treatment summarised above, although arrived at independently and described somewhat differently, is identical in substance to the 'recovery orientated psychotherapy' treatment model outlined by Zweben [1997] in her proposals for work with alcoholism and drug dependency and Keller's proposal [2003] for an integrated psychoanalytic and cognitive-behavioural therapy for the treatment of substance abuse.

At the beginning of this section I said that the theory of sexual addiction grows out of an experience of treatment and that most treatment providers were, in my experience, recovering addicts. What impact does this have on the provision of programmes of treatment? I think it gives to programmes of treatment 'insider' knowledge, authenticity, enhanced credibility, an example of the possibility of recovery, and high levels of empathetic understanding. It also creates an on-going programme of recovery for the treatment provider.

### **Sexual Addiction and Research Methodology**

I have included a section on methodology in this chapter because the recovering addict's experience has been central to the methodology of

addiction research. The theory of sexual addiction has its roots in a strongly heuristic methodological process. Treatment and methodology have come before the development of theory and theory has largely grown out of treatment and methodology.

It is clear from a review of the sexual addiction literature in the next chapter that all of the work on sexual addiction has this strong heuristic quality. In other words, recovering sex addicts have done the pioneering work on sexual addiction. For example, I once heard one of the main contributors to the literature on sexual addiction talk in private about his exhibitionism [the practice of exposing his genitals to women in public places] and to connect his work on sexual addiction with his personal journey away from that behaviour. Although the methodology of sexual addiction research, as it has developed, has been both quantitative and qualitative, at its core it has been very much a heuristic qualitative pursuit. This is reflected in the powerful role of individual experience in the development of the theory, in its clinical and case history orientation, and in the strong narrative drive that characterises the literature.

The roots of this kind of qualitative methodology go back to the 1920's and 1930's and to the development of ethnographic anthropology [Denzin and Lincoln, 1994]. Throughout the history of qualitative research and throughout its major developmental stages, there 'stands the biographically situated researcher' [Denzin and Lincoln, 1994, p11] as well as a 'reciprocal relationship between the researcher as person and the process of the research' [Reinharz, 1979]. The distinctive character of psychotherapy and counselling research is a

continuation of the participant observation process of the cultural anthropologists [Rennie, 1994]. This approach, which Karp [1996] describes as 'autoethnography' has been congenial with my own interest, first as an undergraduate in anthropology, as well as with the heuristic and reflexive qualities developed in theological training and used in routine ministry and parish life.

The distinctive feature of psychotherapy and counselling research is the employment of the self as an agent and a co-operative in the process of the research. This is certainly true of sexual addiction research. The self of the researcher is not seen as a contaminant to the process [Karp, 1996, Richardson, 1994]. This 'employment' of the self assumes that the researcher is motivated by his or her reflexive 'need to know'. 'Becoming a knower' is one of the chief goals of the qualitative research [McLeod, 2001, p6] and 'becoming a knower' is one of the chief goals of sexual addiction recovery. McLeod [2001, p20] writes that 'all qualitative research or enquiry is basically attempting to fulfil the same aim, which is that of developing an understanding in how the world is constructed'. West [1998] 'ups the ante' further. He describes qualitative research as 'passionate research' and writes that heuristic research capitalises on a 'passionate but disciplined involvement by the researcher' [West, 1998, p60]. These approaches assume that the researcher works in the context of his/her setting [Altheide and Johnson, 1994], and that there is 'a reciprocal relationship between the researcher as person and the process of the research' [Reinharz, 1979]. There is an emphasis upon the generation of concepts *in vivo*. The researcher becomes both observer of the field and a participant in the field of enquiry. Reinharz [1979, p11] provides a comprehensive outline of the

components of qualitative enquiry contrasted with 'mainstream research'. The former he describes as a mixture of 'subjective and objective orientations'.

This research project has sought to explore the use of the self as the subject of a particular methodological process as well as to employ the self in application of that methodology to the subject. It has been in many parts 'autoethnographic'. With the first aborted proposal on offender behaviour, the toxicity of the subject washed back into the self of the researcher. In the second completed proposal on sexual addiction treatment and training, the self of the researcher was used to validate, enrich, and animate the subject of the research. In both cases here stands the 'biographically situated researcher' [Denzin and Lincoln, 1994, p11].

At the beginning of this section, I said I have included a section on methodology in this chapter because the theory of sexual addiction has largely emerged from the recovering addict's experience and the addict's experience has been central to the methodology. What impact does this have on methodology? I think it gives to the methodology, as it does to the programmes of treatment, 'insider' knowledge, authenticity, enhanced credibility, and it contributes to on going programme of recovery for the researcher. I think it gives to the research a 'passionate' quality. In the field of sexual addiction since most of the researchers are also clinicians this gives a much more client centred character and grounded character to the research.

## Why Call It Sexual Addiction?

In a recent press interview about the nature and concept of sexual addiction the point was made [Guardian, 16<sup>th</sup> September 2003] that this is not the invention of a new disorder but rather a new way of conceptualising and understanding an old behaviour. But why use the term *addiction*?

I use the term *addiction* and *sexual addiction* to describe this behaviour for the following reasons. It has emerged as self-referential term that is used by people who experience these behaviours to describe how they experience the behaviour. It seems to me to be good practice to accept and use the self-referential language of the client group, in the same way that one might use the term black rather than coloured, or gay rather than homosexual, or she rather than he, in describing or talking of a male to female transsexual. The term sex addiction emerged as a grassroots self-identifying term and has since come to be used by, rather than assigned by, psychologists, psychotherapists and medical practitioners. Nathan writes [1995, p352]

...many patients, see in the addiction concept ideas that speak to their own experience—the sense of being driven to do something even though they know they will regret it, the feeling of being high when engaged in sexual acting out, the experience of painful withdrawal when trying to control sexual activity.

It also seems to me that the practice of limiting the use to the word addiction to substances is entirely a matter of social construct and/or professional territoriality. I take the view, the view shared by Cames and Goodman and many others, that people do not in fact become addicted to the substance but to the experience created by the substance. I do not smoke a cigar because I

want nicotine. I smoke a cigar because I want the experience that the nicotine brings. The addict uses substances or behaviours to effect a change in affect and it is to the change in affect state that the person becomes addicted.

Against the convention of only using the word addiction in relation to substances, I would site the much older use of the word in relationship to repeating behaviours. In the Latin, *dictare* means 'appointed' rather than chosen [Dictionary of Word Histories, 1999]. Addiction, which has at its root the meaning of being under the control of a dictator, or in the thrall of some kind of slavery, is a foundational concept in the western theological and intellectual tradition and appears clearly in Paul and in an even more developed way in Augustine. I cite Augustine especially because the evidence points to sexual addiction and sexual addiction recovery in the life of Augustine and because Augustine is considered by many to be the father of the western intellectual tradition. Augustine writes [Boulding, 1997, p192]

The enemy had my power of willing in his clutches, and from it had forged a chain to bind me. The truth is that disordered lust springs from a perverted will; when lust is pandered to, a habit is formed; and when the pattern is not checked, it hardens into a compulsion. These were the interlinking rings forming what I have described as a chain, and my harsh servitude used it to keep me under duress.

Augustine uses the imagery of slavery and the language of addiction and compulsivity.

### **Why Call It an Addictive Compulsive Behaviour?**

In the literature, it is common to find the terms addictive and compulsive linked together to describe this kind of behaviour. American psychotherapeutic

professionals and researchers have formed the National Council on Sexual Addiction and Compulsivity and a journal is published which is called the **Journal of Sexual Addiction and Compulsivity**. This is because there is, especially in the medical literature, a technical distinction between an addiction and a compulsion.

Although no consistent pattern is used across the professions [Carnes, 1996] the word compulsion is normally associated with the relief of painful affect and the word addiction with the production of pleasure. As these sexual behaviours produce pleasure as well as relieve negative affect the two terms are naturally combined. Carnes points out [1996] that many political considerations lie behind the choice of terminology and that the term compulsivity is often more readily received in adjacent professional communities. Such considerations temper our choice of nomenclature. Dr Robert Lefever, a leading and long established British specialist in the treatment of addiction, has noted the political and economic consequences of nomenclature in an article on sexual addiction [**Sunday Telegraph**, 18<sup>th</sup> October 2003]. I have found much the same to be true. For example, the sex offender treatment professionals have been so hostile to the word sexual addiction that to be heard at all in that community I substitute the word compulsivity. I have found much the same to be true in the field of sexual medicine. I also use the term sexual compulsivity within the church community to avoid the more sensational language of addiction.

The principal objection to the term *sexual addiction* is almost always that the term addiction provides an excuse and suggests the denial of responsibility.

This view continues to circulate even though this is very clearly not the case, either in my treatment programme, any other treatment programme that I have researched or in any of the twelve step recovery fellowships. However, professionals must address their distinctive constituencies and the choice of nomenclature, and objections to nomenclature, are dictated as much by political and social agendas as by any clinical consideration. It is upon such choices and decisions that influence is brought to bear, government grants are awarded, and legal arguments are constructed and important judgements are made. There are many social, political and financial implications if a pattern of behaviour can be designated or defined as an illness. These include custody, compensation, and civil and criminal responsibility. The choice of nomenclature is about many considerations other than aptness and/or the clinical usefulness of the language.

### **The Application of Theory to Practice: Two Case Studies**

In the following case studies the details have been changed to protect the anonymity of the clients.

#### **Case Study One**

I use this particular case study for three reasons: it clearly illustrates the chief characteristics of sexual addiction, it is a particularly clear example of the 'cycle of addiction', and it is the case study that I use in sexual addiction treatment and training programmes.



## **Scott**

Scott is 34, a university educated accountant working with a large and prosperous firm in the City. He is middle class and grew up in the suburbs where he now lives with his wife and new baby. He has the following pattern of behaviour:

About once a fortnight he enters a cycle of addictive/compulsive sexual behaviour. Each cycle has a ritualised sequence. It will begin with browsing the top shelf of the newsagent on his lunch hour. He then begins to visit phone boxes and ring prostitutes. He then starts to visit them and check them out when they answer the door. This may last two to three hours. Eventually he winds up, either with one of the women, or, more usually, at a sauna massage parlour where he is masturbated and receives unprotected oral sex. Throughout the episode he uses amyl nitrate.

After orgasm he goes into a time of profound remorse, regret and mortification. He hurries away and heads for home. On his way home he stops at church and goes to confession and thus begins a cycle of repentance, abstinence and withdrawal until eventually a sense of need or entitlement brings him back into the cycle of sexual behaviour. He has been 'locked' into this alternating sequence for over 8 years. He has been threatened with violence on more than one occasion and, to date, owes just under £10,000 to his client account that he has improperly taken out to pay for sexual services.

He lives most of his life in fear, anxiety, and regret, and loathes himself, in general, and, in particular, for this pattern of behaviour. He recognises that this behaviour is out of control, dangerous to his job, his marriage, his family life, his health, and his whole sense of self and yet he goes on doing it.

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This case history illustrates all the features of sex addiction that have been described in this chapter and in the products of this doctoral project. The treatment priority, as an immediate priority, was to stop the behaviour. His indebtedness to his own client account, the threat to his marriage, the impact upon his capacity to parent, his use of amyl nitrate, and frequent danger from pimps and prostitutes, and the health risks are all examples of harmful consequences. The treatment priority was to deepen his cognitive awareness of these harmful consequences and to encourage him to participate in a cognitive behavioural intensive group programme of sexual addiction recovery. It was clear from his history, which is not given in the case study, that shame was a major factor in creating the behaviour. Additionally, cascading and spiralling shame were a major outcome of each addictive episode. The preamble to London's First Meeting of Sex Addicts Anonymous describes this as the 'downward spiral of despair'. The goal was to help him identify his own version of the addictive cycle and to learn exit strategies and relapse prevention techniques. This involved a much deeper investigation into the original shame scenarios that underpinned his addictive patterns and the development of cognitive-behavioural techniques for shame reduction and the deliberate development of new affective responses. Once the actual behaviours had been

left largely to one side, 'recovery orientated psychotherapy' [Zweben, 1997] could be left to one side as well, and the exploratory and reparatory psychodynamic psychotherapy could begin. The final goal was to help him towards the development of a capacity for relatedness, greater self-acceptance and to develop a way of living and being that was so fulfilling that he had little need for compulsive addictive patterns of behaviour.

### **Case Study Two**

I have chosen this case study because it illustrates preoccupation, harmful consequences, and the process of recovery. It also illustrates the 'crisis' that often necessitates intervention.

#### **Liam**

Liam is a middle aged successful lawyer who has founded and runs a small law practice made up of about six people, including partners, secretaries and a receptionist. He was referred to me because one of his colleagues had, without his permission, gone into his computer and found large quantities of pornographic material. Although this client is sexually attracted to older rather than younger women and there was nothing actually illegal on his computer there were pictures in the 'barely legal' category. In the end, the practice fell apart and the overall financial costs to my client were in excess of £60,000. Liam is a happily married man with three children but his compulsive sexual patterns involved hours masturbating on the Internet before and after work.

The behaviour began with threats to his wife's health from suspected ovarian cancer. At the same time, full Internet access was set up at his legal practice.

His history suggests an emotionally absent father, early maternal attachment anxieties, a narcissistic mother who was both needy and over-bearing, and an early use of fantasy to manage negative affect. There was no indication of any kind of abuse in his family of origin. In my view sexual fantasy and the use of the Internet were adult continuations of his earlier use of non-sexual fantasy in his family of origin.

A specialist in human resources referred this client to me and the client immediately joined and fully participated in a sexual recovery programme. He has joined my sexual addiction outpatient treatment programme. He has been in one-to-one psychotherapy with me for six months. In the past six months he has relapsed three or four times. In his case, relapse means logging on the sexually explicit websites. With this particular client, in the early stages of work, the cognitive behavioural components of the work contributed to immediate change. Now it seems to me change is the effect of the male alliances in psychotherapy and in the group work that contributes to his programme of recovery.

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The treatment priority with this client was not to confront denial or to stop the behaviour. He came to me in a state of shock about the size and scale of the consequences. There was no denial and he had effectively stopped the behaviours. Here the priority was to provide supportive and exploratory psychodynamic psychotherapy and, since he was going to several meetings a week, to leave most of the cognitive behavioural work to the sexual recovery

fellowships and to my outpatient programme. At the time of writing he continues in all of these, reports feeling 'very well' and has been almost continuously free of addictive compulsive sexual behaviours.

### **Limitations of the Addiction Model as Applied to Sexual Behaviour**

In addition to making reference to the limitations of the addiction model where appropriate in the wider context of this document, I have divided the literature review that follows into two chapters: the literature on sexual addiction and the literature critical of addiction theory and sexual addiction in particular. Here I set out my own views about the limitations of this particular theoretical model.

These can be summarised as:

- Heuristic predominance
- Subjectivity of the definitional criteria
- Universality of narcissistic damage
- Ubiquity of anaesthetizing behaviours
- The negative labelling of shame
- Assumptions about human purpose
- The exaggerated status of treatment

Heuristic Predominance— I use the term 'heuristic predominance' to describe the almost overwhelming presence of heuristics in the theory of sexual addiction in both treatment and methodology. It runs throughout the literature in the next chapter and strongly operates in this document and in the products

of this doctoral project. While this brings with it undoubted strengths, it also has the capacity to create a closed system, making claims to a 'superior kind of knowledge' that automatically invalidates critical argument. External criticism can be dismissed and rebuffed on the grounds that those outside this experience cannot know and therefore cannot speak with insight or authority.

**Subjectivity of the Definitional Criteria—** Within the theory of sexual addiction, so much is subjective. Three of the major components of the definition are subjective: preoccupation, harmful consequences and function. The implications of this means that two people could have exactly the same behaviours and one could be a sex addict and the other not. In this sense it is not a disorder in its own right but a subjective evaluation of a pattern of behaviour.

**The Universal Nature of Narcissistic Damage—** There is similar subjectivity around the definition of narcissistic damage: 'maladaptive', 'inflexible', 'subjective distress'. The word 'damage' is filled with pejorative overtone. Surely all human beings are narcissistically damaged and narcissistic damage is part of the human condition and if that is so why is this a disorder? It is only a problem if it is a problem.

**The Ubiquity of Anaesthetizing Behaviours—** We all use anaesthetizing substances and behaviours to manage painful/negative affect. In this sense it is not a disorder in its own right but a value judgement about substances, amounts of substances, and patterns of behaviour.

The Negative Labelling of Shame— With addiction theory and sexual addiction theory, shame is almost always described as 'toxic' and viewed as the major driver of the problem. Although most theoreticians recognise the important social functions of shame these functions are largely by-passed in the literature.

Assumptions about Human Purpose— Addiction treatment and theory brings with it many assumptions about human purpose. These are often couched in quasi-medical language or in the language of psychology. There are many of these, but the central one is that the avoidance of behaviours that are defined as 'addiction' is a 'healthy life' priority and that balance, relational sexuality, living as a couple, intimacy and the 'perfecting' of self are the goals of life.

The Exaggerated Status of Treatment— In the pursuit of this doctoral project I have spent time thinking about treatment and programmes of treatment. I have been through the process. I have seen others go through it. I have visited treatment centres and explored and developed a treatment programme and a training programme. These programmes are all regimes for affect, cognitive and behavioural change and as such they are no different than schools, re-education programmes, reformatories, reparative therapy, square-bashing, boot camp, therapeutic communities, religious noviciates and the Alpha Course [a programme of recruitment currently fashionable in Evangelical Churches]. They all use the same ingredients, although the proportions change from regime to regime. They are distinguished from

'brainwashing' only in that most of them are voluntary or, at least, involvement is achieved only through persuasion.

## **Conclusion**

For all the limitations and inadequacies that apply to the theory of sexual addiction, and the use the language of addiction in relationship to sexual behaviour, the theory of sexual addiction, as I have described it in this chapter, has the following advantages:

- It provides practitioners with a systematic and parsimonious theoretical model for understanding, connecting and classifying a wider range of sexual behaviours than is provided by DSM IV or traditional psychoanalytic classifications.
- It provides practitioners with a systematic approach to effective treatment that can simultaneously be used with a wide range of otherwise disparate behaviours. The treatment programme summarised in this chapter, and outlined in the treatment and training programme, provides a more task-orientated approach than traditional psychodynamic and psychoanalytic treatment alternatives and a richer and deeper programme than cognitive behaviour therapy alone. DSM IV provides no programme of treatment.



- The highly subjective character of the definitions and diagnostic criteria for sexual addiction means that the locus of treatment and diagnostic authority lies not with medical establishment or with psychotherapeutic practitioners but with the individual client.

In the *Review of Previous Learning*, I wrote that 'to feel the hold of addiction, to experience the craving of withdrawal, to have lived in denial, and to know the wretchedness of the aftermath is a different order of knowledge that can be gained from a text book or a slide show'. I use the language of addiction because no other wording quite conveys the helplessness of the subject or the repetitious tyranny of the process.

## **Chapter 3**

### **The Literature on Sexual Addiction**

#### **Introduction**

Although this review is specifically limited to sexual addiction, it is important to note that a whole range of subjects narrow down to the study of sexual addiction. These include the philosophy of science and the ethics of medicine, reflections on social construction, various modalities of treatment, recent developments in neuroscience, the psychological therapies, and addiction studies. Similarly, it is important to note that a whole range of studies open up from the study of sexual addiction: narcissistic structure and the nature of the self, the effect of childhood abuse, religious behaviour, lesbian and gay studies, sexology, marital therapy, anorexic and avoidant behaviours, and, most recently, the relationship between sexual addiction and the Internet. This chapter focuses almost entirely on sexual addiction and largely on the work of Patrick Carnes.

#### **Sexual Addiction Literature**

The literature is scarce, difficult to access and from the United States. A search for 'sexual addiction' using PsychINFO produced 262 entries. All of these were browsed for relevance. 76 were downloaded in précis form and of that 20 were ordered in their entirety for further investigation. There is one journal, adopted by the National Council on Sexual Addiction and Compulsivity, devoted to the subject.

This section reviews the following material in the following order:

- The Patrick Carnes 'Corpus'
- Aviel Goodman: **Sexual Addiction**
- Charlotte Kasl: **Women, Sex and Addiction**
- Other Contributors
- Internet Sexual Addiction
- The Journal: **Sexual Addiction and Compulsivity**

The format for this section is as follows. Each contribution is briefly described, put into context, assessed for value, and related to the products of the project, but not always in that order. A disproportionate amount of attention will be given to the Carnes Corpus because his work represents the first domino.

### **The Patrick Carnes Corpus**

The concept of sexual addiction began to develop with the development of Twelve Step Sexual Recovery Fellowships. Sex and Love Addicts Anonymous was founded in 1976 and Sex Addicts Anonymous in 1977 [Parker and Guest, 2002]. Sex Addicts Anonymous was founded in the United Kingdom in 1987. The conceptual basis for sexual addiction was taken up and developed in the first place by Patrick Carnes.

He has systematised, refined and promoted the concept of sexual addiction and has made the original and most extensive contribution to its development and application. Although Freud refers to masturbation as the 'primal

addiction' and Fenichel uses the term 'sexual addiction' [Goodman, 1998], Cames' work on sexual addiction is 'original' in the sense that he is the first person to take an idea that emerges from the sexual recovery fellowships, that some people are, in effect, 'addicted' to sex, and he investigates, explores, researches, develops, applies, and makes this concept publicly accessible. His work is developmental in that it is possible to take the idea as it emerge in his first book and see it expand in the second and third. After the second book there is a major piece of research done with surveys and interviews with just under 1000 people who self identify as sex addicts. This research creates the content of his book **Don't Call It Love**. Subsequent books and articles tend to develop some constituent part of his overall theoretical approach, for example, in later publications the concept of sexual anorexia and trauma bonding. His work is influential because he is not only the first but he is the most prolific proponent of the concept. He has written the largest number of books, edited the journal **Sexual Addiction and Compulsivity** for the most number of years, enjoys a popular reputation with the media as an expert [Fortune, May 1999], and is clinical director of the Meadows, an internationally accessed addiction recovery centre. It is hard to fault Cames as a man passionately committed to his subject and motivated by a desire to understand and clinically respond to a phenomenon that causes pain and distress. His work on sexual addiction includes the following:

- **Out of the Shadows: Understanding Sexual Addiction** [1983]
- **Contrary to Love: Helping the Sexual Addict** [1989]
- **Don't Call It Love: Recovery from Sexual Addiction** [1991]

- **A Gentle Path Through the 12 Steps** [1993]
- **Sexual Anorexia: Overcoming Sexual Self Hatred** [1997]
- **Clinical Management of Sexual Addiction [ed]** [2002]

As well as theoretical information, Carnes' work contains, self-assessment questionnaires, diagnostic criteria, stories, exercises, helpful diagrams, concise and memorable summaries, flow-charts and useful illustrative typologies. He has published videos and audiotapes. He has a website, an online bookstore and an online lecture on sexual addiction. He is a teacher as well as a clinician and a theorist. Carnes is also a clinical psychologist.

### **The Golden Valley Project**

The largest body of direct research was done between 1986 and 1988 at the Institute for Behavioural Medicine, Golden Valley, Minnesota [Carnes, 1991]. This was based on two 28-page surveys, one for addicts, and one for their partners. Data was collected by interviews and questionnaires. According to Carnes [1991] each survey took between four to eight hours to complete. There was a team of 12 researchers. About one third of the survey was undertaken with members of Twelve Step sexual recovery fellowships and the rest with patients in treatment for sexual addiction at Golden Valley. In **Don't Call It Love** [1991], Carnes provides a modified version of the survey and a selected data sets and a complete summary of the data from the survey for the ordinary reader. There were 932 participants of whom 293 had been in sexual recovery programmes for more than three years [Carnes, 1991]. Additional research was done with this second group, 'those who had actually transformed their lives and could tell us about it [Carnes, 1991, p186]. This

second group and their partners were asked to complete an extensive 'life-status inventory' and a 'month by month history of their recovery'. A pattern was developed on the basis of this retrospective information. Other people were interviewed at different time intervals [six months, one year, etc]. The two strategies yielded the same pattern of data. Carnes [1991] includes a table that lists the baseline behaviours of both groups to demonstrate that there was minimal difference between those entering recovery and those in advanced recovery. Carnes writes as follows [1991, p185]

Unfortunately, professionals in sex addiction do not yet have the extensive longitudinal studies that exist for alcoholism. At this point, more than anything else our task was simply to document that some sex addicts can achieve recovery, there is a possible solution as well as a problem.

**Don't Call It Love** [Carnes 1991] is, in effect, the discussion of the data from the larger set, which yields up information about the problem, and the data from the smaller set that yields up information about the solution.

### **Don't Call It Love**

While all the results are discussed in **Don't Call It Love**, I focus and comment on four units of information. Two of these are related to the problem and two are related to the solution. This reflects the presentation sequence in the Training Manual for the Treatment of Sexual Addiction [Appendix i]. The first is, according to Carnes, 'on the basis of our research and clinical practice', the 10 Signs of Sexual Addiction [1991, p11]. These 'Ten Signs' represent a development of the description of sexual addiction from his earlier two books:

1. A pattern of out-of-control behaviour
2. Severe consequences due to sexual behaviour
3. Inability to stop despite adverse consequences
4. Persistent pursuit of self-destructive or high-risk behaviour
5. Ongoing desire or effort to limit sexual behaviour
6. Sexual obsession or fantasy as a primary coping strategy
7. Increasing amounts of sexual experience because the current level is no longer sufficient
8. Severe mood changes around sexual activity
9. Inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual experience
10. Neglect of important social, occupational, or recreational activities because of sexual behaviour

These 'ten signs' appear over and over again in the wider subsequent literature on sexual addiction and remain a foundation in describing and diagnosing sexual addiction.

It is normally the 'harmful consequences' of sexual addiction that bring people to treatment. It is the province of the clinical practitioner to respond to appropriately. As noted in the section on the specialist seminars, Butler [1999] referring to Frank [1986] points out that patients come to psychotherapy 'because they are demoralised by the menacing meaning of their symptoms'. The participants in the Golden Valley project reported the following harmful consequences, among others, due to sexual addiction:

- 40% the loss of a partner or spouse
- 70% severe marital and relationship problems
- 13% lost rights to their children
- 42% women sex addicts had unwanted pregnancies
- 58% severe financial consequences
- 27% not able to work in the career of their choice
- 59% pursued their behaviours to the point of exhaustion
- 58% pursued activities for which they could have been arrested
- 19% were arrested for their behaviours

The principal book of the Twelve Step recovery fellowship, Sex and Love Addicts Anonymous, called by members after AA tradition the 'Big Book', includes a number of personal histories that point to harmful consequences. One addict described his experience in this way [Anonymous 1986 p200],

But going to the strip joints in Boston's Combat Zone, peering in windows, compulsive masturbation, and eventually exhibitionism were not 'cheating' on my wife... I would spend spring and summer nights exhibiting myself, masturbating, drinking, peering in windows, and gradually getting sicker.

This story exemplifies the unmanageability and chaotic nature of some sexually addictive behaviour, how it takes up inordinate amounts of time, impacts on marriage relationships, interferes with the rest of life, can be unsafe and unsatisfying and sometime occupies a world of offending and near offending behaviours. Sexual addiction is often experienced as relentless and unstoppable. Another graphic illustration of the harm and damage that can result from sexual addiction is given in Jenny's story [Anonymous 1986 p 205]



My addiction was worse than ever, but I felt that I had no reason to change my behaviour.... Over a period of time I had been hospitalised for various 'accidents', but no one ever questioned me about them. Eventually I found that I needed even more physical pain in order to achieve an orgasm, and I resorted to self-flagellation, electric shock, and burning myself while I masturbated.

In reading these stories it is easy to understand why Krafft-Ebbing described these behaviours as 'a dreadful scourge'.

While Cames is interested in the problem of sexual addiction he is especially interested in the solution, 'there is a possible solution as well as a problem' [1991, 185]. From this side of the equation there are two things that I explore below. The first is the 'discovery' of the stages of recovery and the recognition of characteristic features for each of the stages. These stages are reproduced in Fig. 3 and, as shown in Fig. 4, all addicts have all stages at all times in different proportions. I draw attention to this part of the research for two reasons. First of all, the strategic tasks of recovery outlined in the Training Manual [Appendix i] are ordered to reflect the stage by stage character of the process. The second is his emphasis on an involvement in Twelve Step recovery as an almost indispensable requirement for a successful recovery.

In the Golden Valley project he asked those with three years or more in recovery for their 'best advice' to the still suffering addict. They identified the following six challenges: 'breaking isolation, surviving withdrawal, reducing shame, working through emotions, resolving crisis, and defining sobriety' [Cames, 1991, p212]. The addict's best advice number one is Developing

# Recovery Over Time

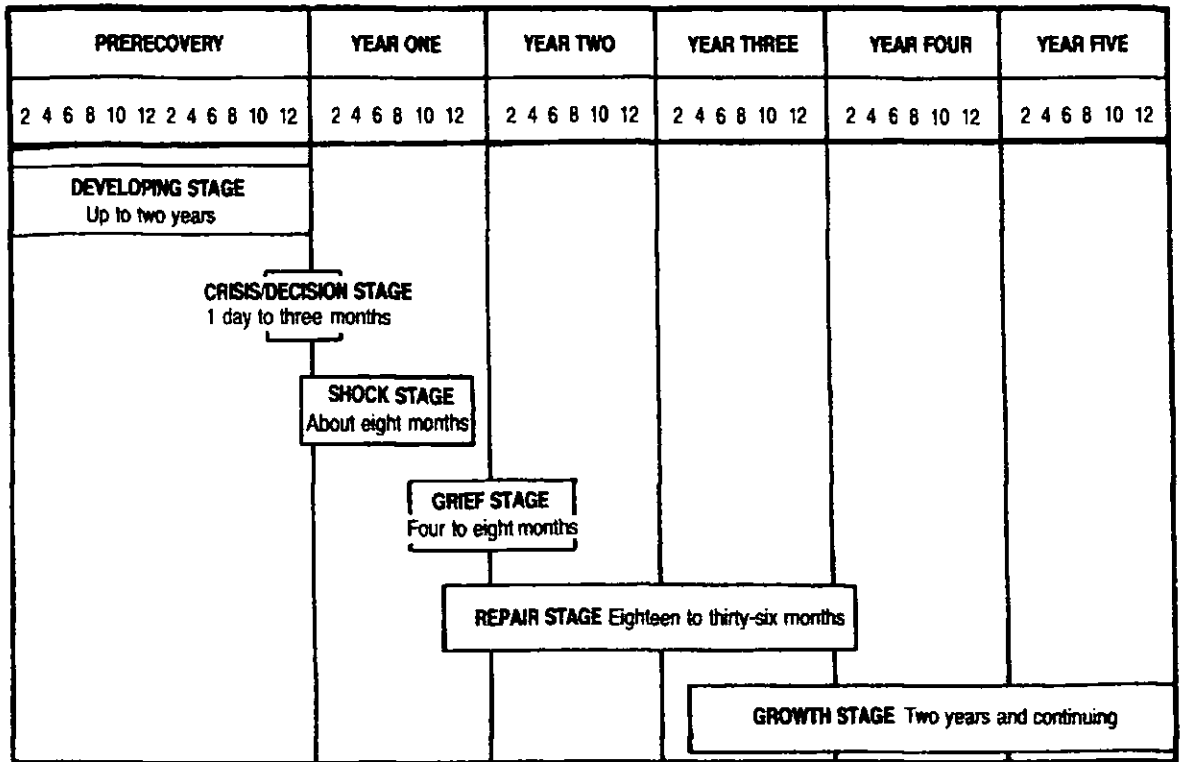


Fig. 3

# Stage Mix in Recovery

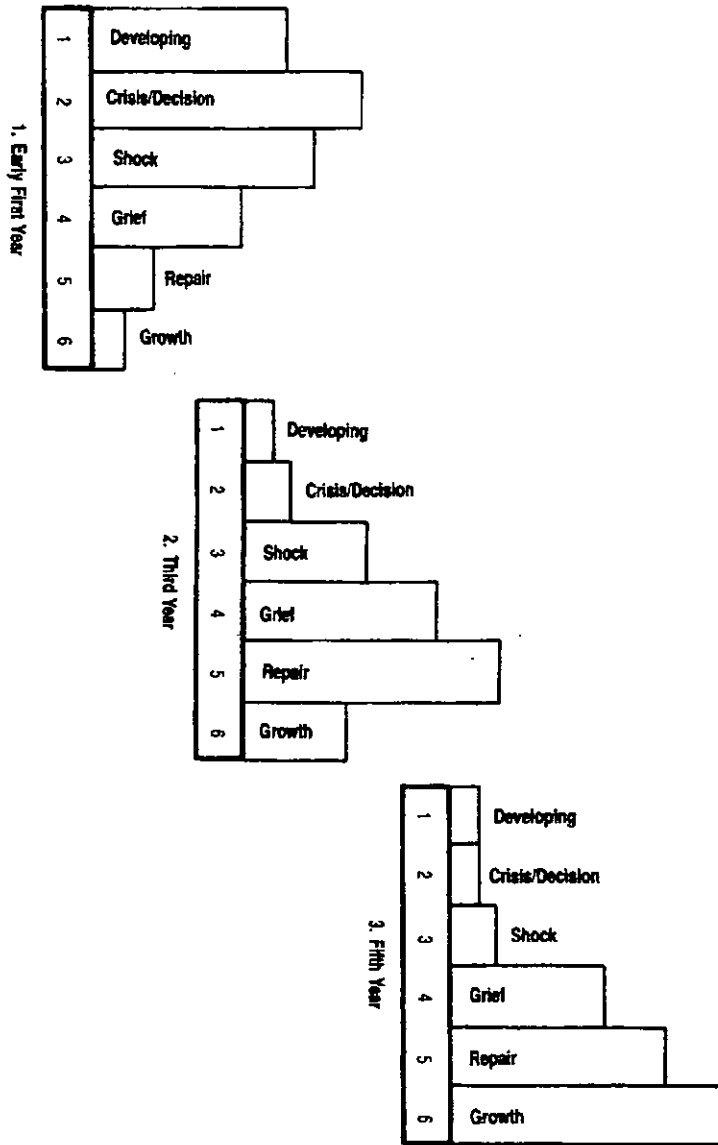


Fig. 4

Twelve Step Support and the first recommendation is 'Find people with significant recovery and learn from them'. This is the recovering addict's best advice to the addict desirous of recovery. In clinical practice encouragement towards Twelve Step recovery is the number one priority. The research suggests those who participate in the programme get well and those who do not participate in the programme do not get well [Cames, 1991]. The importance of this information cannot be over-emphasized and therefore referral to twelve step groups has an important place in the article on narcissistic damage and religious and sexual behaviour [Appendix F] and in the sexual addiction treatment and training programme [Appendix I]. This is not about the magic of Twelve Step recovery but about the power of the group process to facilitate behavioural change. At the time of writing, apart from my own treatment programme, there is little else suitable and available apart from twelve step recovery programmes in the United Kingdom.

As an outcome of the project, we can find, in great abundance, the classic products of qualitative data analysis: the generation of concepts and the building of typologies. The movement from his first two books and into his third book by way of the Golden Valley project classically illustrates analytical induction [Bryman and Burgess, 1994] as well as the 'research cycle' outlined by Barker, Pistang and Elliott [1994] as a movement containing the following sequence:

- Form ideas about the world    **Out of the Shadows/ Contrary to Love**
- Interact with the world        **Golden Valley Research Project**
- Interpret the results            **Don't Call It Love**
- Compare with original ideas    **Following books and publications**
- Refine or modify as necessary

Lincoln and Guba [1985] propose four criteria for assessing the trustworthiness of qualitative research: credibility, transferability, dependability, and confirmability. Carnes fulfils these criteria. It is confirmable because an audit trail is possible. Credibility is enhanced by prolonged involvement [Robson, 1993] and the use of more than one category of informants and more than one data gathering technique. Transferability is possible to test because the tools are available and the same populations are available to allow the same work to be done again with different people. The dependable nature of the research comes from all of the above.

It is hard to fault Carnes as a qualitative researcher. None of the critical literature seriously criticises Carnes for flaws in methodology or on the absence of transparency. The distinctive characteristic of Carnes work, represented in varying degrees in all of his books, is that his work is clinically based. His work is a work of 'reflexive knowing',

Reflexive knowing occurs when researchers deliberately turn their attention to their own process of constructing a world with the goal of saying something fresh and new about that personal [or shared professional] world. [McLeod, 2001, p4]

His is the work of a researcher-practitioner. His books are full of individual stories illustrating every aspect of sexual addiction and the processes that provide the best chances and choices for successful recovery. The heuristic urgency behind Carnes, and most of the other sources cited in this review, suggest that all the significant contributions have come from researcher-clinicians who have themselves experienced the problem and have found a solution in their proposals.

The criticisms that are applied to Carnes are the criticisms that can be laid at the door of qualitative research but that is not a criticism of Carnes but of qualitative research as category of endeavour. To date there has been no double-blind outcome research and such research is clearly needed [Sealy, 2002]. However, I think that there are a number of other criticisms that can be offered in relationship to Carnes work. These criticisms are about judgements of value rather than methodology. His research has ignited a number of political and social issues about social control, the nature of sexuality and attitudes to sexual license. Certain patterns of behaviour are turned into a pathology that needs intervention, treatment, and commitment to Twelve Step recovery. In other words the door of such behaviour needs to be acted upon. Carnes work makes many value-laden assumptions. These include the judgement that the goal of life is balance and serenity achieved by the development of the self, along specified lines that includes a commitment to sexuality in the context of a relationship that resembles life-long monogamous marriage, absence of excess, avoidance/control of prohibited substances and behaviours, the pursuit self knowledge and a the development of spirituality of

choice. In this philosophy of life, 'healthy-unhealthy' and 'appropriate-inappropriate' become synonyms for 'right-wrong' and 'good-bad'. While one may share this value system it is right to be identify and represent it as a value system.

Thomas Khun a central twentieth figure in the philosophy of science suggests the concept of the 'paradigm' to 'describe the central body of ideas within which a body of scientists are working at any given time' [Barker et al, 1994, p18]. Carnes offers a shift within the psychotherapeutic paradigm itself. He changes our perception about sexuality, moving us away from the old categories of paraphilias, hypersexuality, crimes against nature, perversion, nymphomania and satynism, and so on, to this new more unified concept of sexual addiction and compulsivity.

Carnes gives us a way of looking at things, valuable insights and useful clinical material for working with clients. Carnes is also a successful entrepreneur [[www.sexhelp.com](http://www.sexhelp.com)] but the successful promotion of his work is based on the story that lies behind it, its 'autoethnographic' quality, its strong narrative drive, its cultural appropriateness, and its popular client-orientated commitment. It resonates with the addict. Most of all, it holds out the possibility of change and locates that change in the action of the self. This makes change seem possible and seem accessible to all.

## **Aviel Goodman**

Ariel Goodman's book [1998] is a different type of contribution to the literature.

He proceeds from the premise, [Goodman, 1998, p9],

that a condition exists in which the subject engages in some form of sexual behaviour in a pattern that is characterised by two key features: recurrent failure to control the behaviour, and continuation of the behaviour despite significant harmful consequences'.

He shares with Carnes an over-lap of definitions and similar approaches to treatment. They differ in style and this reflects differences of background and target audience. Goodman is a psychiatrist and a psychodynamic psychotherapist. He writes, with elegance and restraint, for medical and scholarly practitioners. He describes his work as an 'integrated approach' to the understanding and treatment of sexual addiction. One of his distinctive contributions, and one of the most important from the point of view of the profession of psychotherapy, has been to compare the concept of sexual addiction to the concepts of hypersexuality and perversion in the psychoanalytic and psychotherapeutic literature. He does this very well.

Goodman writes in his preface that [1998, p. vii]

the psychoanalytic material on sexual addiction and on related subjects is closer to subjective experience, more rich in detail, and more directly relevant to the clinician-patient relationship than is the biological, behavioural, or social-interpersonal material. Thus, in my opinion, the psychoanalytic material can contribute more to our understanding and treatment of individuals who suffer from sexual addiction, whatever treatment modality we may choose to emphasize.

The above supports my decision to develop a training and treatment programme aimed for the community of psychotherapeutic practitioners.



Goodman's preface therefore justifies and endorses my decision to create and promote a treatment and training programme for sexual addiction. While it is clear that Goodman, like Cames, is a practitioner-researcher, unlike Cames, who develops his theoretical approach from a survey of participants, Goodman develops his approach from his clinical practice and a comprehensive meta-analysis of the relevant theoretical material. He assesses and amalgamates as appropriate.

While it is not possible to review or assess the whole of Goodman's methodology or the theoretical outcomes of his research there are two components of his research into sexual addiction that I outline here. Goodman reviews and analyses over 90 years of psychoanalytic literature. He does this with particular reference to hypersexuality and perversion. He then explores the same literature by relevant theme i.e. ego weakness, castration anxiety, the illusion of the maternal phallus, superego pathology, and the functions of perversion. He provides a summary function of perversion, drawing from Kohut and Mitchell describing perversion as 'an attempt to repair the sense of self.

Goodman then reviewed the research literature on conditions that have been grouped together as addictive disorders i.e. alcoholism, drug addiction, bulimia, pathological gambling and sexual addiction. The review revealed 'significant lifetime comorbidity, family history relationships, neurobiological similarities...and psychometric parallels' [Goodman, 1991, p142]. The review suggested that all of these conditions share significant psychobiological

characteristics. He then reviewed longitudinal and archival studies. This all suggests that addictive disorders, as listed above, have 'in common a underlying psychobiological process' and that this process precedes the onset of the disorder and is not merely a consequence of an addictive lifestyle. He extrapolates from these findings that behind all addictive behaviours there is an addictive process. He defines this as 'an enduring, inordinately strong tendency to engage in some form of pleasure-producing behaviour as a means of relieving painful affects and/or regulating one's sense of self [Goodman, 1998, p159].

Having established his view of the addictive process, Goodman goes on to explore how the addictive process becomes a sexually addictive process. Drawing on the psychoanalytic literature he locates the constitutional factors in disturbances in the mother child relationship and he enumerates these as follows [1991, p171]:

- Impaired internalisation of a variety of self-regulatory ego and super ego functions
- A disrupted transition through the separation-individuation process
- Abnormally high levels of aggression, which derives primarily from the frustration of early need

These give rise to the following sequelae:

- Impairments in affect regulation
- Reliance on some form of pleasure producing behaviour to regulate affects and self-esteem, repair narcissistic balance, manage aggression, and to compensate for missing pieces in psychic structure and the inner object world

As discussed in the previous chapter, Goodman [1991] suggests that the specific factor that promotes sexual addiction, as opposed to addiction in general, is 'maternal seductiveness'. This 'seductiveness' can be expressed openly but is more usually expressed covertly or disavowed. It is not entirely clear on what basis he becomes so specific about maternal seductiveness. He provides no empirical data to support this view.

To support his view of aetiology in chronic disordered attachment, he draws upon many psychotherapeutic authorities [Goodman, 1991, p199]

Most psychoanalytic investigators have agreed that the characteristic historical background of addictive disorders is a long persistence of disturbed interaction with the primary caregiver, not a single traumatic event or series of events. The pathogenic experiences are likely to be small, multiple and cumulative over time, rather than isolated and massive.

Goodman has an encyclopaedic knowledge of the neurobiological and psychological research on addiction, as well as the relevant psychoanalytic literature. He combines all of these to formulate his integrated theory of sexual addiction and his integrated treatment process. Goodman's insights have greatly influenced the development of the treatment and training programme

for working with sexual addiction [Appendix I]. The training manual begins and ends with an emphasis on 'quality of life' as a therapeutic goal. This is a direct response to the need to provide alternative techniques for the regulation of affects and self-esteem in working with sexually addicted clients.

In summary, Carnes and Goodman, come to a similar view. Both take the view that this pattern of sexual behaviour is rightly described and treated as an addiction. Carnes draws on the reports of the participants in the Golden Valley project as evidence and discusses this in his book **Don't Call It Love** [1991]. Goodman draws on an analysis of the theoretical and research material as evidence and discusses it in his book **Sexual Addiction** [1998]. Both draw on their experience of clinical practice. There is probably a heuristic element for both Carnes and Goodman. I have spent time with Carnes on a course he runs in Arizona on sexual addiction and I have had correspondence with Goodman in relationship to the conference on sexual addiction that I was organising for BASRT. I have found them both to be men of very considerable stature. My view is that taken together, Carnes and Goodman make a persuasive case.

### **Charlotte Kasl**

Charlotte Kasl's book **Women, Sex and Addiction** [1989] is one of the pioneer contributions to the literature on sexual addiction. The focus of her work is to explain sexual addiction and to explore the behavioural patterns of women who are in relationships with those who are addicted or sexually addicted. She develops the work done on co-addiction, that is the relationship

between the addict and the addict's significant other. She uses the term codependency and defines it as follows [1989, p31].

I describe a codependent person as someone whose core identity is undeveloped or unknown, and who maintains a false identity built from dependent attachments to external sources—a partner, a spouse, family, appearances, work, or rules.... The term codependent [or co-addict] was originally created to describe a person, usually female, who is the partner of an alcoholic, usually a man.

In effect, the codependent is addicted to the addict. This seems to be another way of describing the impact of narcissistic damage on relationships of choice. Like the term 'sexual addiction' this term 'codependency' has generated controversy. Kasl goes on the list the five characteristics of codependency:

- Powerlessness
- Harmful consequences
- Unmanageability
- Escalation
- Withdrawal

As Kasl notes, these are also the characteristics of addiction. Whatever the wording that is used to describe their relationship, the addict and the partner of the addict often have a distinctive reinforcing systemic dynamic.

Kasl's professional history is work with abuse survivors. The book is strongly based on her personal experience [1989, p x], connections with Sex Addicts Anonymous and other associated Twelve Step fellowships. It was built on a

four-hour focus group of seven women, 'lengthy questionnaires' or interviews with 90 women who were members of sexual recovery programmes and a 'series of group interviews with a wide range of people on topics from multiple addictions, to prostitution, to successful relationships, to spirituality and recovery' [Kasl, 1989, p. x].

Kasl has made the earliest and the single most substantial contribution to the subject of sexual addiction and co-addiction by a woman largely for a female audience. She was working in the same geographical area as Carnes at about the same time but she seems to be parallel and not to be derivative of him. The clinical usefulness of the book is psycho-educational. This is particularly true for female clients who are in relationships with male sex addicts.

### **Other Contributors**

Earle and Crow [1989] are also early contributors to the field of sexual addiction. They draw heavily on Carnes [Earle and Crow, 1989] and have applied his conceptual framework to their respective clinical practices. One is a family psychologist specialising in marriage, sex and the family, and the other a psychologist specialising in chemical dependency and the family. They draw on case studies from both sides of their practice to 'illustrate the destructive consequences of sex addiction to both addicts and those close to them' [1989, p5]. The distinctive thrust of this book is its emphasis upon the family and the addictive system. The book continues from an exploration of the problem to the presentation of healing strategies. Among the strategies

recommended is Twelve Step recovery, individual therapy, couples and family therapy.

Most of the other contributors have drawn on Carnes and taken on the specialised subjects that have led out of Carnes original work. Lasser [1991, 1992] has focused on sexual addiction, church membership and ministerial vocation. His book, **Faithful and True**, [1992, p13] is highly confessional,

Once there was a young pastor who became a full-time individual, marriage and family counsellor. He, his wife, and three children lived in a middle-sized city in a nice neighbourhood.... However this pastor was also a sex addict.

Much of the book is a rehearsal of Carnes, but Laaser particularly explores the problem of sexual addiction in the ministry. This is a very heuristic pursuit but he clearly draws from his experience as a counsellor and his experience as a pastor. He like other researchers draws attention to studies that suggests that sexual misconduct is more prevalent among the clergy than other caring professionals [Leadership, 1988, Fortune, 1989, Sipe, 1995, Grenze and Bell, 1995, Francis and Baldo, 1998, Birchard, 2000]. He also suggests, like Pattison [2000], that ordination can be an exercise in the management and reduction of shame.

Sealy [2002], a medical doctor has made contributions on psychopharmacology and sexual addiction. His work on the appropriateness of psychotropic medication was based on 'retrospective consideration of over 300 cases of sexual behaviour disorders in a 28-day inpatient setting using the sexual addiction model of treatment' [2002a, p199]. Through his research

he was able to identify two categories of sex addicts for whom psychotropic medication is recommended and one for which it is discouraged. He notes that the reported benefit in the case of the two may actually be for 'associated psychiatric disorder responses' [2002a, p215]. Sealy concludes his research with the recognition that double-blind trials are needed and he writes that meanwhile [Sealy, 2002a, p215],

Cognitive restructuring with individual and group behaviour therapy, including 12-step programmes, and psychotherapists with addiction training are providing patients with skills to manage this painful, destructive disorder.

Although there are very few therapists working specifically with sexual addiction in the United Kingdom, I am aware that medication, and in particular the use of SSRI antidepressant medication, is an issue of some debate even in the United Kingdom. Sealy [2002b] has also published a useful article on dual diagnosis that contains guidelines for therapists on addictions, mental illness, and HIV infection. Sealy's research and his endorsement of psychotherapists 'with addiction training', [2002a, p215] confirms the importance of a training programme for psychotherapists to work with sexual addiction and compulsivity.

Griffin-Shelley [2002] writes from his experience of the particular problems of working with young people. He describes five barriers to the treatment of young people, these include:



- Diagnosis—the absence of DSM diagnostic recognition
- Parents—not keen not to be seen as bad parents etc
- Other adults—reluctance to admit to sexual addiction in young people
- Peers—shame, ignorance, lack of information or understanding
- Lack of Training / Research—for professionals working with youth

Schneider [1988, 1989, 2000] has done long- work on sexual addiction and the marriage relationship. One of her articles [2000] examines the impact of Internet sexual addiction on the partner of the person using Internet pornography. All these are studies are invaluable to psychotherapists working with marriage and relationships. The last article in particular [2000] is important to help psychotherapists who are working with the increasing problem of Internet sexual addiction.

Schneider [2000] conducted an e-mail survey of 91 women and 3 men on the subject of the impact on them of their partner's sexually addictive use of the Internet. She wrote to 20 therapists and asked them to forward her letter and questionnaire to people that they knew were having Internet sexual addiction problems in the family. This survey asked open-ended questions about the adverse effects of Internet sexual addiction on the partner. Schneider [2000, p35] includes the survey questionnaire in her discussion. There was no definition or formal diagnosis of sexual addiction given in her survey. When asked about their partners Internet sexual behaviour 'all responses included viewing and/or downloading pornography along with masturbation' [Schneider, 2000, p36]. Some of the results from her survey:

- 68.1% of respondents reported that their couples sexual problems related to their partners Internet sexual activity
- 22.3% had left the addictive partner

Partners overwhelmingly reported feelings of emotional pain, as painful as if the partner was having a live affair. Harmful effects were reported on the children in these family units:

- 26.4% reported harmful loss of parental attention
- 14.3% of children had seen pomography and/or masturbation

In summary, Schneider's research shows that partners feel a great deal of hurt and pain. Internet sexual addiction contributes to divorce, is connected to a breakdown in relational sex, and has adverse effects on the children. Based on her research Schneider's article also includes advice to therapists working with the partners of Internet sex addicts. These include the importance of history taking. Schneider [2000, p55] states that 'the negative consequences' [i.e. of Internet sexual addiction] 'constitute a lengthy list of issues to explore in therapy'.

Her work is relevant to the growing body of direct research and theoretical formulation that is evolving with the development of sexual addiction research. This is expanding with increased acceptance of sexual addiction within the treatment community. However as Schneider points out, her research is not without its limitations. The chief is that it includes only a 'self-selected population of people who have experienced significant adverse consequences

as a result of their partners cybersex addiction' [Schneider, 2000, p56]. It tells us nothing about the impact on the family of recreational users or the prevalence of the adverse consequences among all those use the Internet sexually. In chapter five, I describe and explain my own research on sexual addiction, Internet sexual addiction, and psychotherapy treatment and training. Schneider provides further evidence of the harmful consequences of sexual addiction and explores some of the harmful consequences of Internet sexual addiction.

In this connection, of particular importance to clinicians working with sexual addiction, and to marriage and relationship psychotherapists, is work done on the issue of partner or spouse disclosure. The latest of these was done by Schneider, Corley, and Irons and is reported in Schneider and Corley [2002]. They undertook a qualitative study with addicts and their partners using an anonymous self-administered survey containing multiple-choice and open ended questions. It was used to determine, among other things, the effect of disclosure on the couple's relationship. Of 100 sex addicts who specified their compulsive behaviours, 91% had sex outside the relationship. A large majority of partners 81.3%, despite the pain of disclosure, felt that disclosure was the right thing to do. Many threatened in anger to leave on disclosure of sexual addiction but 60.3% stayed. Even those whose marriages eventually ended in divorce endorsed disclosure and the majority recommended disclosure to other couples. While this is the briefest summary of their research, the full research provides therapists and sex addicts in the quandary of disclosure with useful empirically sound information to inform the

client and guide the disclosure process. The limitation of this research is that it only provided a cross-section of the recovery process and a longitudinal study was not possible. The work of Schneider and Corley [2002] provides an example of a growing body of hard data on the issues of sexual addiction, its consequences, and the best courses of action in treatment and recovery.

Adjacent to the work on sexual addiction has been Beattie's [1987] work on codependency and Melody's [1992] work on love addiction. Beattie has a background similar to Kasl. She is a recovering addict and has worked as a counsellor in a chemical dependency in Minnesota, organising support groups for the wives of alcoholics. She draws on this experience and, while adding nothing new to the literature or to research, her book has been influential as a 'self help and 'how to' book [Beattie, 1987, p6]. Melody drawing on the concept of codependency defines love addicts in the following way [Melody, 1992 p9],

1. Love Addicts assign a disproportionate amount of time, attention, and 'value above themselves' to the person to whom they are addicted, and this focus often has an obsessive quality about it.
2. Love Addicts have unrealistic expectations for unconditional positive regard from the other person in the relationship.
3. Love Addicts neglect to care for or value themselves while they're in the relationship.

Mellody [1992] proposes that Love Addicts are in the grip of two fears—the fear of abandonment and the fear of engulfment. Having heard her speak on many occasions, it is clear that the methodology behind her book is heuristic. She also draws on her work with inpatients at the Meadows where she is a colleague of Patrick Carnes. I have included her work here, not only because of the interconnection between sex and love addiction but because it illustrates the developmental quality of ‘addiction discourse’ that is critiqued in the next chapter. Her work references Kasl but not Carnes.

### **Sexual Addiction and the Internet**

**Virtual Addiction**, [Greenfield, 1999] is a useful, all-purpose introduction to the Internet and to the phenomenon of Internet sexual addiction. It advertises itself as ‘a self help book for those of you who have found that you’ve become *too connected* to the Internet’ [italics in the original] [1999, p. xi]. It also provides an introduction to ‘what the Internet is and why it is so popular’ [1999, p xi]. To the novice computer user, Greenfield’s explanations of chat rooms, cookies, cams and spam, are, indeed, useful and informative.

Using criteria adapted for diagnosing compulsive gambling and drawing data from nearly 18,000 worldwide participants, he found that 6% met the criteria for Internet addiction/compulsivity with another 4% having lesser problems. Of this population he found that 62% reported logging on to adult sites, and 37% reported masturbating online. While it has not been possible to examine his diagnostic criteria, or any aspect of the data collection and analysis, the implications of this research are formidable.

In the wider context of Internet usage, Greenfield [1999] introduces the concept of Internet sexual addiction and explores some of the sexual and relationship ramifications of adult sites, public chat rooms, private member rooms, live video feeds, and online personals. He draws extensively on other addiction recovery literature and writes in a popular style for the wide market of computer users.

Three years ago the journal **Sexual Addiction and Compulsivity** published a special edition **Cybersex: The Dark Side of the Force**. This book [Cooper, 2000] contains articles on Internet sexual addiction and auxiliary articles on special subjects including the implications of the Internet and Internet sexual addiction for couples, families, children, teenagers, and men who have sex with men. Schneider's research [2000] into the impact of Internet sexual addiction on primary partnerships appeared in this special edition and has been noted earlier in this chapter.

Subsequent publications [Schneider and Weiss, 2001, Carnes et al, 2001, Cooper 2002] follow much the same format and formula and draw from the same stable of contributors. The exception is **Cybersex Unhooked** [Delmonico et al, 2001], a book 'for breaking free of compulsive online behaviour'. This is a workbook, clearly drawing on the Carnes corpus, to use cognitive writing exercises in a sequenced way to help effect recovery. It incorporates Carnes distinction between first and second order changes, follows Carnes six stages of recovery and introduces the Hermes Web as a psycho-educational treatment tool [Delmonico et al, 2001, p162]. Most of

these techniques could be incorporated, as appropriate, into any strategy or treatment modality.

The most comprehensive, scholarly and clinically useful of books on the Internet and sexual addiction is **Sex and the Internet** [Cooper, 2002]. It contains a preface by John Bancroft, the Director of the Kinsey Institute and Fellow of BASRT. Having had a conversation with John Bancroft in 2000 when he denied the 'existence' of sexual addiction, this suggests to me that the concept of sexual addiction and Internet sexual addiction is moving into the mainstream and taking up a position of acceptance outside its own theoretical family of origin. This book describes itself as a guidebook for clinicians and it brings together in one place a wide range of articles by a wide range of researchers and clinicians. It includes a descriptive section on the nature of the problem, an extensive section on special populations, and a section on therapeutic considerations.

The research and theoretical reflection that is available in this book is of particular relevance to treatment and training, but was published too late to have been incorporated in the treatment and training programme [Appendix I]. I explore here one article [Delmonico et al, 2002] for its contribution to the treatment of Internet sexual addiction. The article notes [2002, p148] that

Not all cybersex users report problems with Internet sexual behaviour. Research by Cooper, Delmonico, and Burg [2000] found that 83% of all users of cybersex did not report any difficulties in their life as a result of their Internet sex. However, they also found that 17% of their sample were either at-risk users or actively engaged in cybersex-compulsive behaviours.

Definitions are given and types of cybersex users described. A variety of screening instruments are suggested and a sample treatment plan [Fig. 5] provided. The steps suggested in the treatment plan are equivalent to the therapeutic tasks outlined in Appendix I. The authors note that 'clinicians have little to guide them in the assessment and treatment process' for Internet Sexual Addiction [Delmonico et al, 2002, p163] and they suggest the following notes for clinical guidance:

- Recognising the importance of timing in the application of any treatment of technique
- Considering a referral for psychiatric evaluation for possible medication
- Encourage healthy online usage
- Not to involve the partner as enforcer
- The importance of the therapist being well informed on the issues

The research that I conducted on sexual addiction and on Internet sexual addiction is discussed in chapter six, but this article supports the importance of that research and the importance of education and training. Delmonico, Griffin and Carnes [2002, p165] are clear that clinicians 'should resist the urge to allow the partners to function as 'monitor'. They argue that this arrangement undermines accountability and makes the partner responsible for the addict's success or failure.

### **The Journal**

Many of the same, as well as other clinician-researchers, have contributed to the journal **Sexual Addiction and Compulsivity**. Material from the journal



# Treatment Plan for Internet Sexual Addiction

## First-Order Phase

### Goals:

Stop inappropriate behavior

### Action Steps

1. Move computer to high traffic area in house
2. Face computer monitor at home and at work so people can see the screen if walking by the computer
3. Have client tape a picture of significant people on the computer both at home and at work
4. Have client put a picture of self and family as computer's background both at home and at work
5. Have client switch to a family-oriented service provider at home
6. Have client disclose the problem to at least one person

Note: If above steps do not assist client with stopping the cybersex behavior, then consider the more drastic step of eliminating Internet access.

## Second-Order Phase

### Goals

1. Look honestly at denial and minimizations
2. Accept responsibility for cybersex behavior
4. Assess psychological health and needs
6. Develop a support system
7. Understand the dynamics and decision process of the sexually intrusive behavior

### Action Steps

- a. Completes a description of the offense
- b. Reads/discuss victim statement
- c. Completes therapeutic polygraph
- a. Completes statement of responsibility
- a. Completes psychological testing: MMPI 2, Millon, MSI, BDI, BAI Sexual Card Sort, Gender Attitudes
- b. Completes substance abuse screening
- c. Completes assessment for medication
- a. Finds a sponsor
- b. Attends and participates in group therapy
- c. Attends and participates in support group
- d. Discloses to appropriate people in their life
- a. Completes addiction cycle exercise
- b. Completes behavior chain exercise
- c. Understands dynamics underlying offense

(Continued)

Fig. 5 Delmonico, Griffin, and Carnes [2002]

## Treatment Plan for Internet Sexual Addiction Continued

- |  |   |
|--|---|
| 8. Understand the distorted thinking involved in the sexually intrusive behavior | a. Adds distorted thoughts to behavior chain<br>c. Completes distorted thinking exercise<br>d. Adds new thoughts to behavior chain  |
| 9. Develop a healthy lifestyle maintenance plan                                  | a. Completes a healthy lifestyle cycle<br>b. Completes living your life differently<br>c. Completes relapse prevention plan<br>d. Develops an plan for stress/anxiety<br>e. Monitor stress and overcommitment<br>f. Understands first-order vs. second-order recovery |
| 10. Understand the nature of your sexuality and develop a sexual health plan     | a. Arousal template exercise<br>b. Implements techniques to manage inappropriate arousal<br>c. Develops a sexual health plan  |
| 11. Understand family of origin/ childhood trauma issues                         | a. Completes genogram<br>b. Completes family dynamics exercise<br>c. Completes childhood survival strategies  |
| 12. Demonstrate victim empathy   | a. Writes narrative from victim point of view<br>b. Adds victim empathy statements to behavior chain<br>c. Writes letter to victim/s  |
| 13. Develop healthy communication skills   | a. Becomes familiar with healthy communication<br>b. Completes communication exercise identifies style of communication/ impact on others<br>c. Attends couple therapy when partnered   |
| 14. Develop healthy personal relationships                                       | a. Attends couples therapy when partnered<br>b. Becomes familiar with healthy courtship   |
| 15. Develop a spiritual life   | a. Joins a spiritual community<br>b. Develops a spiritual passion   |

Fig. 5 Delmonico, Griffin, and Carnes [2002]

has been sifted and selected and re-published in the most recent book on the clinical management of sexual addiction [Carnes and Adams, 2002]. All of the material has emerged from the experience of clinician-researchers. In some cases, these clinical practitioners are themselves addicts in recovery. From the point of view of my project, with its emphasis on heuristics, the reflective practitioner, and the clinician-researcher, this is interesting and congenial. These practitioners exemplify the aims and goals promoted in this doctoral programme— the process and inter-relationship between clinician and researcher.

The journal was first published in 1993 and was edited by Carnes until 1997, then by Carnes and Delmonico until 2001. Since 2002, Delmonico has been the editor. The journal is not held by the British Library and can only be accessed in the United Kingdom from the Radcliffe Science Library in Oxford. They have one volume and two numbers. The journal was clearly set up to provide a forum and access point for the development of scholarly and clinical reflection on sexual addiction. The material taken into Carnes and Adams [2002] includes, for example: sexual addiction and sexual offending, treating sexual trauma, working with sexual addiction and Christian ministry.

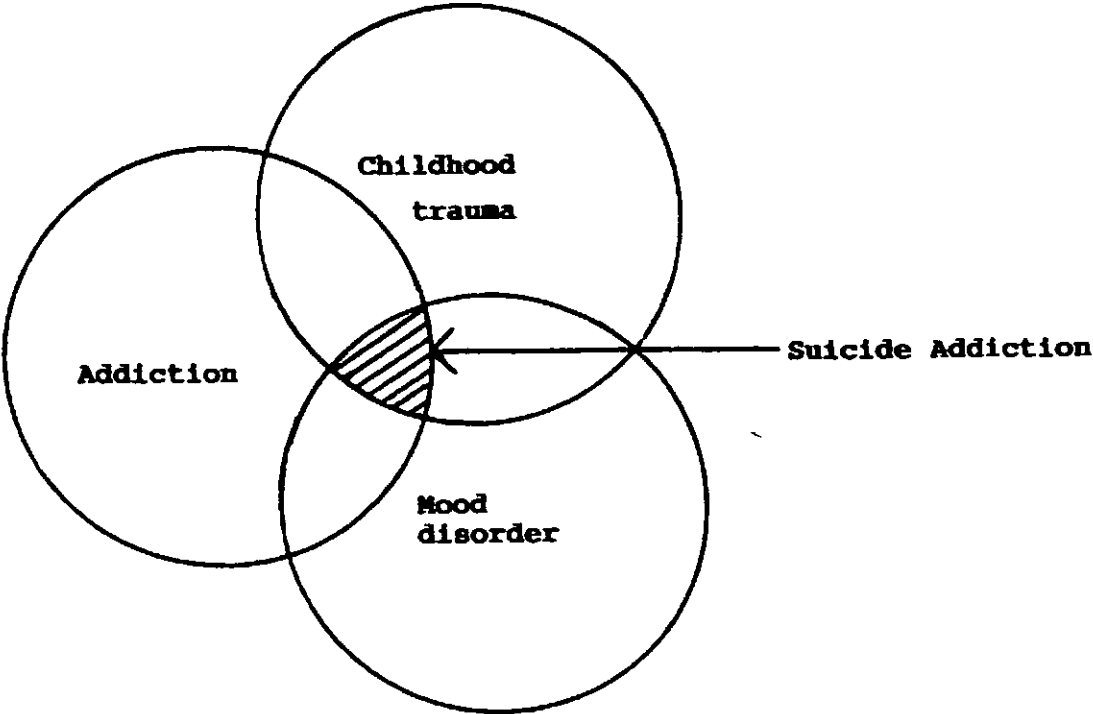
There are other useful articles. The journal published an article [Adams, 1999] on sexual harassment that explored sexual harassment as trauma re-enactment. There has been a special edition on sexual addiction and work [Delmonico, 2002] that contains material on sexual harassment and includes the problem of online sexual behaviour in the work place. My MSc dissertation

[Birchard, 1998] on clergy sexual misconduct was, prior to, but influenced by, the thinking about sexual addiction in the workplace and in other professional environments. My work with the Churches Together in Britain and Ireland Working Party on Sexual Abuse in the Church suggests that work place sexual harassment is often an outworking of sexual addiction [Appendix H]

The journal has also provided a place for the publication of innovative theoretical and direct research. It usually has a section called 'In My Opinion' in which controversial ideas are explored. One of these, relevant to sexual addiction treatment and psychotherapy in general, explores the nature of suicidal ideation under the title 'A Theory of Suicide Addiction' [Tullis, 1998]. Given the compulsive nature of the behaviour and the profoundly disturbing and debilitating consequences of sexual addiction, suicidal ideation is not uncommonly presented in work with these patients. Tullis' research suggests that there is a subgroup of suicidal people for whom suicidal ideation is a mood altering experience and as such functions as an addiction. He bases his view on research with 50 selected patients who 'overwhelming' display seven characteristics of addiction as they apply directly to suicide.

The research was undertaken with 50 patients who were given a 27-item questionnaire followed by interviews. All 50 reported life-long struggles with suicidal preoccupation. They described a set of characteristics that are equivalent to the characteristics of addiction:

**Matrix Illustrating Suicide Addiction**



**Fig. 6 Tullis [1998]**

- Early on-set
- Mood alteration
- Secrecy
- Fantasies
- Tolerance
- Preoccupation
- Rituals
- Multiple attempts
- Trance like state
- Withdrawal

Tullis provides a 'possible matrix of predisposition to suicide addiction' [1998, p316, Fig. 6] and concludes that 'for some people suicide is an addiction, not the product of a mood disorder, other addictions, psychosis, or obsessive-compulsive disorder' [1998, p321]. He does not provide information about the questionnaire or the structure of the interviews. Whatever the usefulness of his work, the seemingly endless extension of the language of addiction can have the effect of de-valuing the nomenclature [Satel, 1993].

In summary, there are a number of observations to be made about the nature and content of the sexual addiction literature. For the most part, this literature has developed from the self of the clinician. It is practitioner research. It is largely popularist, user friendly and heavily orientated towards the well-being of the client. It draws from many sources and is congruent with its cultural setting. It has grown out of drug and alcohol recovery. A number of people in drug and alcohol recovery in Minneapolis in the 1970's began to understand

that their patterns of sexual behaviour seem to mimic their substance addiction patterns. From this understanding Sex Addicts Anonymous was founded and from that a group of clinicians and body of reflective heuristic theoretical material began to emerge. As this developed, and increasing numbers of people found the fellowships, literature, and treatment programmes helpful, increasing programmes of direct research began to contribute to the development and refinement of thinking. The first direct research 'break through' was the Golden Valley project and the work of Patrick Carnes has been the prime mover in the conceptual and clinical development of the understanding and treatment of sexual addiction. The theory and treatment of sexual addiction has been relatively unknown to psychotherapy and counselling in the United Kingdom but developed, systematic, institutionalised and more widespread in North America.

The reliability and methodological soundness of the developing research varies from project to project. This is a young discipline. The narrative is its central driving force. The narrative has two principal manifestations. The constructed story is central to promote the therapeutic task and the principal therapeutic task is the construction of the personal story. This is another version of the construction of the 'plausible story' [Butler, 1998] in the service of the reconstruction and liberation of the self. This technique announces the possibility of change, offers the tools and technology of change, and since, it locates the problem and the solution in the self, change is made accessible and possible for all.

There are a number of 'roadblocks' to the development of the research [Sealy, 2002] these include the fact that the legitimacy of the disorder is largely unappreciated or disputed, there are few sources for large samples, there is little funding available, and educational institutions are largely uninterested. In the United Kingdom there are very few centres for the study of human sexuality, sexual problems are usually outside the scope of private health insurance, and trained NHS provision is either limited or unavailable. Human sexuality is seen as a matter of comedy or shame. All of these factors work against the pursuit of the research that is needed to extend knowledge and strengthen credibility.

### **Comments on the Theoretical Contents of Literature**

In this section I make a number of observations on the conceptual content of the literature on sexual addiction from the following: from experience as a clinical practitioner in the field in sexual addiction, from experience as someone who is multiply addicted and from experience of addiction recovery.

I draw on this reserve to make comments on the following concepts:

- Escalation
- Harmful Consequences
- Stages of Recovery
- Twelve Step Groups
- Maternal Seductiveness
- Sexual Addiction and Committed Relationships /Codependence
- Work Place Misconduct

As already pointed out, almost all, if not everyone pioneering in the field of sexual addiction have brought to writing and research a personal experience of addiction and recovery. These comments and observations are likewise written from a personal experience of addiction and recovery.



**Escalation**—Carnes [1991, p11] asserts that from his ‘research and clinical practice’ increasing amounts of the sexual behaviour are required because the current level is experienced as no longer sufficient. I have seen escalations of these behaviours in clinical practice and in twelve step recovery groups and I can confirm that escalation is a characteristic of sexual addiction. However I have also seen behaviours that do not escalate but remain at on-going and chronic levels of presentation, rather like a low-grade infection that never seems to flare up into some acute. As I have noted in the last chapter, I take the view that escalation is not an invariable sign of sexual addiction and compulsivity.

**Harmful consequences**— The participants in the Golden Valley project reported the following harmful consequences, among others, due to sexual addiction:

- 40% the loss of a partner or spouse
- 70% severe marital and relationship problems
- 13% lost rights to their children
- 42% women sex addicts had unwanted pregnancies
- 58% severe financial consequences
- 27% not able to work in the career of their choice
- 59% pursued their behaviours to the point of exhaustion
- 58% pursued activities for which they could have been arrested
- 19% were arrested for their behaviours

Although my practice is too small to be able to comment on the proportion of clients who have experienced similar consequences, it is not too small to comment on type and character. A number of my clients inhabit a dangerous and shadowy world of near offending. Many have suffered severe financial consequences, and for many, sexual addiction has made marriages miserable that were already struggling. My clients suffer from a multiple of harmful consequences. Through my clinical practice, through involvement with Twelve Step recovery, and through observing recovering addicts in residential treatment, I can confirm the reality, strength, and character of the harmful consequences.

**Stages of Recovery**— Earlier in this chapter I outline and include diagrams to explain Cames' 'six stages of recovery'. These stages are reproduced in Fig. 3 and, as shown in Fig. 4, all addicts have all stages at all times in different proportions. I draw attention to this part of the research because I have marvelled in my clinical practice at the extraordinary accuracy of his recovery timetable. I have been able to plot almost to the month where someone is in the recovery process and match that person almost exactly to the time scale.

**Twelve Step Recovery**—There is in the sexual addiction recovery literature a view that participation in twelve step recovery groups is virtually an indispensable requirement for successful sexual addiction recovery. In the Golden Valley project Cames asked those with three years or more in recovery for their 'best advice' to the still suffering addict. The addict's best

advice number one is 'Developing Twelve Step Support' and the first recommendation is 'Find people with significant recovery and learn from them'. In my clinical experience those who participate in such programmes get well and those who do not participate in programmes do not get well. This is not about the magic of Twelve Step recovery but about the power of the group process to facilitate behavioural change.

**Maternal Seductiveness—** I am persuaded from my own personal experience of narcissistic damage, the addictive process, maternal seductiveness and addictive behaviour that Goodman is right in every respect. In working with male sex addicts in clinical practice there are normally suggestions of covert sexualization and 'maternal seductiveness' in the family of origin. In my own case, as I have referred to it in the previous chapter, the 'seductiveness' was hardly subtle. In the case of the very few female sex addicts that I have seen in clinical practice, there has always been covert or overt sexualization and paternal seductiveness. These issues need more analysis and more investigation. I hope that the data that emerges from the sexual addiction treatment programme will be able to throw more light onto the issue of parental seductiveness.

**Codependence—** Like the term 'sexual addiction', this term has generated controversy. Although I tend not to use the word, I have certainly seen this codependent dynamic at work in addictive systems and have found Kasl's delineation outlined earlier in this chapter conceptually useful and regularly validated in clinical practice, especially that part of my practice that is

committed to working with marriage and relationships. In much the same way as I refer sex addicts to sexual recovery fellowships, I sometimes refer the partners of sex addicts to CODA, Codependents Anonymous, as a useful adjunct to one-to-one psychotherapy and/or marriage and relationship work. In my clinical experience the codependent dynamic is not anchored with the female partner but shifts from person to person in the relationship and applies as much to same sex partnerships as to heterosexual relationships.

**Work Place Misconduct—** The journal, **Sexual Addiction and Compulsivity**, published an article [Adams, 1999] on sexual harassment that explored sexual harassment as trauma re-enactment. There has also been a special edition on sexual addiction and the work place [Delmonico, 2002] that contains material on sexual harassment and includes the problem of online sexual behaviour during working hours. My MSc dissertation on clergy sexual misconduct was, prior to but influenced by, the thinking about sexual addiction in the workplace and in other professional environments. My clinical practice supports the view that, in many cases, work place sexual harassment is an outworking of sexual addiction.

Having begun a treatment programme for sexual addiction and compulsivity in the autumn of 2003, and extended that programme in the early part of 2004, I am confident that with the expansion of clinical practice and with an increase of clinical experience that new observations will emerge. Some of these will challenge and some of these will confirm the available conceptual material.

## **Chapter 4**

### **Literature Critical of the Concept of Sexual Addiction**

This chapter is devoted to articles and books that make judgements and observations about the concept of sexual addiction and compulsivity. There are not very many of these: a hand full of articles and one book. This chapter explores and evaluates that literature.

All the literature accepts the reality of the phenomena that lies behind the label 'sexual addiction and compulsivity'. Most express sympathy for the plight of individuals. Some of the debate is over designation [Moser, 1993]. To date, the critiques contain no reference to Internet sexual addiction or the implications of the World Wide Web for patterns of sexual behaviour. The content of some of the articles seems to be driven by professional bias and this has been taken into account in the selection and evaluation of the material.

Carnes [1989] and Goodman [1998] acknowledge and respond to the criticisms made to the concept of sexual addiction. Carnes [1989] explores 'other models' and includes in this, 'failure of morals', 'biological models', 'personality and behavioural' models, and societal explanations. He particularly explores the problems of professional bias and professional prejudice. Goodman [1998] classifies the arguments against the concept and nomenclature of sexual addiction into four categories: moral, conventional, scientific, and sociological.

Based on Goodman [1998], the criticisms and arguments can be divided into the following four categories. Those who claim that the concept of sexual addiction is:

- Reductive of moral responsibility
- In contravention of convention
- Contrary to science
- A social construction

Of these critiques, the last is the most telling and the most persuasive.

### **Reductive of moral responsibility**

These are the arguments that the concept and appellation of sexual addiction allows people to reduce or avoid moral responsibility. This argument is used at both ends of the spectrum. Conservatives fear that the concept will be used to avoid personal responsibility and liberals fear that the concept will be used to deprive people of their freedom of choice [Coleman, 1986, Levine and Troiden, 1988]. This argument usually comes up in sexual addiction workshops and seminars. It seems to me that a treatment programme that is effective in freeing people from addictive compulsive sexual behaviours contributes to, rather than reduces, moral responsibility. The particular tasks and strategies proposed in the treatment and training programme for sexual addiction [Appendix I], include challenges to denial and minimisation, attention to harmful consequences, commitments and support for changes of behaviour, can all contribute to increased well being and self esteem, better functioning, greater safety, improved parenting and family relationships.

Twelve Step recovery programmes emphasize moral responsibility. Most recovery programmes use this slogan: 'You may not be responsible for your disease but you are responsible for your recovery'.

### **In Contravention of Convention**

Moser [1993] criticises Goodman on the grounds that he has not made a persuasive case for sexual addiction to be added as a separate diagnostic category in DSM. This criticism is not in response to the book **Sexual Addiction** [Goodman, 1998], but to a preliminary article written before the later book [Goodman, 1992]. Moser [1993, p221] writes that he normally finds that the real problem is not sexual addiction but depression, paraphilias, and conflict with societal expectations. No doubt this debate will continue for sometime.

Barth and Kinder [1987] reject the appellation because it is not in DSM IV and Levine and Troiden [1988] reject the concept of sexual addiction on the grounds that in their view, by definition, addiction is about a substance. The history of the DSM is full of movement and change that reflects changes in perception and understanding, politics and society. DSM-III listed homosexuality as a sexual deviation and dropped it entirely from DSM-III-R [Kutchins and Kirk, 1997]. While the history and authority of DSM is much more complex, the reality is that for usefulness, 'DSM is a book of tentatively assembled agreements' [Kutchins and Kirk, 1997, p xiii]. Given the history of DSM sexual addiction could just as much be in as out.

Coleman [1986] suggest that the term sexual addiction should be rejected because it dilutes the usefulness and meaning of the word addiction. As I have already indicated in the last chapter, in the section on suicide addiction, I have some sympathy with this argument. In a sense if everything is an addiction then the word is so devalued that it becomes meaningless. This process is not restricted to addiction. The fact that a word or a concept can be devalued does not seem to me to be an argument not to use it but rather not to devalue it. Satel [1993] suggests that the term should not be used because many believe the term necessarily implies a Twelve Step programme. The evidence suggests that people recover from sexual addiction more surely when they are involved in group work and a culture of recovery. This may or may not be a Twelve Step programme. Even if it were, the appropriateness of a choice cannot properly entirely be made on the idea that someone might misunderstand it.

### **Contrary to Science**

Coleman [1986] also argues that many clinicians are not properly trained. Goodman [1998] points out, that is not an argument against the concept of sexual addiction but rather an argument for improvements in the quality and availability of training, such as the treatment and training programme developed as a product of this project [Appendix I]. Coleman also argues against the concept for lack of research, but this was prior to the publication of the work by Carnes [1991] and Goodman [1998]. Carnes work [1998] was based on extensive research with nearly a thousand subjects. More research



has been published with the foundation of the journal and with the development of the Internet [Cooper, 2002].

### **A Social Construction**

A number of publications have been examined that provide a social constructionists critique of the concept of sexual addiction. Levine and Troiden [1988, p355] use a social constructionist critique of the concept of sexual addiction and compulsion and call them 'stigmatising labels attached to sexual patterns that diverge from the norm'. They argue that sexual addiction can only be understood in the context of changing 'erotic codes in American culture', and that they are 'pseudoscientific codifications of prevailing values', defined as pathological only because they 'violate prevailing erotic norms'. They also write [1988, p355] that the concepts of sexual addiction and compulsivity provide examples of the 'medicalization' of sexual conduct. Both of these observations seem to me to be true.

Irvine also takes the view [1993] that the concept of sexual addiction has emerged from changing sexual norms. He suggests that the diagnosis is about the social regulation of sexuality, the 'diseasing' of what were formerly seen as perversions. He sees the development of addiction diagnosis as the usurpation of moral and religious authority by medicine and psychology.

Saulnier [1996, p159] argues that the concept of sexual addiction is 'faulty and that succumbing to such a questionable diagnostic category is a serious mistake'. Her approach is strongly feminist. For example Saulnier [1996,

p166] suggests that all forms of sexual violence [harassment, coercion, rape, incest] should be approached not as, sometimes, addictive behaviours but as a political problems 'requiring the dismantling of sexist structures'. She proposes that shame be tackled by helping people become aware of unwarranted social messages about sexuality [1996, p166] and she regards, especially, the concept of codependency and co-addiction as contributing to a pathology of women. I accept her critique but argue that her proposals provide no clinical response to individuals in need and should be read along side as a counter-balance rather than instead of the work on co-addiction and codependency

The only book that critiques sexual addiction, in a wider critique of what the author calls 'discourses of addiction', argues that [Keane, 2002, p6],

...addiction is not a universal feature of human existence, but an historically and culturally specific way of understanding, classifying and regulating particular problems of individual conduct.

She assigns the development of addiction discourses to particular movements and changes in North American culture and she shares many of the perceptions of the previous writers.

Keane notes that addiction discourse is not only North American but that it is a combination of Christian revivalism, temperance doctrine, Jellinek's disease model of alcoholism, New Age spirituality, growth psychology, feminism, and recent theories about genetics and neurobiology. It treats overwhelming erotic desire as a virulent disease. The boundaries that are marked out between

healthy and unhealthy sex, she notes, conform to the precepts of sexual morality traditionally associated with marriage and monogamy. Homosexuality, for example, is honoured to the extent that it operates on the same lines as heterosexual marriage. She too suggests that the expansion of addiction discourse 'strengthens' the power of the medical and psychological expertise and pathologises and objectifies the addict as one in need of intervention.

Her distinct focus, and I think her most telling critique, is on the nature of the self. Keane uses the term 'a technology of the self' to describe the recovery movement and programmes of addiction treatment. Keane [2002] writes that 'through these technologies of the self, an inner self is produced that can be continually judged and worked on in the name of freedom and health'. These technologies of the self include sexual addiction treatment and programmes of recovery. Keane [2002, p65] further writes

It is easy to label this popular discourse banal and incoherent, but this fails to recognise its productive power and its engagement with compelling questions of self-management and self-production. Popular addiction texts produce the inner self as an object of inspection and rectification.

Keane further notes that addiction recovery is narrative based and driven by a narrative logic that makes sense: childhood pain creates low self-esteem and other symptoms that give rise to an adult pathology. Happiness, according to addiction discourse, [Keane, 2002, p172] 'is an awareness of the difference between self and other and an absence of lack within the self.

### **A critique of the social constructionists narratives of criticism**

These are powerful arguments and cogent representations. They also apply to medicine, psychological medicine and to the psychological therapies in general. However, it is the social construction character of the 'technologies' that make them accessible and effective. The greatest problems with all the critiques is that they fail to take into account that clinicians are faced with the realities of people whose lives are in disarray, whose families and relationships are in distress and whose inner world is filled with misery leading to despair. Social constructionist theory, as insightful as it is, offers no treatment response, no 'technology', for a clinical response to the 'dreadful scourge' [Krafft-Ebing, 1886, p70].

## **Chapter 5**

### **Quantitative Research**

#### **Exploring the Need for Sexual Addiction Treatment and Training**

##### **Introduction**

The development of a treatment and training programme [Appendix I] for sexual addiction has been one of the products of this doctoral project. This product was preceded by a quantitative research project to test the hypothesis that a sexual addiction treatment and training programme, not only breaks new ground in the United Kingdom, but fills a gap in current training programmes and would be welcomed by therapeutic practitioners. The research project focused on two issues: the frequency that people with addictive compulsive behaviours presented with these issues in the practices of psychosexual psychotherapists and the level of training that these therapists had in the treatment of addictive compulsive patterns of behaviour.

##### **The Participants**

The participants in the research project were psychosexual psychotherapists accredited by BASRT. These participants were chosen for the following five reasons:

- The group makes up a distinctive professional unit within the systemic section of UKCP.

- Participants could all be presumed to have an interest in psychosexual therapy, all would have been trained in psychosexual psychotherapy and all could be expected to be actively working in the field of psychosexual therapy.
- Names and addresses of members were accessible and members of the association are used to participating in research projects.
- These participants could reasonably be expected to know something about sexual addiction and be able to answer questions on sexual addiction and compulsivity as well as on the provisions of treatment and training.
- This group could also be expected to be among the first to access a sexual addiction treatment and training programme if such a programme were needed and made available.

The questionnaires revealed that the participant group had the following demographic characteristics:

**Age**

20 – 29	1
30 – 39	2
40 – 49	7
50 – 59	9
60 – 69	9

Although the average age of the participants was 52, the majority of practitioners were over 40.

## **Gender**

Men	8
Women	21

71% of the participants were women and 29% were men.

## **Geographical Distribution**

London	9
Home Counties	5
SE	1
SW	4
NW	2
NE	3
Midlands	3
Blank	1
Unable to tell	1

A preponderance of participants came from London and the Home Counties.

## **Years of Psychosexual Practice**

In training	1
1 – 5	6
6 – 10	8
11 – 15	9
16 – 20	1
More than 20	4

75% of the participants had been in practice more than five years and most of those over 10 years.

## **Hours of Practice per Week**

1 – 5	12
6 – 10	9
11 – 15	3
More than 15	2
Not given	3

79% of the participants worked as psychosexual psychotherapists less than 10 hours per week. Only about 7% reported that they dealt with sexual addiction 'often' in clinical practice but about twice that number dealt with Internet sexual addiction. Just over half had been trained by the marriage and relationship charity, Relate.

### **The Procedures**

A confidential questionnaire [Appendix C], with a covering letter, self-addressed stamped envelope was sent to 100 psychosexual psychotherapists chosen at random. A follow up information request form was included so that interested participants could be sent outcome information. My contact details were given to allow participants to seek further information if required but there were no reminder letters. The questionnaires were sent out at the end of July 2002. The return deadline was scheduled for the first week in September. Outcome information has already been sent.

### **Measures**

The sole measure was the confidential questionnaire. This questionnaire went through several drafts. The penultimate version was piloted by five senior practitioners and approved by them for clarity, usefulness, and comprehensibility. The final version incorporated their recommendations.

The purpose of the questionnaire was primarily to determine the following:

- Is sexual addiction presented in clinical practice and, if so, how?
- Is Internet sexual addiction presented in clinical practice?



- Is Internet sexual addiction thought likely to be an increasing problem?
- Have therapist been trained to work with sexual addiction?
- Do they feel that such training would be useful?
- Would they access such training if it were offered?

To conform to standard ethical guidelines the five senior practitioners were also asked to confirm that, in their view, participation in the survey would be harm free to all participants. This was confirmed. The questionnaire was submitted and approved for distribution by the Chair and Trustees of BASRT. The final questionnaire is available for inspection [Appendix C].

## Results

There were 29 replies to the questionnaire. The questions took the following form and yielded the following information:

The first question was about sexual addiction in general.

How often in clinical practice do you see 'sexual addiction'?

7% Rarely	51% seldom	24%occasionally
7%often	0%very often	0% blank

The next set of questions was based on Cames [1991] eleven types of sexual addiction. They were set to determine the extent that these behaviours are currently presented in British psychosexual psychotherapy practices.

How often in clinical practice does sexual addiction take the following form?

Fantasy Sex: i.e. inordinate amounts of time spent lost in sexual fantasy

7% Rarely	37% seldom	27% occasionally
14% often	3% very often	10% blank

Seductive Role Sex: i.e. many relationships at the same time, or one after another

10% Rarely	37% seldom	24% occasionally
21% often	0% very often	0% blank

Anonymous Sex: i.e. engaging in sex with anonymous partners

34% Rarely	14% seldom	24% occasionally
14% often	3% very often	10% blank

Paying for Sex: i.e. escorts, telephone sex, massage parlours etc.

7% Rarely	27% seldom	44% occasionally
14% often	0% very often	7% blank

Trading Sex: i.e. posing for sexually explicit photos or videos, receiving money for sex, etc.

51% rarely	34% seldom	7% occasionally
0% often	0% very often	7% blank

Voyeuristic Sex: i.e. using pornography, strip shows, peeping, etc.

10% Rarely	20% seldom	34% occasionally
24% often	3% very often	7% blank

Exhibitionist Sex: i.e. exposing, flashing, etc.

41% Rarely	37% seldom	7% occasionally
7% often	0% very often	7% blank

Intrusive Sex: i.e. indecent liberties, professional misconduct, inappropriate touch

14% Rarely	27% seldom	10% occasionally
7% often	7% very often	7% blank

Pain Exchange Sex: i.e. giving or receiving pain or causing physical harm

24% Rarely	44% seldom	24% occasionally
0% often	0% very often	7% blank

Object Sex: i.e. masturbating with objects, bestiality, cross-dressing to add to sexual intensity

10% Rarely	31% seldom	37% occasionally
10% often	0% very often	7% blank

Sex with Children: engaging in sex or using child pornography

64% Rarely	14% seldom	10% occasionally
0% often	0% very often	10% blank

The next two questions were designed to determine the extent that Internet sexual addiction is presented in psychosexual clinical practice and to test the hypothesis that practitioners anticipate that this is likely to be an on-going and increasing problem.

How often in clinical practice do you see people for whom the Internet has become sexually problematic?

10% Rarely	20% seldom	37% occasionally
14% often	10% very often	7% blank

Do you think that this is likely to be an increasing problem?

Yes	25	85%
No	1	3%
Uncertain	1	3%
Blank	2	7%

The last section of the questionnaire was designed to gather information about real and perceived training needs.

I have already had sufficient teaching on the treatment of sexual addiction as part of my training as a therapist.

Yes	3	10%
No	24	82%
Uncertain	0	0%
Blank	2	7%

I have been on a short-term course or supplementary workshop since training to learn about this subject.

Yes	8	27%
No	20	68%
Uncertain	0	0%
Blank	1	3%

I believe a sexual addiction information and training module would be a useful component of an overall training programme.

Yes	28	95%
No	0	0%
Uncertain	0	0%
Blank	1	3%

If a short course on the treatment of sexual addiction were available at the right price, I would consider attending it.

Yes	28	95%
No	1	3%
Uncertain	0	0%
Blank	1	3%

I believe that such a course ought to be broader and include information about substance use, process addictions, romantic fantasy, co-addiction and the Internet, as well as, sexual addiction.

Yes	24	82%
No	2	7%
Uncertain	1	3%
Blank	2	7%

Of the participants who had already been on short training courses, five of those attended courses that I have run either as part of this project or as part of a wider overall clinical work. Some categories of data from the questionnaire have been omitted here because these were in excess of requirement and/or had no relevance. All percentages have been rounded up or down to the nearest whole figure.

The results of the questionnaire can be summarised as follows:

The main figures that stand out is that therapists reported dealing with Internet addiction in a greater frequency than the other behaviours [Occasionally 37%, Often 14%, Very Often 10%] and a much larger number [85%] think that Internet sexual addiction is likely to present more frequently in the future. Very few therapists saw the 11 types of sexual addiction suggested by Carnes with the exception of seductive role sex [21% often], voyeuristic sex [24% often]. In this group of therapists surveyed 95% felt that they were under-trained in the treatment of sexual addiction and the same number considered that they would actually attend such a training course if it were offered.

## **Discussion**

The questionnaire was interested in three things: sexual addiction, Internet sexual addiction and the training needs of psychotherapists. The data associated with each of these categories of enquiry is discussed below.

### *Sexual Addiction*

The prevalence of sexual addiction is unclear and more work remains to be done to clarify what percentage of the population is sexually addicted and what percentage of the population is addicted to sex on the Internet. The sensitive nature of such an enquiry and the ethical complexities involved in asking for this kind of information makes reliability, clarity and verifiability on these issues difficult to obtain.

Cames [1991] suggests that 3 – 6% of the population is sexually addicted but he offers no evidence or information to explain how he arrived at these figures. Schneider [1991] in an article written to educate medical doctors and to heighten diagnostic awareness offers a similar figure, but also offers no substantiation. Research into the area of Internet sexual addiction is only just beginning but, in addition to Greenfield [1999], other research [Cooper and Griffin-Shelley, 2002] indicates that 20% of Internet users engage in some form of sex online and that 70% of all dollars spent online are spent on sexual pursuits. Ross and Kauth [2002] suggests that 1% of all Internet users spend 40 hours a week on on-line sexual activities and that 9 to 15 million people access the Internet each day at a rate that is growing by 25% every three months [Cooper et al, 2000].

The psychosexual therapists surveyed in my research project seem mostly only occasionally to come across the behaviours that have been identified as specific manifestations of sexually addictive behaviours. 51% of the therapist reported that they saw sexual addiction 'seldom' and only 30% occasionally

and 6%, often. This suggests that sexual addiction is not a problem and that psychosexual psychotherapists do not routinely encounter sexual addiction in the course of their day-to-day practice. What is the explanation for this?

It could mean that I have over-estimated the prevalence of the behaviour and that it is problem for very few people and, for that reason, it rarely presents in clinical practice. The usefulness of this programme, however good it might be, is therefore limited. It might also mean that, by their own admission, such therapist themselves are untrained in this aspect of sexual behaviour, and its consequences, that they fail to see it and fail to respond to it. Similarly, clients could be experiencing and manifesting the behaviour but not themselves understand how to identify or name the behaviour. There is so much shame attached to these behaviours that unsolicited information is often not given. Comes [1999] has said that 'most therapists do not ask enough questions'. If it is true that as therapists we tend to find what we look for then the reverse would also be true, that we tend not to find that about which we have no knowledge and little awareness. This second interpretation seems more likely, partly because it is supported by the responses to other parts of the questionnaire and partly because it has been borne out in my personal experience. Most of the practitioners who took part in the survey were trained at a time when the 'addiction model' and its application to sexuality had not been developed. Sexual addiction has been seen as very much a male phenomena and given that men are under-represented as clients, it is also likely that this fact may contribute to the under-presentation of this behaviour in clinical practice. Most of the practitioners surveyed had very small

psychosexual practices and this may well further contribute to under-presentation. A margin note written by a male nurse and sexual health advisor, who is also a psychosexual therapist, suggests some of this. He wrote in the margin of his questionnaire that while he never worked with sexual addiction in its various forms as a psychosexual psychotherapist, his 'answers would be very [his italics] different if questions were directed at my work as a nurse / health advisor' [Appendix E]. This supports my assumption that the problem is 'out there', but largely, unrecognised and untreated, even by psychosexual psychotherapists.

On the core question of the prevalence of sexual addiction, there is a discrepancy of answer between the first question, 'How often in clinical practice do you see sexual addiction?' [7% often], and the penultimate question 'How often in clinical practice do you see people who seem to be addicted to the use of the Internet [nearly 14% often]?' In other words, these practitioners had not identified Internet sexual addiction as sexual addiction. This suggests to me that the respondents are unaware of, or confused about, the addictive compulsive process that lies behind such behaviour. Hopefully this training programme will raise awareness of the problem and will be able to provide therapists with appropriate and useful clinical tools to work with this category of clients.

### *Internet Sexual Addiction*

Internet sexual addiction was seen more frequently than any other addictive behaviour. Almost all of the therapists [85%: 25 yes, 1 no, 1 uncertain, 2 not



answered] took the view that Internet sexual addiction was a growing problem. This information backs up my original assumption, an assumption promoted by the literature [Cooper et al, 2000], that Internet sexual addiction is a growing problem. This view is further backed up by the publication of a special issue of the Journal of the British Association for Sexual and Relationship Therapy that focuses entirely on cybersex and the Internet. The evidence suggests that this treatment and training programme will be a useful and timely contribution to psychotherapy practitioners and others working in relevant adjacent health care provision.

### *Training*

The questionnaires reveal that few therapists felt that they had any training on this subject, and the few that did, most had only done courses that I have taught as antecedents to the training programme. On the psychosexual training syllabus at the Whittington Hospital, there was no teaching about the impact of addiction on domestic partnerships or the subject of addictive compulsive sexual behaviours. Almost all therapists surveyed felt that such training would be useful and that they would attend such a course if it were 'a short course available at the right price'. This substantiates a view that I had already formed from my knowledge of treatment and training.

### **Limitations of the Questionnaire**

Reflecting on my research, there are a number of weaknesses in the substance and usefulness of the questionnaire. It was a small sample. I do not know why it had such a low response rate. It might reflect an absence of

professional solidarity in BASRT or a general indifference to research in parts of the profession. UKCP did not have its first research conference until 2002. With hindsight, I am not sure that the format provided enough clarity or sufficient ease of access. The choices of category were too vague. 'Rarely' and 'seldom' are terms that are too imprecise and I offered no distinguishing criteria. The margin note suggests that follow up research would be useful with other practitioners especially those working the field of sexual health.

### **Conclusions**

However, the results of this quantitative research project point to the reliability of the following assumptions:

- Psychotherapists are untrained in the field of sexual addiction
- Psychotherapists would welcome and attend such training
- Internet sexual addiction is an increasing problem

These findings suggest that the principal proposal of this doctoral project, the construction of a sexual addiction treatment and training programme for psychotherapists, makes a distinctive, valuable and unique contribution to the field of psychotherapy. Perhaps we are only just becoming aware of it but the Internet has put us on the cusp of a revolution in human sexuality [Cooper and Griffin-Shelley, 2002]. If this is true then this training programme, with its emphasis on Internet sexual addiction, puts it at the cutting edge of a cutting edge.

## Chapter 6

### Introduction to the Products of the Project

#### Introduction

The journey to the doctorate really began when I began my own journey into addiction recovery. The products of the project summarised in this chapter reflect the shape and direction of that journey [Fig. 7]. The products are not only contributions to the field of psychotherapy in their own right but they markers or milestones along the academic, clinical and professional journey described in the first chapter. They include the following [Appendix F, G, H, I] as well as two additional products [Appendix J, K]:

- **Narcissistic Damage, Religious Behaviour and Sexual Addiction**
- **Time for Action**
- **Researching Sensitive and Distressing Subjects**
- **A Sexual Addiction Treatment and Training Programme**

The first product was an attempt to use the early stages of the doctorate to synthesize the heuristic reflections on addiction and religious behaviour that had developed prior to enrolment. The second product, the contribution to the book **Time for Action**, came at an invitation from the Revd Jean Mayland, Secretary for Church Life at Churches Together in Britain and Ireland, to participate in the working party on sexual abuse. She had heard that I was on this doctoral programme. The third product, a UKCP conference paper, at the time of writing accepted for publication by Karnac as part of a book, was an attempt to make sense of the distress I experienced with the first work on sexual offending and to use that experience to contribute to the literature on

# Six Products of the Doctoral Process

## Built on the Foundation of a Theory of Sexual Addiction

Developed prior to April 2003

Developed since April 2003

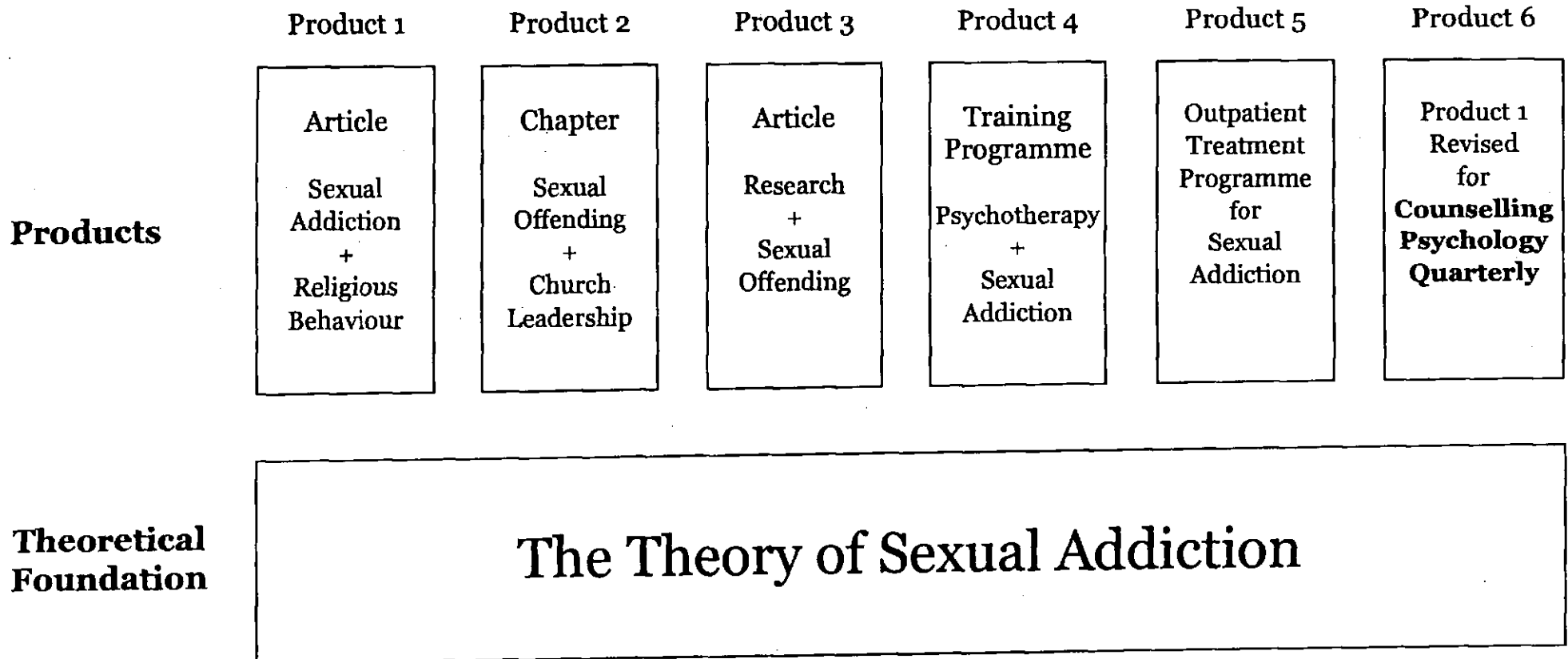


Fig. 7

researching sensitive and distressing subjects. The last product, the creation of a sexual addiction treatment and training programme, grew out of the decision to withdraw from the work with sexual offenders and to refocus on sexual addiction and compulsivity.

Although in many ways over-lapping, each of the products was a unique learning experience. Each drew from a body of literature integral or adjacent to the literature on sexual addiction. The preparation and composition of each project was an exercise in synthesis and application. The writing of each project gave shape, structure, detail, and rigour to the accumulation of knowledge and the advancement of learning. This introduction to the four products contains a brief description of the product, a description of the methodology, a summary of the learning outcomes, and a note about its usefulness to the profession of psychotherapy. 'Writing is thinking, not the report of thought' [Miles and Huberman, 1994, p101].

## **Product 1**

### **Narcissistic Damage, Religious Behaviour and Sexual Addiction**

This article argues that much sexual misconduct in religious communities is caused by sexual addiction and it assigns causation, in part, to narcissistic damage. The article grew out of heuristic reflection, group participation and observation, theological training, ministerial experience and a review of the literature on narcissistic damage, sexual addiction, the psychology of religion, and psychotherapy with religious patients. In the light of the amount of media interest, public scandal, litigation, allegations true and false, appeals for

compensation, this paper makes a timely contribution to a subject of importance to theoreticians and practitioners in the caring professions and within religious organisations as well as to psychologists, counsellors and psychotherapists. Its distinctive contribution is its emphasis that sexual addiction and religious behaviour have a common root.

## **Product 2**

### **Time for Action**

This report was commissioned by Churches Together in Britain and Ireland and unanimously received and recommended to its member churches. Like the previous product, this was heuristic and reflexive but the methodology was more intense, complex and multi-faceted. This report grew out of 11 residential meetings of a working party that met over two years. The meetings took evidence from, among others:

- The Most Revd Rowan Williams [then Archbishop of Wales]
- Sir Ronald Waterhouse [Chair of North Wales Tribunal]
- Mr John Morgan [Child Protection Office, Dublin]
- John Kelly [Founder of Survivors of Child Abuse]
- Donald Findlater [Director Wolvercote Clinic]
- Ms Hilary McCallun [Women's Unit, Hackney Council]

There were many other presentations and the list above is just to give a flavour of the programme. The working party also took evidence from interviews with adult survivors of sexual abuse and from video interviews with convicted paedophiles. The final report grew out of a methodology that included 'intensive discussion and much work in small groups...set in a framework of worship, prayer and reflection' [Time for Action, p5]

This is the first report in this country that draws attention to, and substantiates, the assertion that the clergy have higher rates of misconduct than other comparable helping professionals [Birchard, 2000]. The importance of this was noted in the press reports. As I have said elsewhere, I believe that the summary of causation in the report is the best and most complete summary of causation currently available [Time for Action, p99]. The challenging nature of this report is supported by its reception by the churches and by the interest of the media. The report is meant to bring change and reform to the churches and [Time for Action, p5]

'to help them care more appropriately for those who have been sexually abused and also to enable the Churches to become more fully the just, open and caring communities which we believe God wants them to be'.

Given the national and international concern about sexual abuse in the church and the unanimity of the reception of the report by the churches, it would be difficult to describe this as not a significant contribution to a subject of public importance.

### **Product 3**

#### **Researching Sensitive and Distressing Subjects UKCP Conference Paper**

This paper was written in an attempt to salvage as much as possible and to gain as much as possible from the change of direction in the middle of the doctoral project. The paper was to explore the impact of the research that I was doing on paedophile offenders on my own professional and inner world with a view to alerting others to the potential problems associated with researching sensitive and distressing topics and to researching such topics in times of moral panic. The methodology was largely heuristic and reflexive combined, but it also involved discussions with my therapist, my clinical supervisor, my academic supervisor and senior colleagues, as well as more extended reading. The decision to turn this experience into a product for publication was partly inspired by **Reflections on a Journey: A Research Story** [Hyde, 1994], partly by the desire to turn a problem into a solution and partly by the desire to explore the process that had contaminated my inner life. The purpose of the paper was to alert others to the academic, administrative, ethical, political, professional and personal issues that need to be considered when undertaking such research.



## **Product 4**

### **Training Manual**

#### **A Training Programme for Psychotherapists, Counsellors and Health Care Professionals to Work with Sexual Addiction and Compulsivity with Special Reference to Internet Sexual Addiction**

This product was developed to provide an accessible training programme for psychotherapists, counsellors, and other health care workers to assist them to be able to work better with clients with addictive and compulsive sexual behaviours. It has been designed for the United Kingdom and distinctly designed to facilitate the work of independent psychotherapeutic practitioners. While it is a synthesis of the work of others, it has been supplemented by offender treatment programme protocols and informed, as well, by my clinical practice, residential treatment, training with Patrick Carnes, prior workshops and seminars [Appendix D] and personal experience of addiction recovery. Its need and usefulness is supported by the survey of practitioners in advance of its preparation and by the evaluation of the pilot project participants.

The Training Manual has emerged by degrees. It is difficult to say when it began. In a sense it was begun almost 15 years ago when I began my own process of addiction recovery. In the medium term it has grown out of talks, workshops, and seminars given to professional communities over the past few years. While these go back to at least 1992/1993 with a day conference on sexual addiction organised by the Drug and Alcohol Foundation, the bulk have been since I began this doctoral project. The Training Manual also has its roots in the earlier products of the project. Very specifically it began the moment I

finally made the decision not to continue the earlier project with paedophile offenders. The usefulness of a sexual addiction treatment and training programme was established by the quantitative research project described in Chapter Five.

The sexual addiction treatment and training programme was piloted at the Leicester Counselling Centre on the 18<sup>th</sup> – 19<sup>th</sup> October 2002. There were 11 participants in the pilot scheme, all volunteer counsellors at the Leicester Counselling Centre, Leicester. None of the participants had any previous training in sexual addiction.

All participants took part in evaluation and feedback [Appendix C]. The participants overwhelmingly found the pilot training programme 'very good' or 'good'. The participants felt that the course achieved its aims and objectives and that the course had kept them interested. They all registered replies that make it clear that they enjoyed the course and that they felt that they understand sexual addiction and feel able to respond to sexual addiction in clinical practice. It was also clear from their evaluation forms as well as their enthusiasm in the workshop itself that they found the 'cycle of addiction' particularly enlightening. This has been taken into account in the final drafting of the Training Manual.

Additional comments and margin notes give the 'feel' of a project. One of the participants wrote,

'Given the connections between computer technology and sexual addiction, I experienced this course as being at the cutting edge of understanding the work with clients and its implications for the future'.

If the results of the postal questionnaire are evidence that a sexual addiction treatment and training programme makes a contribution to the profession, the evaluation forms establish, at least in this instance, that the actual participants benefited and learned from the process. One participant wrote,

The two days felt so rich— both in terms of the programme content but also the 'pearls of wisdom' that you dropped in through out. Real depth behind it all. Good use of the self. Wish you could reach a wider audience. Created safety for personal exploration in the exercises.

The development of a sexual addiction treatment and training programme is intended to be an extension of this '*good use of the self*'.

### **Additional Products**

In addition to the four products that make up the substance of this research, there have been two further products emerging from the research but falling outside the time frame of the doctoral project. The first of these is an article accepted for publication by **Counselling Psychology Quarterly** for March 2004 [Appendix J] based on the first product and the second is an outpatient treatment programme based on product four [Appendix K].

## **Chapter 7**

### **Overview and Conclusion**

#### **An Overview of a Four-Year Journey**

I attended an introduction to the doctoral programme in 1998 and decided to enrol in 1999. This timetable allowed me to complete UKCP registration in the spring/summer of 1999 and to use the intervening time to round off the MSc with a journal article based on the MSc dissertation [Birchard, 2000]. Although I had taken an excellent 'taught' methodology course at South Bank University, I attended the methodology seminars at Metanoia to further my understanding of qualitative methodology and to increase my knowledge of issues in research particularly relevant to counselling and psychotherapy. The four products of the project introduced in the last chapter were also created within that four-year time frame.

#### **The Four-Year Time Frame**

The four-year time frame is divided into two parts. On the 6<sup>th</sup> July 2001 there was a farewell service to celebrate the end of 21 years of ministry in the parish of St John's, Hyde Park. The background to the first two years of the doctoral programme is set against winding down and concluding that ministry. The background to the second two years of the doctoral programme is set against starting and developing a new way of life and a new programme of work.

The backdrop to the first two years of the doctoral programme involved the preparation of the parish for handover to a successor, the handing over of a capital campaign that had raised about one million pounds with another one million still needed. On a personal level it also meant trying to find somewhere to live and some way of making a living. Parish clergy are required to live in church property and only in exceptional circumstances are the clergy able to own property or have a home separate from the vicarage.

The backdrop to the second two years of the doctoral programme involved the need to find and adjust to new housing, to build a psychotherapy practice, to undertake a new way of living, to earn enough money, and to adjust to a new less prominent identity. By convention, the previous incumbent relinquishes all contact with previous parishioners, so all of this had to be done without the supportive friendships that have naturally developed through parish ministry.

This doctoral project has taken place against a backdrop of immense life changes: change of career, routine, accommodation, friends and contacts and the loss of security and identity. From being the centre of attention and the central decision maker, even the embodiment of a cohesive organisation, and having a mantle piece full of invitations to social and civic events, I became yesterday's man and I descended overnight into obscurity.

## **The Doctoral Project as a Hasp**

I now look back, from a four-year vantage point, on the enormous personal and professional changes that have provided the backdrop for this doctoral programme and its products. The research and the work done has been more than a doctoral programme. Yes, it has been pursued for all the good reasons outlined elsewhere and it has been useful for the all the gains and achievements listed through this document. But I am aware now that it has also been a bridge of transition into a new professional status and a new professional identity. ***Looking back over the four-year time frame, divided as it has been into two parts, it is my conclusion now that the doctoral programme has acted as the hasp to hold me, and the two parts, together.***

## **Limitations**

This work has not been without its limitations. Each of the products of this doctoral project has its own limitations and these have been noted in an earlier chapter. Here I describe some of the limitations that apply to the overall project rather than to any particular product that has been an outcome of the project.

## **Change of Proposal**

The first limitation has resulted from the decision to change from the first research proposal to the second research proposal. While such a change is not unusual, and is also not without benefits, I believe that it makes the overall work less confident and seemingly less tidy. Even though I have tried to

maximise the benefits of the change by writing a paper about that experience [Appendix G] and even though that paper has made real contributions to qualitative research nevertheless the resulting doctoral process is less seamless, personally satisfying and coherent than if no such change had taken place.

## **Ethics**

Although ethical issues have already been considered in the second chapter in reference to research on human subjects and in the complexity of the treatment and training programme more could have been done to expand and develop this subject. Not only are there ethical issues around disclosure to partners and, sometimes, legal authorities, in working with sexual addiction and compulsivity, there are the more subtle and complex issues around truth telling in an unreceptive and hostile environment. It was clear to me in my research with paedophile Roman Catholic clergy that any views, however well founded, suggesting that these men were intrinsically worthy of value and respect, simply would not be heard. This raises questions about truth telling in research especially when research questions and outcomes challenge conventional wisdom, public prejudice, or political expediency.

## **Feminist Critique**

In the schedule of public lectures and workshops that I have given during the pursuit of this doctoral research, I was invited to do an evening seminar [Appendix D] on sexual addiction sponsored by Confer, an organisation specialising in continuing professional education. This was attended by a number of experienced women therapists. It was this group of women who

noted and rightly commented on the absence of any feminist critique or feminist content in the presentation of the material on sexual addiction. Although I have made efforts to correct this in subsequent public presentations, I am aware that the absence of such a critique weakens the quality of the overall project as well as the products that have grown out of this work. This is especially true since sexual addiction is so largely a male behaviour and so much of it is directed towards the use and abuse of women.

### **Neurobiology**

I am aware of the absence of a medical education and/or other similar training in human biology that would equip me to relate narcissistic damage, sexual addiction, religious behaviour to the chemistry and biochemistry of addiction. It is not that I would necessarily have done anything differently or come to different conclusions; it is more that such a background would allow me have expanded my work on the biochemistry of addiction and to present the views and outcomes that have emerged from this work to a wider academic and research community. This could well have included the biochemistry of ecstatic religious behaviour. It would also allow me to debate the issues of sexual addiction as a medical dialogue and to engage with the medical establishment from a position of greater conversancy. Although this is entirely outside of my control, I think this has limited the quality and breadth of the overall research project.



## **Other Limitations**

This research project has been done almost entirely without reference to cross-cultural studies. I know of no cross-cultural work on sexual addiction. Such work could make important future contributions. Every research project is both enriched and limited by the time availability, background, gifts and inclinations of the researcher, the presuppositions that are brought to the project, and by the style and personality of the researcher. The passionate and highly subjective nature of research and the experience and motivation behind the products of research can be the biggest weakness and concomitantly the greatest strength.

## **Conclusions from the Journey**

The research process— attendance at the specialist seminars, the development of the products of the research, all the preparation and writing of the interim submissions and the creation of this 'accompanying document' have all contributed to personal, professional and academic development. I divide the learning outcomes into the following five categories, but the over all conclusion is one of synthesis and completion.

- Outcomes that affect clinical practice
- Outcomes associated with academic practice
- Outcomes associated with the use of research methodologies
- Outcomes that provide new knowledge
- Conceptual contributions

### **Outcomes that Affect Clinical Practice**

The doctoral project has influenced my clinical practice in three ways: the expansion of practice, the specialisation of practice and the status of the practice. These are especially important because of the clinical nature of this doctoral programme.

Over the four years of the doctoral programme the practice has increased from one evening a week to five days a week, from one client to 30+ on the books. With this increase has come an increase and broadening of the referral network. Many psychotherapists set up and develop busy practices without doing any doctoral research, although the research done in advance of the treatment and training programme [Appendix C] suggests that over half psychosexual psychotherapists work less than 10 hours a week doing psychosexual psychotherapy. I am persuaded that my own practice has flourished directly as a result of this doctoral programme. The routine content of clinical practice has been regularly infused with new material drawn from reading and research. Some of the effect has been direct and tangible, like a particular referral or a particular invitation to speak, but more has been indirect and intangible, an outcome of research and an energetic engagement with the subject.

The second outcome to effect clinical practice has been an increase in the number of people that are referred to me because of addictive compulsive patterns of sexual behaviour. I estimate that over 40% of my clients have

come to me specifically to deal with sexual addiction and compulsivity. This is clearly due to the number of public presentations I have made on sexual addiction in the process of the doctoral research [Appendix D] and directly to the specialised referrals that follow.

The third contribution of this doctoral programme to clinical practice has been to identify the practice and this practitioner as 'knowledgeable' in the field of sexual addiction and compulsivity. The evidence that the practice is seen in this way lies in the number of media enquiries on the subject of sexual addiction that are forwarded to me from professional organisations. This is also due to the number of public presentations that have been made to professional organisations on the subject of sexual addiction that have accompanied the pursuit of the doctoral programme. While I have not listed these presentations [Appendix D] formally as 'products of the programme' they are indeed such products and impact audiences as much if not more than written material.

### **Outcomes Associated with Academic Practice**

Having spent most of my life in parish ministry one of the interesting outcomes of the doctoral programme has been its introduction to academic life and the career structures that are associated with academic life. This has brought with it a set of new experiences and a set of new insights and learning outcomes.

In the summer of 2002, I presented a paper at the UKCP Inaugural Research Conference at the University of Surrey at Guildford, the second product of this project [Appendix G]. This was an entirely new learning experience. I learned the following things, mostly from the experience of others: never give a presentation that relies on high technology without a backup plan, never read out a conference paper, never think that everyone else necessarily knows more than you know. It was clear at the conference that the skills of the researcher and the skills of the presenter are not always held in combination.

Apart from a series of essays during my MSc, during my time in parish ministry, I had not written much more than magazine articles and book reviews. I had done, however, regular public speaking. In the preparation of the last two journal articles and the construction of this 'accompanying document' it has become clear to me that I am so programmed to speak in public that I am automatically more interested in how the material should be presented than I am in the content of the material itself. Whatever the nature of the material that has emerged from the research, I have always wanted to give it an introduction, three points and a conclusion.

One of the unexpected spin-offs of this work is a fresh look at effective expository prose, a different genre to the structure and purposes of effective rhetoric. At the same time this tendency towards the spoken word has been productive in the preparation and presentation of the workshops and the public engagements [Appendix D] that are also in some sense 'products'

Before I decided to construct a training manual as the forth product of this doctoral project, I had never written or even read such a training manual. Prior to the beginning of that work I had to examine a variety of formats and choose a format that would be acceptable in a standard academic environment. This has been an entirely new venture and an entirely new learning experience. The task was not only to gather and select the material on sexual addiction but also to organise it into an acceptable structure. Having done this once with sexual addiction this process will be easier to do in the future, even if working with some other topic. Because the written material on sexual addiction is difficult to access, I added an appendix of data to the training programme to make it more useful to other presenters not already familiar with the subject.

### **Research Methodology**

Having begun to look at qualitative methodology during the MSc, I have had an opportunity to explore qualitative methodology in greater detail over the past four years. This has been one of the pay offs of the programme. In the preparation of the first proposal, the uncompleted proposal on sexual offending, I focused on the ethical issues behind such research, the formation of semi-structured interview protocols, and on the recording and analysis of narrative stories. I had committed to using a social policy methodology very similar to grounded theory [Strauss and Corbin, 1998]. It is a 'second generation' grounded theory type methodology called 'Framework'. It was developed by Ritchie and Spencer [1994, p174] for actionable outcomes and with 'the intention of providing insights, explanations, and theories of social

behaviour'. I was well into the process of immersion when I decided to apply for a change in the doctoral programme. While I was only able to begin the process of coding, I was aware that patterns were emerging from the data confirming the theoretical propositions that lie behind the article on narcissistic damage, religious behaviour and sexual addiction [Appendix F]. The basic argument in that article [Appendix F] is that some sexual offending is sexual addiction, and that the addiction and the religious behaviours are parallel solutions to disturbed attachment and narcissistic damage. This argument was introduced and was influential in the report of working party on sexual abuse in the church [Appendix H]. Much of what was learned in the first research proposal contributed to the theory of causation in the report of the Working Party on Sexual Abuse to Churches Together in Britain and Ireland. The tapes and notes have been retained for a possible return to this earlier research. The second 'completed proposal' on the treatment and training for sexual addiction was very product orientated. I learned about qualitative methodology from the first research proposal and quantitative methodology from the second research proposal. Although methodology must be determined by the questions and the nature of any future research, I am aware that this project has strengthened my interest and conversancy in both quantitative and qualitative methodology.

### **New Knowledge**

This doctoral programme has given me an opportunity to explore and reflect on the following:

- The nature of the self
- The distinction between a healthy self and impairment of the self
- The nature and implications of narcissistic damage
- The symptoms of narcissistic damage
- The nature and function of addiction
- The nature and function of sexual addiction and compulsivity
- The impact of addiction on sexual functioning and relationships
- Sexuality and religious behaviour
- Religious behaviour as an 'addiction alternative'
- Sexual behaviour and religious professionals
- Sexual abuse in the church
- Sexual offender treatment programmes
- Sexual addiction treatment strategies
- Teaching and training formats for psychotherapists and health care professionals

In a final word to embarking researchers Bell [1993, p165] writes,

There may be occasions when, in spite of careful planning and preparation, a project does not go according to plan....You may have learnt a great deal about conducting an investigation and the topic you were investigating, even though the outcome may not be what you had hoped.

## **Unexpected Learning Outcomes**

A number of other unexpected learning outcomes have also emerged from the overall experience of this doctoral project.

**Teaching and Training—** Although I had contemplated, in the Level 5 application, doing doctoral work on the wider subject of sexual addiction, I did, in the end, opt for sexuality and religion with a view to understanding and explicating offender behaviour. To withdraw from this and to go back and focus instead on sexual addiction was not entirely unexpected and, in the end, was not without advantages and important lessons gained. The unexpected outcome was the decision to devise a training programme and create a training manual for psychotherapists and other health care workers.

**The Self—** I have been intrigued by the ubiquity of the self. In this research, behind every door I have pushed, there has been some aspect or utility associated with the concept, nature and character of the self. The research has made me aware of just how much of my religious behaviour and the behaviour of my faith community is about the survival and well being of the self. Whenever I am asked to speak on some aspect of my research, I usually manage to quote the strap line of a Christian counselling organisation that I work with from time to time, 'from brokenness to wholeness'. I do that to illustrate that the repair of the self represents a primary interconnection between psychotherapy and the Judaeo-Christian tradition, the first being a secularising and an interiorising of the second [Krischner, 1996].



The more I know about qualitative methodology, and about counselling and psychotherapy research methodology in particular, the more aware I become to the use of the self as the agent and the object of research. This is paralleled in the therapeutic process itself. The therapeutic process requires a strategic use of the self of the therapist in the service and assistance of the self of the client. While I have always known that to be true, in the pursuit of this research that idea has been central and ubiquitous.

**Researching Sensitive and Distressing Subjects**— Most important for me, and I suppose the most unexpected, as a learning outcome was an understanding of the refluent nature of the qualitative research process. I have already stated that the inner turmoil that led me to change projects in the middle of my research was an experience of vicarious or secondary traumatization. In preparing to do that research, I had no warning in the various texts potentially distressing nature of the research process. I learned, rather unexpectedly, that the shamed and diminished nature of the other can trigger, however different the subject, shame and traumatic affect in the self of the researcher. The course director, Jenifer Elton Wilson, tried to warn me of some of the potential pitfalls but her warning was difficult to grasp. This was probably because her warning was given, at a seminar, from within the supportive environment of the organisation. According to Straker [1993] it is just such an environment that prevents and mitigates secondary traumatic impact. The effect would have been to hear her warning in an environment and atmosphere that would, in itself, cancel out such a warning.

**Trauma**— I have, because of this research, become more aware of the nature of trauma and the long-term implications of trauma on human functioning. I am particularly interested in the effect of childhood trauma on adult functioning and on how trauma outworks and impacts on sexual functioning. I find that in clinical practice, I am treating many aspects of sexual dysfunction, and anti-social or unwanted sexual behaviours, as the consequences of childhood trauma on the formation of the sexual and relationship template. This greater emphasis on trauma has consequences for the development of my practice and in the treatment of my clients. While I would have paid lip service to the role of trauma in sexual functioning and sexual patterning, it would not have come from the same place of conviction and interest that it does now. This has been an important and un-expected learning outcome.

**Treatment Commonalities**— The last observation to make about unexpected learning outcomes is an observation about the commonalities involved in different treatment approaches. In exploring Twelve Step recovery, psychoanalytic approaches, cognitive behavioural approaches, residential addiction treatment centres, offender treatment programmes and institutions, one-to-one psychotherapy, and therapeutic communities they seem to share common features with different combinations of emphasis. I note this because, in my experience, they tend to set themselves up as different and to suggest that one approach is the best or, less admirably, that some other approach is less than theirs. The offender treatment people criticise psychotherapy, the offender treatment specialists misunderstand and

sometimes misrepresent the Twelve Step process, and the cognitive behavioural specialists do not meet with those who work with offenders using a psychoanalytic model. In my observation, all the committed treatment modalities, whatever they say about themselves, combine psycho-education, some kind of group process [even if it is only a dyad], recognise the importance of the therapeutic relationship, do family of origin and cognitive behavioural work. The tendency towards professional territoriality hinders the development of work and prevents a proper analysis of approaches across the board that might generate a 'best ever' approach to responding to these behaviours.

### **Conceptual Contributions**

The products of this doctoral project contain a number of distinctive conceptual contributions to psychotherapy and adjacent disciplines.

**Summary of Causation**—The first is the development of my own summary of causation in the case of clergy sexual misconduct [Appendix H]. I believe that this is the best summary that is currently available. This summarises and explains, in a nutshell, the reasons for the greater prevalence of misconduct that occurs among the clergy than among other caring professionals. I quote it here because of its importance to understanding sexual misconduct among religious officials,

The high levels of sexual abuse in the church can be explained, in summary, by this combination: vulnerable people with sexual and personal problems in positions of power, functioning in multiple roles, in stressful jobs with much boundary ambiguity, working with other people, often vulnerable and needy and without boundaries, in an organisation without training or supervision, in an ecclesiastical culture dominated by systemic sexual shame and pandemic secrecy.[2002, p99]

While this summary statement goes back to earlier research into sexual misconduct, it has been strengthened, tested and expanded in the pursuit of both proposals that have been part of this doctoral project.

**Addiction Recovery and Offender Treatment**—Another thing that stands out has been a learning of approaches to offender treatment and the integration of these, where appropriate, into the strategy of treatment for sexual addiction and compulsivity. Standing out among these has been the work of Bays and Freeman-Longo [1989] on cycles of behaviour and the work of Ward [in press] on the importance of working towards creating an individually tailored and enriched quality of life as a goal of offender treatment. Not only have these approaches been integrated into the training manual, I am aware that they have come to play, in their different ways, a significant role in my clinical practice.

**Narcissistic Damage: A Common Root**—The last thing that stands out as distinctive is the development of thought about the way in which religious behaviour and addictive behaviours are both connected to narcissistic damage. As this connection became clear to me, the linking through narcissistic damage, I went back to William James. I had not read **The**

**Varieties of Religious Experience**, first published in 1902, for many years.

In re-reading James I realised that, over a hundred years ago, he was exploring this connection between religion and addiction. He writes as follows

[1982, p426]

It is evident that from the point of view of their psychological mechanism, the classic mysticism and these lower mysticisms spring from the same mental level, from that great subliminal or transmarginal region of which science is beginning to admit the existence, but of which so little is known. That region contains every kind of matter: 'snake' and 'seraph' abide there side by side

Addiction and religion are both solutions to the problem of non-being and thus both are about the search for life. It is not that religion is an addiction, but that addiction and the search for God are connected by human need. This must be especially true of sexual addiction because sex, in its own right, is about the fulfilment of life. Sex and religious behaviour are both about the search for life... 'life in all its fullness' [John 10:10]. The snake and the seraph do, indeed, abide side by side.

## **Conclusion**

I am aware that while I am interested in sexual addiction and compulsivity, I work with a broader range of psychosexual and relationship problems. Research and clinical practice work in tandem and are richer together than apart. I am glad that I chose to do this particular doctoral programme. I have appreciated the inter-play between the theoretical and the clinical. I look forward to that continuing beyond the programme. The practice has expanded and the practice has been enriched and animated by a parallel academic

process. Four years ago I wrote that the work that lies ahead, and these studies connected with it, to be 'integrative, appropriate, sequential, interconnected, successive, and finally, culminating'. I believe this to have been achieved.

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This reference contains the references for the accompanying document and all of the products of the doctoral project.

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# **Appendix A**

## **Contents:**

**Letter of Arrangement**

**Letter to Clergy Participants**

**Clergy Confidentiality Agreement**

**Clergy Interview Pro Forma**

**Professional Confidentiality Agreement**

**Professional Interview Pro Forma**

**Interview Response Form**

16<sup>th</sup> December 2001

Candida Large  
Wolvercote Clinic, Horton Hospital  
Long Grove Road  
Epsom  
Surrey  
KT19 8PZ

Please find enclosed some packets of information for any perspective clergy candidates for interview. Each packet contains:

1. Letter of introduction
2. Interview pro forma
3. Confidentiality agreement [2 copies]
4. A reply form that can be sent to me
5. SAE

This will allow you to approach any possible candidate and to give them the necessary information. There is also a packet for your own files.

I am coming down on Wednesday 19<sup>th</sup> December at 11:00am to interview Donald and could stay on in the afternoon if there is anyone else to see. I am hoping to have some time to talk to Valerie Sheehan after I have seen Donald. My interview with him ought to end just before lunch.

I know too that you must be hugely busy and I am sorry to add to your burden. You have been very kind to agree to help organise some of this and it is not taken for granted.

I will be on a conference Monday/Tuesday but available some on the mobile 07949 244582.

Best wishes,

Thaddeus Birchard

## **A Letter to Prospective Clergy Participants**

4<sup>th</sup> December 2001

I would like to begin by introducing myself and I would like to ask for your help.

I am a psychotherapist and psychosexual therapist accredited by the British Association for Sexual and Relationship Therapy and registered with the United Kingdom Council for Psychotherapy. I trained at the Whittington Hospital and at the School of Health and Social Care, South Bank University. I am a doctoral candidate in psychotherapy on a programme jointly sponsored by Middlesex University and the Metanoia Institute. I work full time in clinical practice and research. I am also an NSM in the Diocese on London.

This is the help I need—your willingness to be interviewed by me. I would be looking for your view on the connection between sexuality and religious behaviour, especially where this is experienced problematically and as troublesome. The interview would take about an hour and a half and would be open-ended and semi-structured. I would be asking you to share your experience and thoughts on these issues. Confidentiality would be protected by means of a written contract with me, and none of the content of the interview would be attributable to you in any way. Your insights will be of inestimable value.

I enclose a reply form, a self-addressed envelope, a copy of my confidentiality commitment and an outline of the interview pro forma. I would be pleased to speak to you in advance of your decision so that I could answer any questions you might have about confidentiality, the structure of the interview, the research, or about me, the researcher. If it is permissible, and should you wish to ring, please feel free to reverse the charges.

I would also be happy for you to make reference to my Archdeacon, the Revd Dr Bill Jacob, 15a Gower Street, London, WC1 6HW [020 7323 1992] or to my Academic Advisor, Professor Michael Carroll, 73 Upper Church Road, Weston-super-Mare, BS23 2HX [01934 643762].

All good wishes,

Thaddeus Birchard

## **Confidentiality Agreement between the Researcher and Clergy Participant**

### **Research Project on The Relationship between Sexual and Religious Behaviour**

#### **Interview Contract**

This project is part of a study at doctoral level that aims to explore the connection between sexual and religious behaviour, particularly where this is troublesome or leads to problematic situations, experiences of great anguish or, sometimes, offender behaviour. The goal of the research is to contribute insights into causation, the better care and treatment of the clergy, and of offenders, and the creation of better systems of repair, education, awareness training and prevention. Further information about this research and my academic and professional background is found on the letter initiating this interview.

I would like to emphasize that

- You participation is entirely voluntary
- You are free to refuse to answer any questions at any time
- You are free to withdraw at any time
- Neither you nor your treatment programme is being evaluated
- Involvement in this research has no bearing on your part in any programme of assessment or treatment
- Should the interview schedule raise difficult issues there will be opportunities for feedback and debriefing at the end of the session

I am committed to abide by the Code of Ethics and Conduct of the British Association for Sexual and Relationship Therapy and by similar codes governing research undertaken at Middlesex University and the Metanoia Institute. Within this, and the policy of any treatment provider, I give the assurance that any records of the interview, whether written notes or on tapes, will be held confidentiality by me, any essential secretarial support, and by my doctoral research supervisor. Tapes will be destroyed on transcription. Any excerpts from the interview that form part of the report will not be attributed to you and no identifying characteristics will be included in the report. A copy of the written transcript will be sent to you for further comment and/or amendment.

I would be grateful if you would be kind enough to co-sign this form with me as a contract between us of these interview conditions.

Participants Signature \_\_\_\_\_ Date \_\_\_\_\_

Name [block capitals] \_\_\_\_\_

Researchers Signature \_\_\_\_\_ Date \_\_\_\_\_

If you would like to be kept up to date on the progress of this research and to have copies of the outcome studies please tick here: \_\_\_\_

**Interview Pro Forma for Clergy Participants in the Research Project**  
Version 1

During the interview I intend to ask open-ended and general questions about the psychology of clergy sexual offending. The topics covered will be as follows and in the following order:

General Thoughts and Comments  
Descriptions of the Phenomena  
Sexual Development and Adult Sexual Behaviours  
Religious Development and Adult Religious Behaviours  
Co-existing or Connected Behaviours  
Causation  
Antecedents  
Treatment  
Prevention  
Recommendations to Psychotherapists  
More General Thoughts and Comments

I would be grateful if, in advance of the interview, you would fill in the attached sheet. At the end to the interview I will ask for your views about some ideas that have emerged from the literature.

Thaddeus Birchard



## **Brief Demographic Information Request Form**

*[Please use your own words and write as much or as little as you would like]*

Age:

Marital Status:

Children:

Academic Background:

Career Development and Last Position:

Years of Experience Working in the Ministry:

Training, Qualifications and Types of Experience:

Church Background:

Denominational Affiliation:

Current Church Commitment:

Anything else that you would like to say about yourself:

## **Follow up information request form**

Additional Questions [to be completed at the end of the interview or left with the person interviewed with an sae to be posted on]

The literature and the research, to date, suggest that some of the following factors are important in the understanding of the relationship between sexual and religious behaviour.

Would use your experience, background, life, ministry, and knowledge, to venture some thoughts on the following issues...as they might, or might not, relate to a connection between sexual and religious behaviour in general...

Please comment:

Psychosexual 'set ups' in early family life:

Conflicted feelings over gender, sexuality, or orientation:

Deficits [unintended or otherwise] in the experience of being parented:

Low self worth masked by other behaviours:

Alcohol usage:

Sexual behaviour experienced as a kind of addiction:

An inner sense of deep loneliness:

Lack of career fulfilment:

Unrecognised or unappreciated personal skills and abilities:

A sense of powerlessness over the behaviour:

Cycles of 'release and control':  
A need for personal consolation:

Profound feelings of guilt and shame:

Damaged or flawed sense of self:

A sense of deserving a treat after hard work or service:

The capacity to hold different parts of life in separate compartments:

A desire to be respected and taken seriously:

Perfectionism scripts:

The need to control others for one's own comfort or safety:

Unexpressed fear or anger:

The need to be heard and taken seriously:

Narcissistic damage :

**Confidentiality Agreement  
between the Researcher and the Professional Participant**

**Research Project on The Relationship  
between Sexual and Religious Behaviour in Clergy**

**Interview Contract**

This project is part of a study at doctoral level that aims to explore the connection between sexual and religious behaviour in clergy, particularly where this is troublesome or leads to problematic situations, experiences of great anguish or, sometimes, offender behaviour. The goal of the research is to contribute insights into causation, the better care and treatment of the clergy, and of offenders, and the creation of better systems of repair, education, awareness training and prevention. Further information about this research and my academic and professional background is found on the letter initiating this interview.

I would like to emphasize that

- You participation is entirely voluntary
- You are free to refuse to answer any questions at any time
- You are free to withdraw at any time
- Neither you nor your programme is being evaluated
  
- Should the interview schedule raise difficult issues there will be opportunities for feedback and debriefing at the end of the session

I am committed to abide by the Code of Ethics and Conduct of the British Association for Sexual and Relationship Therapy and by similar codes governing research undertaken at Middlesex University and the Metanoia Institute. Within this, and the policy of your own organisation, I give the assurance that any records of the interview, whether written notes or on tapes, will be held confidentiality by me, any essential secretarial support, and by my doctoral research supervisor. Tapes will be destroyed on transcription. Any excerpts from the interview that form part of the report will not be attributed to you and no identifying characteristics will be included in the report. A copy of the written transcript will be sent to you for further comment and/or amendment.

I would be grateful if you would be kind enough to co-sign this form with me as a contract between us of these interview conditions.

Participants Signature \_\_\_\_\_ Date \_\_\_\_\_

Name [block capitals] \_\_\_\_\_

Researchers Signature \_\_\_\_\_ Date \_\_\_\_\_

If you would like to be kept up to date on the progress of this research and to have copies of the outcome studies please tick here: \_\_\_\_

**Interview Pro Forma for Professional Participants in the Research Project  
Version 1**

During the interview I intend to ask open-ended and general questions about the psychology of clergy sexual offending. The topics covered will be as follows and in the following order:

General Thoughts and Comments  
Description of the Phenomena  
Sexual Development and Adult Sexual Behaviours  
Religious Development and Adult Religious Behaviours  
Co-existing or Connected Behaviours  
Causation  
Antecedents  
Treatment  
Prevention  
Recommendations for Psychotherapists  
More General Thoughts and Comments

I would be grateful if, in advance of the interview, you would fill in the attached sheet. At the end of the interview I will ask your views about some ideas that have emerged from the literature.

Thaddeus Birchard

**Brief Demographic Information Request Form**

*[Please use your own words and write as much or as little as you would like]*

Age:

Gender:

Academic Background:

Current Position:

Years of Experience Working with Offenders:

Training, Qualifications and Types of Experience:

Anything else that you would like to say about yourself:

## **Follow up information request form**

Additional Questions [to be filled out at the end of the interview or left with the person interviewed with an sae to be posted on]

The literature and the research, to date, suggest that some of the following factors are important in the understanding of the relationship between sexual and religious behaviour.

Would you use your experience of the background, life, ministry, and knowledge to venture some thoughts on the following issues...as they might, or might not, relate to a connection, in your view, between sexual and religious behaviour in general...

Please comment:

Psychosexual 'set ups' in early family life:

Conflicted feelings over gender, sexuality, or orientation:

Deficits [unintended or otherwise] in the experience of being parented:

Low self worth masked by other behaviours:

Alcohol usage:

Sexual behaviour experienced as a kind of addiction:

An inner sense of deep loneliness:

Lack of career fulfilment:

Unrecognised or unappreciated personal skills and abilities:

A sense of powerlessness over the behaviour:

Cycles of 'release and control':

A need for personal consolation:

Profound feelings of guilt and shame:

Damaged or flawed sense of self:

A sense of deserving a treat after hard work or service:

The capacity to hold different parts of life in separate compartments:

A desire to be respected and taken seriously:

Perfectionism scripts:

The need to control others for one's own comfort or safety:

Unexpressed fear or anger:

The need to be heard and taken seriously:

Narcissistic damage :



**Interview Response Form**

[Please Print]

Surname \_\_\_\_\_

First Name \_\_\_\_\_

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

I would be willing / not willing to be interviewed by you.

If you agree to be interviewed, I will make the necessary arrangements and will be in touch at the earliest opportunity.

**Interview Response Form**

[Please Print]

Surname \_\_\_\_\_

First Name \_\_\_\_\_

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

I would be willing / not willing to be interviewed by you.

If you agree to be interviewed, I will make the necessary arrangements and will be in touch at the earliest opportunity.

# Appendix B

# **Appendix B**

## **Contents:**

**Outline of Specialist Seminars**

## **Outline of Specialist Seminars**

### **Psychotherapy Research**

#### **Evidence Based Practice**

19<sup>th</sup> April 2002

Dr Glenys Parry

Professor Associate in Healthcare Psychology  
School of Health and Related Research, Sheffield

#### **Strengthening Your Practice Through Research**

30<sup>th</sup> May 2002

Professor David Shapiro

Honorary Professor at Leeds and Sheffield  
Psychological Therapies Research Centre, Leeds

#### **Poetic Writing as Search and Research**

25<sup>th</sup> October 2002

Dr Miller Mair and David Hart

Miller Mair, Resident Fellow at Kinharvie and  
Visiting Professor at City University

David Hart, Poet in Residence at the South Birmingham Mental Health  
NHS Trust and Honorary Teaching Fellow at the University of Warwick

### **Clinical Practice**

#### **Towards an Effective Process and Outcomes Strategy for Evaluating the Psychological Therapies**

16<sup>th</sup> September 1999

Dr Michael Barkham

Psychological Therapies Research Centre, Leeds

#### **Relating Theory, Practice and Research: A Practical Seminar**

5<sup>th</sup> October 2000

Dr Gillian Butler

Chartered Clinical Psychologist  
Fellow of the British Psychological Society  
Oxford Centre for Cognitive Therapy

#### **Embracing Multicultural Systems**

12<sup>th</sup> July 2002

Dr Valerie Batts

Executive Director of Visions, Inc.  
Adjunct Faculty Member Episcopal Divinity School, Cambridge, MA

## **Project Content**

### **Working with Trauma and Memory**

November 6<sup>th</sup> 2000

Professor Gillian Straker  
School of Psychology  
University of Witwatersrand

### **Attachment, Trauma and Multiplicity**

2<sup>nd</sup> February 2002

Valerie Sinason  
Consultant Research Psychotherapist  
Psychiatry of Disability Department, St George's Medical School,  
London

# **Appendix C**

## **Contents:**

**Letter to BASRT Members**

**Questionnaire**

**Collation of Replies**

**Pilot Project Evaluation**

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THADDEUS BIRCHARD BA DIPTh MSc

---

Psychotherapist and Psychosexual Therapist  
Marriage and Relationships

0 Harley Street  
London  
W1G 9PF

Tel: 020 7372 3155 Mobile: 07949 244582  
Email: [thaddeus@birchard.co.uk](mailto:thaddeus@birchard.co.uk)  
[www.birchard.co.uk](http://www.birchard.co.uk)

21F Devonshire Place  
London  
W1G 6HZ

11<sup>th</sup> October 2002

**Research on Sexual Addiction: Strategies for Treatment and Training**

I am writing as a fellow member of BASRT, with the consent of the trustees, to a random selection of colleagues to ask for your help with a project of research.

As part of the Doctor of Psychotherapy programme at the Metanoia Institute and Middlesex University, I am trying to develop a programme to train counsellors, psychotherapists and other health care professionals to better work with people who present with problems that are currently and popularly being described as 'sexual addiction' or compulsivity.

Please read and complete the enclosed questionnaire. Do not hesitate to get in touch if you would like more information. An SAE is enclosed for your convenience. Participation is confidential and all responses are non-attributable. This survey has been piloted by senior practitioners and assessed as clear, understandable and harm free to participants.

Please return by 31<sup>st</sup> October. I am grateful to you for reading this letter and would like to thank you whether or not you feel able to participate.

Sincerely,

Thaddeus Birchard

---

## Psychotherapy Training and the Treatment of Sexual Addiction

Collation of the information from this questionnaire follows.

This survey has been designed to explore the phenomena popularly being described as sexual addiction and to determine how often and in what ways psychosexual therapists come across this phenomena in clinical practice, what training programmes or teaching units have been part of the training history of therapists preparing them to work with this problem, and what training do therapists think would be useful and practical.

**For the purposes of this survey sexual addiction is defined as:**

**A pattern of sexual behaviour—**

- That the client experiences as 'out of control'
- Is not reliably able to stop
- That brings with it real and/or potential harmful consequences

---

### Professional Demographics

Age \_\_\_\_\_

Gender \_\_\_\_\_

Current Occupation \_\_\_\_\_

In What Area of the County Do You Work \_\_\_\_\_

Year of BASRT Accreditation \_\_\_\_\_

How many years have you done psychosexual work \_\_\_\_\_

Please describe type of training \_\_\_\_\_  
i.e. Relate, BASRT, University Programme, Medical, other

Approximate Length of Training \_\_\_\_\_

Previous Occupation or Professional Background before Accreditation [if any]

\_\_\_\_\_

Approximately how many hours per week do you spend in clinical practice? \_\_\_\_\_

If your practice has been strongly influenced by any other discipline, please note and explain

\_\_\_\_\_



**Sexual Addiction and Behavioural Types**

**How often in clinical practice do you see 'sexual addiction'?**

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**How often in clinical practice does it take the following form?**

**Fantasy Sex:** i.e. inordinate amounts of time spent lost in sexual fantasy

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Seductive Role Sex:** i.e. many relationships at the same time, or one after another

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Anonymous Sex:** i.e. engaging in sex with anonymous partners

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Paying for Sex:** i.e. escorts, telephone sex, massage parlours etc.

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Trading Sex:** i.e. posing for sexually explicit photos or videos, receiving money for sex, etc.

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Voyeuristic Sex:** i.e. using pornography, strip shows, peeping, etc.

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Exhibitionist Sex:** i.e. exposing, flashing, etc.

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Intrusive Sex:** i.e. indecent liberties, professional misconduct, inappropriate touch

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Pain Exchange Sex:** i.e. giving or receiving pain or causing physical harm

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Object Sex:** i.e. masturbating with objects, bestiality, cross-dressing to add to sexual intensity

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Sex with Children:** engaging in sex or using child pornography

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**How often in clinical practice do you see people for whom the Internet has become sexually problematic?**

1 Rarely                      2 seldom                      3 occasionally    4 often                      5 very often

**Do you think that this is likely to be an increasing problem?**

Yes / No

**'Sexual Addiction' Training Needs**

**Please circle Yes or No to the following five statements:**

Yes/No I have already had sufficient teaching on the treatment of sexual addiction as part of my training as a therapist.

Yes/No I have been on a short-term course or supplementary workshop since training to learn about this subject.

If yes, please specify:

---

Yes/No I believe a sexual addiction information and training module would be a useful component of an overall training programme.

Yes/No If a short course on the treatment of sexual addiction were available at the right price, I would consider attending it.

Yes/No I believe that such a course ought to be broader and include information about substance use, process addictions, romantic fantasy, co-addiction and the Internet, as well as, sexual addiction.

General comments and suggestions:

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The definition for 'sexual addiction' is taken from Goodman, A., [1998] **Sexual Addiction: An Integrated Approach**, International Universities Press, Inc., Madison, Connecticut and the 'behavioural types' from Carnes, P., [1991] **Don't Call It Love, Recovery from Sexual Addiction**, Bantam Books, New York

## Psychotherapy Training and the Treatment of Sexual Addiction

### Collation of Information

29 replies out of 100

---

#### Professional Demographics

##### Age

20 – 29	1
30 – 39	2
40 – 49	7
50 – 59	9
60 – 69	9

##### Gender

Men	8
Women	21

##### Geographical Distribution

London	9
Home Counties	5
SE	1
SW	4
NW	2
NE	3
Midlands	3
Blank	1
Unable to tell	1

##### Years of Psychosexual Practice

In training	1
1 – 5	6
6 – 10	8
11 – 15	9
16 – 20	1
More than 20	4

##### Hours of Practice per Week

1 – 5	12
6 – 10	9
11 – 15	3
More than 15	2
Not given	3

##### How often in clinical practice do you see 'sexual addiction'?

7% Rarely	51% seldom	24% occasionally
7% often	0% very often	0% blank

**How often in clinical practice does it take the following form?**

**Fantasy Sex:** i.e. inordinate amounts of time spent lost in sexual fantasy

7% Rarely	37% seldom	27% occasionally
14% often	3% very often	10% blank

**Seductive Role Sex:** i.e. many relationships at the same time, or one after another

10% Rarely	37% seldom	24% occasionally
21% often	0% very often	0% blank

**Anonymous Sex:** i.e. engaging in sex with anonymous partners

34% Rarely	14% seldom	24% occasionally
14% often	3% very often	10% blank

**Paying for Sex:** i.e. escorts, telephone sex, massage parlours etc.

7% Rarely	27% seldom	44% occasionally
14% often	0% very often	7% blank

**Trading Sex:** i.e. posing for sexually explicit photos or videos, receiving money for sex, etc.

51% rarely	34% seldom	7% occasionally
0% often	0% very often	7% blank

**Voyeuristic Sex:** i.e. using pomography, strip shows, peeping, etc.

10% Rarely	20% seldom	34% occasionally
24% often	3% very often	7% blank

**Exhibitionist Sex:** i.e. exposing; flashing, etc.

41% Rarely	37% seldom	7% occasionally
7% often	0% very often	7% blank

**Intrusive Sex:** i.e. indecent liberties, professional misconduct, inappropriate touch

14% Rarely	27% seldom	10% occasionally
7% often	7% very often	7% blank

**Pain Exchange Sex:** i.e. giving or receiving pain or causing physical harm

24% Rarely	44% seldom	24% occasionally
0% often	0% very often	7% blank

**Object Sex:** i.e. masturbating with objects, bestiality, cross-dressing to add to sexual intensity

10% Rarely	31% seldom	37% occasionally
10% often	0% very often	7% blank

**Sex with Children:** engaging in sex or using child pomography

64% Rarely	14% seldom	10% occasionally
0% often	0% very often	10% blank

**How often in clinical practice do you see people for whom the Internet has become sexually problematic?**

10% Rarely    20% seldom    37% occasionally  
14% often    10% very often    7% blank

**Do you think that this is likely to be an increasing problem?**

Yes            25        85%  
No             1         3%  
Uncertain    1         3%  
Blank         2         7%

**'Sexual Addiction' Training Needs**

I have already had sufficient teaching on the treatment of sexual addiction as part of my training as a therapist.

Yes            3         10%  
No             24        82%  
Uncertain    0         0%  
Blank         2         7%

I have been on a short-term course or supplementary workshop since training to learn about this subject.

Yes            8         27%  
No             20        68%  
Uncertain    0         0%  
Blank         1         3%

I believe a sexual addiction information and training module would be a useful component of an overall training programme.

Yes            28        95%  
No             0         0%  
Uncertain    0         0%  
Blank         1         3%

If a short course on the treatment of sexual addiction were available at the right price, I would consider attending it.

Yes            28        95%  
No             1         3%  
Uncertain    0         0%  
Blank         1         3%

I believe that such a course ought to be broader and include information about substance use, process addictions, romantic fantasy, co-addiction and the Internet, as well as, sexual addiction.

Yes	24	82%
No	2	7%
Uncertain	1	3%
Blank	2	7%

#### Notes

All percentages were rounded up or down to the nearest whole figure.

Of the participants who had already been on short course five of those attended courses run by me in preparation for this course.

Other categories of data from the questionnaire have been omitted. These were in excess of requirement and have no bearing on the rest of the data solicited from the questionnaire.

- i.e.
- Current occupation
  - Year of BASRT Accreditation
  - Length of training
  - Previous occupation
  - The impact of other disciplines on psychosexual practice

The question on 'kind of training' was too vague to generate useful information except to note that 16 out of 29 therapists were trained by Relate.

## Evaluation Form

### Leicester Counselling Centre Sexual Addiction and the Internet

Friday 18<sup>th</sup> / Saturday 19<sup>th</sup> October

#### Analysis and Collated Scores from the 11 participants

	Very poor	poor	okay	good	very good
Was the propose of the course adequately outlined?			1	4	6
Did the course meets its aims and objectives?				2	9
How far did the course keep you interested?				2	9
Was there a useful balance between theory and practice?				6	5
Was the course pitched at an appropriate level for you?			1	3	7
Was the pace appropriate?				3	8
Were the teaching methods varied and appropriate?			1	3	7
What was the standard of presentation?				4	7
Did you have sufficient opportunity to ask questions?				2	9

#### Are there any areas that needed more time?

Fine	1
Tic	1
Blank	2
No	1
More time requested on case history	1
More time requested on cycle of addiction	1
More time requested on shame reduction	2
Comment irrelevant to topic	1
Request for more information from my personal practice	1

**Are there any areas that should have been included?**

No 3  
Tic 1  
Blank 4  
More educational material on behaviours [I presume sexual behaviours] 1  
More about child abuse 1  
Some eastern philosophy [I presume to balance Judaeo-Christian bias] 1

**Was there anything that you did not feel was useful?**

No 5  
Blank 4  
Experiential exercises needed more time for feedback and more explanation 1  
Unhelpful cross-referencing of patterns and cycles 1

**What particularly do you want to put into practice as a result of this training?**

Blank 2  
Cycle of addiction 5  
Thinking about other modalities 1  
Working with shame 1  
Working on spirituality 1  
Useful for all addictive behaviours 1  
More compassion for alcoholics 1

**Do you feel that you now understand 'sexual addiction'?**

Yes very much 2  
Yes 7  
[I have interpreted 'part time' as yes]  
Partly 1  
Reasonably well 1

**Do you feel better equipped to work with this phenomenon when presented in clinical practice?**

Yes very much 3  
Yes 7  
Partly 1

**Has sexual addiction been a topic in any prior training? If so please describe.**

No 11

**What do you think would have improved this workshop?**

OK as it is 4  
Blank 3  
More legible writing on flip chart 1  
More time 1  
More information on how to work with clients in a person centred or psychodynamic way 1  
More discussion 1



### **Additional Comments and Suggestions**

- Blank 3
- Thank you. I am for {unreadable}.
- I really enjoyed participating in the workshop and found your style and delivery easy to follow and learn from, thanks.
- Given the connections between computer technology and sexual addiction, I experienced this course as being at the cutting edge of understanding the work with clients and its implications for the future.
- A very worthwhile two days, including pre-reading material and video.
- I found the work on narcissistic personality/shame/guilt particularly helpful. It was wonderful to meet such an inspiring person who cares about people and wishes to share what he knows. Thank you.
- The two days felt so rich—both in terms of the programme content but also the 'pearls of wisdom' that you dropped in through out. Real depth behind it all. Good use of self. Wish you could reach a wider audience. Created safety for personal exploration in exercises.
- Very charismatic presentation. I really valued his sharing his own personal experiences. Interesting and well thought out / well timed workshops. I would be interested to attend future workshop / training with this presenter.
- Good pace, Loads of useful information, energising and enabling, good handouts, including book list!

The evaluation form itself was based on a questionnaire published to evaluate a conference that was organised by the Lucy Faithfull Foundation in the spring of 2001, lead by Tony Ward on new approaches to the treatment of sexual offenders. This foundation is a specialist training-organisation and it seemed to me that this appropriately amended provides an economic and comprehensive evaluative overview.

## **Appendix D**

### **Contents:**

### **Speaking Engagements 2000 - 2004**

## **Speaking Engagements 2001 - 2004**

North West Psychosexual Training Group Training Day, Manchester, July 2004, 'Understanding and Working with Sexual Addiction and Compulsivity'

Confer, January 2004, Tavistock Clinic, London, Lecture, 'Cure of Souls', an exploration into love and psychotherapy

Churches Ministerial Counselling Service, October and November 2003, February and March 2004, Four One-Day Regional Conferences, Taunton, York, Manchester, and London, Facilitation on the Theme 'Abuse of Power in the Church'.

Southwest Theological Training Scheme, Sarum College, Salisbury, November 2003, Seminar, 'Ethics and Non-abusive Ministry'

The Adlerian Society, Conway Hall, London, October 2003, 'Treatment Priorities in a Psychotherapeutic Response to Sexual Addiction with Particular Reference to the Internet'

British Association for Supervision, Psychotherapy and Research, Annual Conference on Supervision, July 2003, Workshop, 'Women, Sexual Addiction and the Internet'

London Marriage Guidance Council, Tottenham Court Road, May 2003, Day Workshop, Sexual Addiction Treatment and Training

Confer, Community Arts, Islington, November, 2002, Lecture, 'Shame and Sexuality'

The Adlerian Society, St Hilda's College, Oxford, September 2002, Lecture 'From Shame to Grace... Continuing the Journey'

British Association for Supervision, Practice, and Research, Annual Conference on Supervision, Workshop, July 2002, 'Men, Religion and Sexual Offending'

UKCP Inaugural Research Conference, University of Surrey, May 2002, Research Paper, 'Researching Sensitive and Distressing Subjects'

British Association for Sexual and Relationship Therapy, Annual Conference, May 2002, Paper: 'Sexual Addiction and the Internet'

Bridge Counselling Service, Basilidon, Saturday Workshop for Counsellors April 2002 'Religious Behaviour. Dysfunctional and Dystonic'

Confer, Tavistock Clinic, London, Master Class in Supervision, February 2002 Presentation of Case Material for Supervision by Dr Joyce McDougall

The Lunar Club, The Sloane Club, Sloane Square, London, February 2002, After Dinner Talk, 'Improving the Quality of Your Relationships'

Adlerian Society, Conway Hall, London, September 2001, Lecture 'Sexual Addiction: Myth or Reality?'

Relate Trainer Day Workshop, Rugby, May 2001, 'An Atmosphere of Shame, Working with the Consequences of Narcissistic Damage'

Advanced Psychosexual Training, Muswell Hill, May 2001, Workshop, 'An Introduction to Sexual Addiction'

Bridge Counselling, Basilidon, November 2000, Workshop, 'Shame and Behavioural Responses to Narcissistic Damage'

Sheffield University, July, 2000, Workshop, 'Narcissistic Damage—Sexuality and Religious Behaviour'

British Association for Sexual and Relationship Therapy, Annual Conference on Sexual Addiction [Organisation and Principal Address] May 2000

The Lunar Club, The Sloane Club, Sloane Square, London, February 2002,  
After Dinner Talk, 'Improving the Quality of Your Relationships'

Adlerian Society, Conway Hall, London, September 2001, Lecture 'Sexual  
Addiction: Myth or Reality?'

Relate Trainer Day Workshop, Rugby, May 2001, 'An Atmosphere of Shame,  
Working with the Consequences of Narcissistic Damage'

Advanced Psychosexual Training, Muswell Hill, May 2001, Workshop, 'An  
Introduction to Sexual Addiction'

# Appendix E

# **Appendix E**

## **Contents:**

**Questionnaire With Margin Notes**



## Psychotherapy Training and the Treatment of Sexual Addiction

(12)

Thank you for being willing to complete this questionnaire.

This questionnaire has been designed to explore the phenomenon described as sexual addiction and to determine how often and in what ways therapists come across this phenomenon in clinical practice, what training programmes or teaching units have been part of the training history of therapists preparing them to work with this problem, and what training do therapists think would be useful and practical.

For the purposes of this survey sexual addiction is defined as:

A pattern of sexual behaviour—

- Which the client experiences as 'out of control'
- Which the client is not reliably able to stop
- That brings with it real and/or potential harmful consequences

### Professional Demographics

Your professional background

Age 37

Gender Male

Current occupation Nurse + Health Adviser

In what area of the county do you work South West England

Number of years of BASRT accreditation N/A

How many years have you done psychosexual work currently in training

Please describe type of training Relate  
i.e. Relate, University Programme, Medical, other

Approximate duration of training 16 months

Previous occupation or professional background before accreditation (if any)

As above

Approximately how many hours per week do you spend in psychosexual clinical practice? 5

If your practice has been strongly influenced by any other discipline, please note and explain i.e. nursing, social work, ministry

Nursing Psychology

Nursing is my professional background - Specializing in Sexual Health. Psychology<sup>1</sup> provides my academic background.

### Sexual Addiction and Behavioural Types

How often in clinical practice do you see clients with 'sexual addiction'?

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

How often in clinical practice does it take the following form?

**Fantasy Sex:** i.e. inordinate amounts of time spent lost in sexual fantasy

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Seductive Role Sex:** i.e. many relationships at the same time, or one after another

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Anonymous Sex:** i.e. engaging in sex with anonymous partners

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Paying for Sex:** i.e. escorts, telephone sex, massage parlours etc.

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Trading Sex:** i.e. posing for sexually explicit photos or videos, receiving money for sex, etc.

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Voyeuristic Sex:** i.e. using pornography, strip shows, peeping, etc.

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Exhibitionist Sex:** i.e. exposing, flashing, etc.

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Intrusive Sex:** i.e. indecent liberties, professional misconduct, inappropriate touch

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Pain Exchange Sex:** i.e. giving or receiving pain or causing physical harm

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Object Sex:** i.e. masturbating with objects, bestiality, cross-dressing to add to sexual intensity

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

**Sex with Children:** engaging in sex or using child pornography

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

How often in clinical practice do you see people who seem to be sexually addicted to the use of the Internet?

- 1 never
- 2 seldom
- 3 occasionally
- 4 often
- 5 very often

Do you think that this problem is likely to present more frequency?

- Yes
- No / Uncertain

NB: Answers would be very different if questions

### Sexual Addiction Training Needs

Please circle Yes or No to the following five statements:

Yes  No  I have already had sufficient teaching on the treatment of sexual addiction as part of my training as a therapist.

Yes  No  I have been on a short-term course or supplementary workshop since training to learn about this subject.

If yes, please specify:

---

Yes  No  I believe a sexual addiction information and training module would be a useful component of an overall training programme.

Yes  No  If a short course on the treatment of sexual addiction were available at the right price, I would consider attending it.

Yes  No  I believe that such a course ought to be broader and include information about substance use, process addictions, romantic fantasy, co-addiction and the Internet, as well as, sexual addiction.

General comments and suggestions:

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The definition for 'sexual addiction' is taken from Goodman, A., [1998] **Sexual Addiction: An Integrated Approach**, International Universities Press, Inc., Madison, Connecticut and the 'behavioural types' from Cames, P., [1991] **Don't Call It Love, Recovery from Sexual Addiction**, Bantam Books, New York

## **Appendix F**

### **Contents:**

#### **The First Product—**

#### **Narcissistic Damage, Sexual Addiction, and Religious Behaviour**

## **Product 1**

### **Narcissistic Damage, Sexual Addiction and Religious Behaviour**

The purpose of this article is to identify and describe the interconnection between sexual addiction and aspects of religious behaviour as a means of informing psychotherapeutic and psychosexual treatment strategies and facilitating the work of other health professionals. Little has been done in this field and it is important to equip health care professionals with the requisite insights and techniques for dealing with these issues when presented. Obviously, this will be particularly important in the treatment of offenders who combine sexual and religious patterns of behaviour. It should also be useful in the treatment of other clients who present with patterns of sexual behaviour which are perceived as unmanageable and deleterious and where these patterns coexist with significant elements of past or current religiosity. It should also be useful in helping therapists to understand the aetiology and outgoing dynamics of some forms of religious behaviour that are presented in the clinical environment. It can sometimes be difficult to work with clients with strong religious convictions because of the high levels of splitting and the existence of defence systems that are underpinned by moral absolutism and a divinely guaranteed certitude that will not be challenged.

This ambiguity and interconnection can bring with it damaging consequences. On the 5th November 1997, a panel of ecclesiastical judges called for the deposition of the Rev'd Clifford Williams. They accused him of adultery and leading a 'double life' within the Church of Wales and recommended that he be 'removed from the incumbency of his parish, expelled from the office of a cleric, and deposed from Holy Orders' [**The Daily Telegraph**, Thursday, 6th November 1997]. Almost ten years ago Marie Fortune wrote [1994, p116],

'The Roman Catholic Church in the US expects to spend \$1 billion by the year 2000 in settlement of cases of misconduct by the clergy'. According to the **Guardian** [Saturday, 8th November 1997], the Roman Catholic Church in the United Kingdom 'could be forced to pay out millions of pounds to settle more than 250 claims from people who claim to have been abused'. Both of these predictions have culminated with the media controversy that currently surrounds the Cardinal Archbishops of both Boston and Westminster. The implications and consequences of the sex and religion interconnection are often expensive, disturbing, and tragic. History has many examples of the unhappy side of the interconnection between sex and religion.

The format of this article will be to discuss sexual addiction, religious behaviour and narcissistic damage and to explore how these three things are associated and interconnected. The remainder of the article will be given over to understanding the implications of this interconnection for the design of appropriate psychotherapeutic and psychosexual treatment strategies.

### **'Sexual Addiction'**

The term 'sexual addiction' began to be used in the United States and has been slowly seeping into British popular culture largely through the media and in relationship to pop stars and high profile media figures going to specialised addiction treatment centres in the United States. As a term taken up by the media, it does not come from the world of academic or medical sexology, or from the world of therapeutic practice, but rather it has grown out of the experience of ordinary women and men trying to make sense of a self-identified shared experience. In this way, it has been introduced through the

growth and proliferation of the Twelve Step groups. These recovery groups began with the foundation of Alcoholics Anonymous and have grown and diversified, first to include substances other than alcohol, and then behaviours, for example, gambling, compulsive debt and sexual behaviour. The term and the concept of 'sexual addiction' have come from two sources: people in the street and specialists in addiction studies. Addiction studies are a relatively new speciality and are informed by very new discoveries in the chemistry of neuro-transmission. The term 'sexual addiction' has been chosen by recovery group members to describe most accurately their experience of themselves in relation to patterns of self-identified sexual behaviour. The concept has met with some resistance partly because of its perceived American coinage, partly because it has its roots in addiction studies rather than psychosexual therapy or sexual medicine, and partly through defensive misunderstandings that have led to an often ill informed debate between academics, clinicians, and journalists.

The term 'addiction' comes from the Greek and means literally 'to the dictator' [Griffin-Shelley, 1991]. It sums up the sense of slavery that is the subjective experience of the people who present with this order of repeating activity. This term, which seems to be so modern, is actually 'describing ancient behaviour' [Butts, 1992 p128]. In classical Greek philosophical thought, these behaviours tended to be seen as disorders of uncontrolled appetite. Good behaviour demanded moderation [Foucault, 1984]. St. Paul used the language of slavery to describe his experience of his own behaviours in Romans [Romans 7:14-end]. Uncontrollable sexual behaviours had a powerful developmental place in



the life of Augustine [Boulding, 1997]. More than a hundred years ago, Freud described masturbation as the 'primary addiction' and fifty years ago Otto Fenichel used the term 'sexual addiction' [Goodman, 1998]. At about the same time as Freud, the German psychiatrist Krafft-Ebing described phenomenon that he named 'pathological sexuality' [1886, p70],

It permeates all his thoughts and feelings, allowing of no other aims in life, tumultuously, and in a rut-like fashion demanding gratification without granting the possibility of moral and righteous counter-presentations, and resolving itself into an impulsive, insatiable succession of sexual enjoyments. This pathological sexuality is a dreadful scourge for its victim, for he is in constant danger of violating the laws of the state and of morality, of losing his honour, his freedom and even his life.

This seems to be the same phenomenon that is now called 'sexual addiction' by people in addiction recovery programmes and in Twelve Step fellowships for sexual recovery.

Much of this behaviour has historically been subsumed in psychoanalytic theory under the headings of hypersexuality and paraphilias. Sex addiction appeared as a term, briefly as a side reference, in the American Psychiatric Association's **Diagnostic and Statistical Manual for Mental Disorders III Revised** [DSM III R] but was dropped in DSM IV. There is currently a working party seeking to gather empirical data and present the case, with the accumulated evidence of new research, for its inclusion in DSM V [Cames, 1999]. Surely it matters less what it is called than the fact that 'this dreadful scourge' is identified, described, and understood, so that effective treatment strategies can be countenanced and properly put in place.

Patrick Carnes [1991], Aviel Goodman [1998] and Charlotte Kasl [1989] have all done seminal research. All of these books are highly recommended. The first is important for its analysis and survey results, the second for its comprehensiveness and its comparisons with historic psychotherapeutic theory, and the last because of its distinctive focus on women and addiction. Carnes lists what he calls the '10 Signs of Sex Addiction' [1991 p11]. Other specialists working in the field broadly share this outline of symptoms.

- A pattern of 'out of control' behaviour
- Severe consequences due to sexual behaviour
- Inability to stop despite adverse consequences
- Persistent pursuit of destructive or high risk behaviour
- On going desire or effort to limit sexual behaviour
- Sexual obsession and fantasy as a primary coping strategy
- Increasing amounts of sexual experience because the current level of activity is no longer sufficient
- Severe mood changes around sexual activity
- Inordinate amounts of time spent obtaining sex, being sexual or recovering from sexual experience
- Neglect of important social, occupational, or recreational activities because of sexual behaviour

In my experience as a clinician, all of these, or almost all, are usually present in the phenomena. However, some sex addicts reach long periods, or a lifetime, of plateau behaviour at chronic levels of intensity. Some use sexual behaviour within a larger mix of other addictive behaviours. These cases can display a more moderate set of sexual symptoms with the principal deleterious symptoms clustering around other behaviours.

Aviel Goodman's [1998] work is a detailed, painstaking, and convincing examination of the phenomena in relationship to historic psychoanalytic

theory and recent advances in the neurochemistry of addiction. His definition of sexual addiction is summary and definitive [1998, p 8],

These two characteristics of the behavioural pattern, recurrent failure to control the behaviour and continuation despite significant harmful consequences represent the key features of the addictive disorders. A condition in which some form of sexual behaviour is employed in a pattern that fits the definition of an addictive disorder merits the designation *sexual addiction*.

Sexual addiction is not defined by type, object, sexual orientation or social acceptability but [Goodman 1998 p234] 'by the relationship between the behaviour and the person's life'.

Charlotte Kasl's contribution is an important book on this subject, written by a woman for women. Kasl writes that [1989 p15]

Addiction has become a popular term because it gives us a concrete way to describe an experience most of us recognise—an obsessive dependency on people, substances, money, material goods, or situations.

She describes the five basic criteria for addiction in this way [1989 p20],

- Powerlessness to stop at will
- Harmful consequences
- Unmanageability in other areas of life
- Escalation of use
- Withdrawal upon quitting

She goes on to say that addiction, most of all, involves 'powerlessness' and 'unmanageability' [1989 p27]. While these clinicians and researchers have different approaches and emphases, Kasl, Goodman, and Carnes all have overlapping definitions, comprehensive and persuasive arguments, and broadly the same view.

Sometimes the term 'compulsive sexual behaviour' is used, in place of, or along side sexual addiction. This term emphasises that the behaviour is undertaken to relieve painful affect. While this is true, these behaviours contain such powerful positive reinforcements that they are clearly sought in their own right. One recovering self-defined sex addict, whose patterns of behaviour had been highly antisocial, said of his behaviour 'I have never experienced anything so intensely pleasurable, neither before nor since'. However, the concept of 'addiction' contains both senses—behaviour used for the avoidance of painful affect and for the acquisition of the intensely pleasurable at the same time.

### **Let the Addict Speak**

Sexual addiction is not about any one type of behaviour but rather it is 'a syndrome in which some form of sexual behaviour relates to and affects an individual's life in such a manner as to accord with the definition of addiction' [Goodman 1998 p234]. Goodman goes on to say [1998 p235]

Whether a pattern of sexual behaviour qualifies as sexual addiction is determined not by the type of behaviour, its object, its frequency, or its social acceptability, but by the relationship between this behaviour and an individual's life, as indicated in the definition and specified in the diagnostic criteria.

Therefore it is not about homosexual, heterosexual, or solitary behaviours but about how these behaviours are experienced and how they are experienced as impacting on the life of the client. The following examples will help to illustrate this point. Three of these examples are taken directly from the testimony of people who self identify as sex addicts and three are case histories.

### **Anonymous Story**

The principal book of the Twelve Step recovery fellowship, Sex and Love Addicts Anonymous, called by members after AA tradition the 'Big Book', includes a number of personal histories. One addict described his experience in this way [Anonymous 1986 p200],

But going to the strip joints in Boston's Combat Zone, peering in windows, compulsive masturbation, and eventually exhibitionism were not 'cheating' on my wife... I would spend spring and summer nights exhibiting myself, masturbating, drinking, peering in windows, and gradually getting sicker.

Notice, in this and all of these examples, the unmanageability and chaotic nature of the behaviour, how it takes up inordinate amounts of time, interferes with the rest of life, is clearly unsafe and unsatisfying and, in some cases seriously anti-social. It is experienced as relentless and unstoppable.

### **Jenny's Story**

This is Jenny's story [Anonymous 1987 p 205]

I became so compulsive about masturbating that I'd inflict pain upon myself in order to have an orgasm.... I now see that my addiction was actually fed by the shame I felt about my sexual behaviour. .... Over a period of time I had been hospitalised for various 'accidents', but no one ever questioned me about them. Eventually I found that I needed even more physical pain in order to achieve an orgasm, and I resorted to self-flagellation, electric shock, and burning myself while I masturbated.

In reading Jenny's story it is not difficult to understand why Krafft-Ebbing described this kind of behaviour as 'a dreadful scourge'. Of particular note is

Jenny's recognition of cascading shame and the way in which the behaviour needed to be intensified to maintain the effect.

### **Alvin's Story**

From the same collection of autobiographical accounts [Anonymous 1987 p292], Alvin's story brings together the twin issues of sexual addiction and religious behaviour,

Very early in my life, I discovered that there were two ways I could successfully avoid reality: perfectionism and sexual preoccupation.... My addiction intensified after ordination. I had a position that commanded respect and trust; my addict proceeded to use that respect and trust in a number of seductive, manipulative, and abusive ways.

In my experience, this combination of perfectionism and sexual addiction is not uncommon in ministerial vocation and brings with it vulnerability to sexual misconduct.

Having drawn from the testimonies of addicts in recovery, I turn to a number of illustrative examples of this phenomenon from my own clinical experience. These are representative and composite descriptions rather than actual case histories. I have changed names and other content to hide identities.

### **Clinical case: Sam**

Some years ago I saw a young man who was out on bail and awaiting trial for sexual abuse of a number of boys on a junior football team. While he was waiting for trial over many months, he was still driving around in his car, cruising playgrounds, looking for opportunities to exposing himself to

youngsters in an attempt to create sexual involvement. This clearly fits the classic criteria of an addiction: 'recurrent failure to control' and 'in the face of harmful consequences'. This young man came from a professional family, was highly intelligent, an engineer and exceptionally well educated. He was eventually sent to prison. The outcome of this version of the 'dreadful scourge' was vast amounts of misery for the youngsters who were abused, their families, this young man's family and the young man himself.

#### **Clinical Case: Liam**

Liam was a middle-aged married man with three children who was in a recovery programme for drug addiction. The 'acting out' patterns, at their worse, involved anonymous unprotected receptive oral sex in public places with sometimes many men in one evening. The major issue behind the other issues was, in his words, 'I am addicted to sex that degrades'. Here, were powerlessness and unmanageability. Given the profoundly grave nature of this man's behaviour for his health and the other dangers involved, the word addiction seems, to me, to be the only adequate term to describe the 'locked in' repetitive character of his behaviour. He was also in despair, in constant suicidal ideation, and overwhelmed by shame. The phenomenon that he experienced was neither intimate nor fun but rather raging and relentless.

#### **Clinical Case: Roger**

Roger was a middle-aged electrician whose sexual patterns outside of marriage involved the use of prostitutes. He was a man of a great and sincerely held fundamentalist religious conviction. His behavioural patterns

were highly ritualised but often culminated with receiving oral sex or masturbation. In spite of this man's religious faith and conversion experience, in spite of the danger and in spite of financial embarrassment, the behaviour continued. He said that 'When I am in my religious behaviour it is though nothing else in the world exists or matters and when I am in my sexual behaviour it is though nothing else in the world exists or matters'. I began to quote this to another man with a similar combination of sexual and religious behaviours and before I was halfway through he was able to complete the quote. This points to, not only the power, but to the similarity of the process. Sexual behaviour and ecstatic worship, behaviourally and chemically, can sometimes create a tunnel of exclusion and, for that moment, nothing else exists.

### **Setting up the Patterns**

Adult sexual patterns are based on a template emerging from family of origin experience and the distinct experience of an individual within the family of origin. It is like a collage of patterns laid down consciously and unconsciously over time. It is, in Kohut's words [Firman and Gila, 1997, p125], a 'telescoping of genetically analogous material'. The patterns of sexual addiction, seem to me, to be a combination of learned behaviours and random incidents. Stern [1998] describes this process as a process of aggregation and distillation. He calls these general schemes Generalised Event Structures and considers them to be the building blocks of cognitive development and autobiographical memory [1998 p97]. Sexual preferences and preferred behaviours are formed



in the same way. Carnes writes that [1999] 'in acting out and in the fantasy is the history embedded'.

Sexual addiction is interfamilial, and intergenerational. Sometimes it ricochets down through generations, alternating, or in combination with religious behaviour, substance abuse, eating disorders or other addiction substitutes or alternatives. These patterns create a tailor-made circuit of arousal and the behaviours are repeated for the avoidance of painful affect and for the intensity of the pleasure. The power is compounded because it is attached to reproductivity. Solitary sexual behaviour is freely available and more accessible than the acquisition of drugs and alcohol. Sexual fantasy is always available and is mostly invisible to others.

### **The Functions and Consequences of Sexual Addiction**

People engage addictively in sexual behaviours to control painful affect, to avoid feelings of loneliness, and to ward off the dread of non-being. In this way it works like a narcotic. Once the addict begins the behaviour he/she is out of pain, and out of reality, for the duration of the episode. From the moment the behaviour kicks in until the cycle is completed [sometimes, but not always by orgasm], there is a sense of oblivion. However bad it is after the behaviour, loneliness, anxiety, and shame are banished for the duration. Sex addiction is driven by the desire and need to merge. The trance-like state reported by sex addicts provides a high level of arousal and relief from painful reality. The behaviour wards off boredom and provides temporary intensity. Many recovering addicts, in hindsight, see the behaviour as having been a

survival tool, a way of dealing with inherited painful affect, that becomes, in its own right, part of the problem rather than the solution.

Sexual addiction has harmful consequences for the individual. The feelings of shame and low self-worth are compounded and exacerbated by the sexual behaviours and create a vicious cycle of self-hatred and contempt. However, the harmful consequences of sexual addiction are often unacknowledged in our society and extend far beyond the individual and his/her immediate circle. For example, as in Julie's story, people are treated everyday in Sexual Health Clinics without health professionals recognising that the disease behind the disease might be sexual addiction. Perhaps much work-place sexual harassment stems from sexual addiction and sexual addiction has a serious, but so far unrecognised, impact on work-place productivity. According to Carnes [1999] by April 1999 the top five paying cyber-sex sites were getting over 19 million hits a month and the free sites 98 million. He reports that 70% of this traffic in the United States of America takes place between 9:00am and 5:00pm. This suggests that sexual addiction has harmful consequences for, not only individuals, but the work place and the wider economy as well. Sexual addiction disturbs family life, affects careers and public office, creates accidents, drives people to suicide, can be associated with crime and anti-social activity and motivates much abuse and contributes to human tragedy.

### **Narcissistic Impairment**

I argue that narcissistic impairment is the core issue behind all forms of addiction. The addictive process produces relief from inadequacy, loneliness,

inner distress, anger, shame, and other painful affects. Laaser [1991 p215] describes sexual addiction as 'used to escape feelings', 'numbing', and used for its 'narcotic like effect' and Kasl [1989 p4], as a way of 'attempting to fill an emptiness' paradoxically 'and getting hungrier and hungrier'.

The experience she describes was confirmed first-hand in the case histories and autobiographical accounts described earlier in this article. She sums up the connection between the symptoms of the behaviour, the causation, and the continuation of the behaviour. In effect, sexual addiction medicates the deep inner feelings of low self-worth, provides windows of intensity and oblivion, and is used to forestall hopelessness and the fear of non-being. The cause is located in narcissistic wounding, in resultant disorders of the self, in the accompanying negative affects, and in an inherent sense of a defective self.

Narcissistic damage arises out of impairments in the mechanism for the formation of the self [Stern 1998]. These are various but include problems and incompleteness in the individuation/separation stage of child development, problematic internalisation of self-regulatory functions, and abnormally high levels of aggression created by the frustration of early needs [Goodman, 1998]. This is reflected not only in personality and life-style but also in internal body chemistry [Pope et al, 1993]. According to Kernberg [1986] there is a need for admiration, a tendency towards grandiosity and / or grandiose fantasies, and at the same time a tendency to feel inferior. Such clients experience boredom, emptiness, and a striving for brilliance or achievement. There is a tendency to lack empathy, to experience chronic

uncertainty, and dissatisfaction with self. Sometimes these clients are exploitative and ruthless. There is often the presence of chronic envy and defences against envy. Much the same list of features and characteristics are outlined by Miller [1987] and can be found throughout psychotherapeutic literature. There is also the formation of a 'true self/ 'false self' split. Firman and Gila [1997 p83] call the second part of this split the 'survival personality'. The psychoanalytic concept of narcissistic impairment is widely held and well-documented [Morrison 1986], its origin increasingly substantiated by new specialist research into child development [Stern, 1998].

The narcissistic personality is 'psychologically vulnerable' to unregulated swings in the central nervous system [Pope et al 1993] and

The patient then turns to a variety of stimulating and numbing activities [and substances] in a desperate attempt to self-regulation.... Such activities, in addition to gambling, would include usage of alcohol, drugs, overeating, excessive sleeping and television watching, jogging and physical exercise, sex, or stimulating and numbing activities.

This gives us an insight into the connection between narcissistic impairment and addiction and, from that, to the connection between narcissistic impairment and sex addiction. The latter is one of a number of possible responses to narcissistic wounding. Sex addiction rarely happens without the presence of other addictions or addiction equivalents [Goodman 1998] as well as, all or part of, the symptoms of narcissistic impairment that are described by Miller, Goodman, Pope, Stern and other writers and researchers. According to Firman and Gila [1997 p2]

...the pain and chaos of human existence may flow largely from this primal wounding to our essential selves. It is this wounded sense of self, this sense of emptiness and isolation, which underlies the violence, addiction, and greed disrupting our lives.

This concept is not unlike the doctrine of 'original sin' and certainly seems to tie in with both the doctrine and the experience of Augustine.

### **Religious Behaviour**

For some people, religious behaviour is a coping strategy to handle the pain and implications of narcissistic impairment. In these cases it will be manifested clinically with addictive patterns and the symptoms and behaviours of narcissism. I therefore expect it to achieve some, if not all, the same purposes of addiction. The literature testifies, explicitly and implicitly, to similar expectations. In the early days of Alcoholics Anonymous, Carl Jung wrote to the founder, Bill W., saying that he thought alcoholism was about the search for union with God [Carnes 1999]. The word 'alcoholism' has at its root the meaning in Arabic 'the desire to be whole' [**Independent of Sunday**, Sunday, 22 November 1998]. Firman and Gila [1997] say that the compulsion to seek 'enlightenment', a unitive state untouched by fragmentation and suffering, is 'the drive that underpins the addictive process as a whole'. Not all, but a very large part of the Christian message, is about the provision of wholeness and the repair of damage that is available to the worshipper through a sincerely meant involvement in the process of surrender and worship. Broucek [1991 p78] writes that 'this shame-glory complex is particularly observable in disorders of narcissism'. He notes that the 'propensity of prominent Christian preachers and evangelists to bring disgrace

upon themselves [usually in connection with some sexual escapade] testifies to the power of this complex'. Griffin-Shelley [1991] emphasises that 'it is not uncommon for sex and love addicts to turn to religion as a solution to their addiction'. In my clinical experience this is true, and it is also true that the two co-exist, religious behaviour and sex addiction, side by side. I believe when this happens they are both responses to narcissistic wounding. Booth [1991, p38] uses the term 'religious addiction' and writes that,

I define religious addiction as using God, a church, or a belief system as an escape from reality in an attempt to find or elevate a sense of self worth or well being. It is using God as a fix.

While I avoid the term 'religious addiction', I am persuaded that, for some people, religious behaviour is an addiction equivalent and that it, like sexual addiction, is driven by narcissistic need.

The principal writers and researchers on the subject of sex addiction stress that we are looking at a combination of behaviours that have [Goodman 1998 p147] 'a common psychobiological process'. Griffin-Shelley [1991 p31] writes,

As we become more familiar with addictive disorders, we are better able to see the similarities between drug addicts and alcoholics, heroin addicts and smokers, sex and love addicts and food addicts, over workers and over religious.

Milkman and Harvey [1987] follow the same idea,

... a rush of anger or of joy, a perceived flooding of light, an accelerating sequence of thoughts, an unmeasurable wave of feeling evoked by music, and a shot for narcotics can all feel like rushes. They all share similar envelopes of neural firings, although in different parts of the nervous system.

Many researchers have long observed similarities among different kinds of addicts [Jacobs, 1997] and have often alluded to religious behaviour as behaviour with similar characteristics. We seem to become addicted, not to drugs or mood altering behaviours, but to the experiences that can be achieved through them.

Religious behaviour provides an antidote to the symptoms of narcissistic wounding. Emptiness, loneliness, and the need to be 'special' are all answered in religious belief and behaviour. Booth [1991 p39] claims that,

Religious addiction, like alcoholism, springs from a reservoir of low self-esteem, a sense of inadequacy, shame, guilt, and the desire to escape, fix, or numb these feelings

Like drugs and other processes, religious activity can be used for the regulation of painful affect and the acquisition of the affects of pleasure.

Drugs and religion are both about merger experiences and this is particularly true of the connection between ecstatic worship in which the experience of oneness with God is both accepted and sought. The grandiose false self that is generated by impairment has plenty of material to feed it within the Christian framework. 'Holy nation, royal priesthood, a chosen people' are a few images that come to mind from the Biblical material that are used by believers to describe themselves in relation to the wider community. These combine together, or in sequence, with language and imagery applied to the self, which is an imagery of humiliation and victim-hood—'unworthy', 'a worm and no man', 'miserable sinners' are a few more that come to mind from the Bible and the Book of Common Prayer. All of the features that Kernberg

[1986] describes as characteristic of narcissistic personality structures can be seen in the lives and behaviours of some believers and religious officials. These characteristics and their accompanying painful affects fit hand in glove into the activity and imagery of worship. While the activity soothes the affect, the imagery expresses, makes sense, and reverses the experience of woundedness.

There is another connection to describe before considering the implications of this for the treatment of clients; the 'figure eight' cycle of addiction. Addictive cycles have two interconnected sequences. This is described by John Bradshaw [1988 p16] and is labelled the 'Compulsive Addictive Cycle'. Bradshaw describes two contrasting sequences of behaviour. One is a cycle of 'acting out'; that is, the excess usage part of the cycle. The other is 'acting in', the anorexic part of the cycle, that is, the avoidance of usage. People are most familiar with this cycle as it applies to eating disorders that have a binge component and an abstinence component—the anorexic and the bulimic sides of the cycle. Fossum and Mason [1986] describe this cycle as a control / release cycle. They take the view that it is systemic and they note that sometimes in families one member will take the control function and another the release function. I have often seen this cycle in my own clinical experience and have seen it split between sexual addiction and religious behaviour. Griffin-Shelley [1991 p67] noted that 'It is fairly common for sex and love addicts to embrace religion as a solution to their addiction'. Carnes writing up the case history of an Orthodox Jew said [1991 p16] 'Ironically as his involvement in religion intensified, so did his sexual addiction and alcoholism'.



In other words, when the acting out, or indulgence side of the cycle, reaches satiation, the religious side kicks in supporting and motivating abstinence. Normally, after a time, a sense of need or entitlement sets in and the process is repeated. Sex then represents the binge side and religion the anorexic side of this 'figure eight' behaviour.

From clinical practice and professional experience, I share Lasser's view [1991] that many addicts become religious addicts but I would add observations on aetiology. For some people, religious behaviour and sexual behaviour are connected; in that they are both responses to narcissistic impairment. This is the key to understanding much professional misconduct and the combined appearance in clients of religious and sexual behaviours that seem to alternate, or are perceived to be in conflict, but are held at the same time. The conjunction of these two patterns, explain splitting, create high levels of shame and requirements for secrecy, all of which fuel the processes of painful affect, low self-esteem, and self-contempt.

### **Implications for Clinical Treatment**

Jenny wrote [Anonymous 1987 p206] that when she finally saw a therapist that he 'jumped up from his chair, screamed at me that I was lying, and ordered me out of his office'. I do not think I have ever met a therapist who would 'jump up out of his chair and scream' but I have met therapists working in this field with little or no awareness of the issues and without an informed approach to treatment. An understanding of the aetiology is fundamental to an adequate approach to the treatment of any disorder. The well-informed and

adequately trained therapist will be able to identify and respond to the presence of addiction in the life of a client. This is obviously true of substance abuse and eating disorders and very few therapists would try to work with such a client without addressing these issues. Because for some people sexual behaviour is part of an addictive system, and for them sex and religion cohere, it is important for therapists to be aware of this and be able to respond appropriately.

In all cases of narcissistic impairment there will be behaviours adopted to relieve pain, protect the self, and sustain the false or 'survival self'. Working with the client to identify the coping and survival strategy, especially where the survival strategy has become part of the problem, is the first stage. Some people will focus on one, or two, or a set of behaviours i.e. food and religion, sex and cocaine, alcohol and work, and the combinations will work alternatively and in tandem. Clients will move between satiation, arousal and fantasy [Goodman 1998]. It is essential for effective therapy to identify and understand these patterns and the way they operate in the client's life. Eventually the goal will be to work to allow the client to understand his/her own patterns of behaviour. Where there is narcissistic wounding, expect to find addiction, or addiction equivalents, and where there is addiction, expect to find the possibility that the client's sexuality and/or religious affiliation has been pulled into the process. Care should be given to recognising that these are inter-generational and family of origin behaviours, repeating or reappearing in a new form, in the life of the client.

The history-taking also needs to be done with this in mind. Very great care needs to be taken with the detail and according to Carnes [1999] the therapist needs to know the addiction story, the addiction history, the abuse history, the arousal templates and a very complete sexual history. 'Always assume the tip of the iceberg' [Griffin-Shelley, 1999] in working with addicts. This process is rarely easy with these clients unless they have reached rock bottom. According to Mollon [1993 p131] 'Psychoanalytic therapy is greatly feared by such people because it threatens to destroy the illusion on which they have based the false self'. The greatest sensitivity and a sense of appropriate timing need to be used.

Because our culture promotes certain patterns of sexual behaviour, sexually addictive behaviours may be seen as 'normal'. Kasl [1989 p227] describes it like this

When a man says 'I think I have a problem because I am sleeping with too many women, his buddies rib him and say 'Hey, I wish I had that problem'

Many therapists might dismiss pornography or the use of prostitutes as normal male behaviour. However it is essential to critically evaluate this behaviour with the client to determine its role and function for the client. Booth writes [1991 p235] that the key to treating religious addiction is 'to learn to connect the symptoms with the core issues that are common to most addictions and then using the various therapeutic techniques for addressing those issues'. While this is the key to treating all addictions, it seems to stand out because we have not much thought of sex or religious behaviour in this way.

At some point, group work is a key part of the treatment plan. Effective treatment involves a combination of individual therapy, extensive group work, an on-going involvement in group work or Twelve Step meetings, and if possible family and couple work. The problem in the United Kingdom, at this time, is that these issues are rarely understood or addressed in drug and alcohol rehabilitation programmes. There are few places where a tailor-made treatment plan can be designed and implemented. Sexual recovery fellowships, while expanding, are not widely known and are seldom available outside big cities. Individual therapy, on its own, is rarely sufficient, but is extremely important in the overall process. A number of drug and alcohol treatment facilities in the United Kingdom advertise that they handle sexual addiction but often this is not something they are geared up to do. I am not aware of any facility in this country that has highlighted the correlation between religious behaviour and addiction. In the United States specialist programmes have been designed and are being implemented to treat religious professionals. These programmes are often located in larger and more general treatment facilities and would tend to link the treatment of all addictive behaviours together and handle them generically.

In the case of a client whose sexual addiction is manifested in highly harmful behaviours, pharmacotherapy might well be the necessary first step. It might be used to hold the client in a non-harming pattern until other interventions can take effect. Cognitive behavioural techniques can be brought into play throughout the treatment. The main goal is to help the client arrest or modify

the behaviour, gain awareness of his/her acting out patterns, what triggers them, where and when they reach the point of no return, and how to set up and choose alternative behaviours. At an early stage it is useful for the therapist to work with the client to create a 'sex plan'. This is a self-defined written analysis of which behaviours the client would regard as acceptable, out of bounds, or in between. This knowledge brings proportion and manageability to the recovery process. Other techniques are useful: helping the client to identify possible alternative behaviours to an addictive episode, writing up a 'list of harmful consequences', or writing in a journal to analyse and externalise shame and painful feelings. More specifically psychotherapeutic techniques would be shame reduction, work with trauma and childhood abuse, and the challenging of built-in negative self-assumptions [Anonymous, Undated]. Because the addictive process is fuelled by low self-esteem, and by the presence of shame, the strategy must include the building of self-esteem. Shame reduction is aided by the 'telling of the story' and the treatment process shares many of the characteristics of the treatment of the victims of trauma. One of the quickest ways for the client to start to build self-esteem is to stop the addictive behaviour. Fossom and Mason [1986 p50] call this 'the first sign of hope'.

Some of the work is psycho-educational and the creation of cognitive awareness about the history and function of the addiction in the life of the addict. Goodman writes [1998 p287]

First of all, having words to describe inner states and processes gives the conscious mind a handle, a more ready means by which to apprehend inner realities. Second, being able to name one's affects and sense of self provides perspective: the part of the mind that names, in so doing, steps back from the part that feels. The individual's emotional states and self states thus no longer occupy the totality of his or her psychic space and he or she is much less likely to be overwhelmed by them

This applies not just to the treatment of addicts but to the treatment of all clients, whatever the issue.

It is important to recognise that in working with addicts that it is possible to switch behaviours; that is to give up one and substitute another addictive behaviour. This may be entirely desirable in that giving up alcohol and taking up religion might be preferable to continuing with the first. However, what happens in this process may not be a cure but a switch from one substance or behaviour that is used addictively to another. Unless the core issue is resolved, and the original wounding dealt with, as one addiction comes under control another one emerges. Many of the accompanying symptoms travel with the change and the person continues in all the familiar symptoms of narcissistic damage described earlier in this article.

A word about the treatment of the clergy, because this is a category of people who have heavy and serious responsibilities in our society. Laaser writes [1991] that ' My main theme is that one of the possible reasons that clergy misconduct occurs is because of sexual addiction'. One of the key issues here is the connection between sexual addiction and religious behaviour and the roots of both in narcissistic wounding.

## **Conclusion**

The purpose of this article has been to examine the links between addiction, sexual addiction, and religious behaviour and to consider some of the implications of any possible link for intervention and treatment. The process has been to examine addiction and sexual addiction and to recognise their origins in narcissistic wounding and then to look at narcissistic wounding in relationship to religious behaviour. Finally, I have tried to provide useful clinical and treatment insights for psychotherapists and psychosexual therapists. Peter Rutter, psychiatrist, ethicist, and Jungian analyst [1989 p61] writes

I believe the search to heal a wounded sense of self is what underlies most destructive sexual behaviour in men.

The woundedness of men and women sometimes seeks its healing in sexual activity, sometimes in religious experience, and sometimes in both. Addictive sexuality and religious behaviour are always about the same thing: the avoidance of non-being and the escape from the pain of the primal wound.

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## **Appendix G**

### **Contents:**

**The Second Product—**

**Chapter 9 in Time for Action**

**Product 2**

**Time for Action**

**Chapter on Causation**

On the 5<sup>th</sup> November 1997, a panel of ecclesiastical judges called for the deposition of the Rev'd Clifford Williams. They accused him of adultery and leading a 'double life' within the Church of Wales and recommended that he be 'removed from the incumbency of his parish, expelled from the office of a cleric, and deposed from Holy Orders' [The Daily Telegraph, Thursday 6<sup>th</sup> November, 1997].

Increasingly, sexual abuse in the church has become an issue of public concern. This is a phenomenon set in society and since the church is set in society, this phenomenon is set within the church. The secular conceptual frameworks that have evolved over the past twenty years to help us understand sexual abuse [Wolf, 1984, Finkelhor, 1984, Marshall and Barbarbee, 1990, Hall and Hirschman, 1991], among others, and the current theory knitting work of Tony Ward and Richard Siegart [2002], all contribute to our understanding of the problem of sexual abuse in the church.

This chapter will solely seek to understand sexual abuse in the church. It will look specifically at the prevalence of sexual abuse in the church, initiate an exploration into the complex question of causation, review cycles of offending, and conclude with recommendations for treatment and prevention drawn from an understanding of causation. Joe Sullivan, Principal Therapist at the Lucy Faithfull Foundation has written in Notanews [2002, p17] that, 'It is impossible to effectively intervene in a process that you do not understand'. This chapter is about understanding.

There is evidence that there are higher levels of sexually abusive behaviour in the church, and by religious professionals, than in other comparable caring professions. This was first suggested in research done by the editors of **Leadership** [1988], a professional magazine for American clergy and, separately, at about the same time, by the Rev'd Marie Fortune [1989], founder of the Centre for the Study of Sexual and Domestic Violence in Seattle, Washington. Richard Sipe, writing as a Roman Catholic in **Sex, Priests and Power** [1995], took much the same view as Fortune and the editors of **Leadership**. Other reports have come in. For example, about the United Church of Canada [Grenze and Bell 1995, p240], research has suggested that clergy are 'exploiting their parishioners at twice the rate of secular therapists'. According to the most up to date research [Francis and Baldo 1998 p2], they estimate that approximately 37% of the current American clergy are involved in some form of sexual misconduct. Even though there has been little research in this country, a comparable result has been reported from work done on the Church of England [Birchard, 2000].

Additionally, our working party was concerned to hear from the Director of the Wolvercote Clinic, a treatment centre for sexual offenders, now closed, albeit as anecdotal evidence, that 25% of the men in residence for offences against children, saw themselves as committed Christians. Fortune in a paper delivered to the American Academy of Religion in 1992 and published in the **Journal of Feminist Studies** [1994, p26] said of such abuse by clergy, other church leaders and religious professionals, that 'a secret long hidden has been disclosed'.

This chapter focuses solely on the subject of causation. What is going on to make this happen at twice the rate of secular helping professionals? Why is this going on at all? What would our knowledge of causation suggest about treatment and prevention?

Causation is usually attributed to one or more of the following six factors:

- Human Condition
- Societal Influence
- Predatory Persons
- Psychological Vulnerability
- Risks in the Role
- Institutional Failure

The last three of these have been identified by the clergy of the Church of England as relevant to understanding sexual abuse in the church [Birchard, 2000] and therefore more attention has been paid, in the rest of the chapter, to the implications of this part of the research data.

### **Human Condition**

This is the view that attributes sexual abuse in the church to our fallen nature, the universal condition summed up in Romans 3:23 that 'All have sinned'. Our working party, made up as it was, of church members and church leaders, recognised throughout the work, the reality and the universal nature of sin.

This is considered in the section on theology. Our concern here is to understand the sociological and psychological functions and dysfunctions that are the substance of the sin and the outworking of our fallen human nature

### **Societal Factors**

The sexual behaviour of church leaders and church members takes place within the sociological context of the mores and practices of the wider society. It cannot but help to reflect, in part, even in very exclusive churches, the prevailing attitudes of the times and of the cultural context. This is particularly true of churches made up mostly of 'second generation' rather than directly converted Christians.

In a post-modern society, sexual behaviour becomes a matter of choice. In our view there exists in our society a powerful and prevailing message that sexual activity is to be much sought after, a matter of individual choice and personal entitlement and necessary to personal fulfilment. Changing attitudes to sexuality, the economic emancipation of women and the women's movement, marriage and divorce, contraception, lesbian and gay equality, the Internet, the media and our capacity to travel to places of anonymity all have an impact on attitudes and sexual practices within and without the church.

Sexual behaviour within the church is not unaffected by such factors and takes place in the wider context of the values and characteristics of society in which the church finds itself. However much we might wish for sexual behaviours to reflect our view of Christian values we recognise that even our

view of Christian values is harnessed to our culture and the values of the wider society.

### **Predatory Persons**

In our research we have come across the idea that the responsibility for sexual abuse can sometimes be assigned to the person, usually the woman, who has been abused. Within Christian culture this has been to blame Adam's fall on Eve, and thus on the tempting and seductive nature of the other person. We recognize that in our society there has been a view that sexual license is in the allowable nature of men and therefore it is the woman's responsibility to refrain from sexual behaviour. This view has been persistently challenged by women's movement and has little place in informed discussion, nevertheless we note it because, in places, this view remains. The effect of such a view is to make the person abused responsible for the abuse and to allow others, usually men, to abrogate responsibility. It cannot be over emphasised that this is a gender issue. Sexual abuse is something done, primarily by men, to women and children.

### **Psychological Vulnerability**

Clearly, church-leaders are not exempt the problems, difficulties, and weaknesses that are part of the human condition. They bring to ministry the reality of their sexuality and the reality of the certainties and the uncertainties, the clarities and the confusions that exist for all of us in the outworking of the vicissitudes and victories of life. From our interviews and from a review of the relevant literature, there seem to be five particularly relevant factors within the



personality and personal history of some church leaders and members pertinent to the issue of sexual abuse: sexual shame, sexual confusion, developmental uncertainties, narcissistic damage and addictive compulsive behaviours, including sexual addiction.

Narcissistic damage is probably the most crucial concept to understanding the relationship between sexual misconduct and religious behaviour and therefore this term needs to be defined and explained in greater detail. The term 'narcissistic damage' is the term used here to describe 'damage' to the construction and functioning of the self. It is the 'self experienced painfully', as 'less than' and, 'as in danger of fragmentation'. This experience is true for all of us, but some people experience this unbearably, and some people adopt highly dysfunctional patterns of behaviour to medicate, regulate and conceal these distressed inner states. A detailed and substantiating analysis of the physiology of the self can be found in Daniel Stern's book **The Interpersonal World of the Infant** [1998].

Shame is a primary human emotion and the principal by-product of narcissistic damage [Lewis, 1987]. It can best be described as a profound sense of somehow being intrinsically flawed and, at the same time, a sense that, if others were to know the reality of the self, there would be fearful consequences. Shame has the capacity to derail both cognition and coordination [Nathanson, 1987]. Sexual shame is a feeling that sexuality in general, and our own sexuality in particular, is an intrinsically bad thing. High levels of sexual shame generate fear, a need to hide, discomfort with sexual

information or behaviour, a need for secrecy, and an unconscious need to split off inner realities from outward appearances. Since the clergy and other church leaders are sexual beings as a condition of their humanity, they are caught in a trap: experiencing sexual desire and sexual need, and at the same time, experiencing shame and distress at the presence of these natural processes. The catch-22 of this predicament is that such shame can seek comfort in religion and, at the same time, can drive addictive compulsive behaviours. Among behavioural outcomes, there can emerge a whole range of problems, including a distinctive pattern of sexual abuse that is rooted in sexual addiction [Cames, 1991, Earle and Crow, 1989, Fossum and Masson, 1986].

In interviews with those who have abused others, it became clear that there was also a great deal of sexual confusion [Birchard, 2002]. This manifested itself in a variety of ways: uncertainty about sexual functioning, sexual problems inside marriage, sexual anorexia, problems of courtship and relationship building, problems of accepting orientation and/or the implications of orientation for a responsible and ordered ministry. Although it is clear that most sexual abuse in the church is committed by adult heterosexual men against adult heterosexual women [Fortune, 1994 p19], nevertheless in the in-depth interviews, uncertainty and anxiety about sexuality was a distinguishing feature. Confusion and uncertainty adds to inner distress and, in our view, contributes to the propensity to abuse. It is the shame and the confusion that leads to vulnerability and not issues of orientation. Sexual preference is not the problem; the problem is an outcome of institutional confusion, double

standard, and sexual shame. The high levels of homophobia in parts of the church, especially in those who would see, or present, themselves as heterosexual, evidences high levels of covert or repressed homosexual interest in these same people [Adams, Wright, and Lohr 1996] and, with that, more double standards and further shame, confusion, and inner turmoil.

It is clear from an analysis of a series of interviews undertaken with clergy sexual offenders [Birchard, 2002], that, at least among older Roman Catholic priests, many of these men have an arrested psychosexual development and have entered ministry with very little sexual experience, little experience or capacity for relationships with either women or men. They bring, therefore, to adult church leadership a serious sexual and relationship immaturity. Sexual desire is not eliminated by a commitment to ministry. In one researcher's view [Birchard, 2002] the expectations of celibacy and the nature of ministry, unfortunately, keep such men arrested, under-developed, secretive and vulnerable to committing sexually abusive behaviours. It also seems that there is, quite commonly, a pattern of systemic or inter-generational abuse, in that, those who abuse were, in fact, in some way, also abused. This is frequently, but not always, the case.

Sexual addiction is a concept that can help to explain some of the phenomena of sexual abuse that takes place both inside and outside the church. Sexual addiction is defined as a pattern of sexual behaviour which is distinctive in that it cannot be reliably controlled and which brings with it harmful consequences [Goodman, 1998]. It is characterised [Cames, 1991] as a 'survival strategy'

that is out of control, high risk, mood altering and inordinately time consuming. There is often a desire to stop, or limit the behaviour, along side a seeming inability to stop [Cames, 1991]. Addictions are embedded patterns of behaviour, involving substances or processes that emerge to medicate the feelings of narcissistic damage, especially feelings of shame, stress, loneliness and worthlessness. The idea of 'slavery' inherent in the notion of addiction is not without theological resonance, particularly in Paul, and later and more clearly apposite for our work, in Augustine. It is important to note that not all sexual addiction is abusive but rather that some abusive behaviours may be attached to patterns of sexual addiction.

All addictions, sexual addiction included, seem to emerge from narcissistic damage [Goodman, 1998]. This is a 'family of origin' experience normally associated with impaired parenting, and with disturbed attachment [Stem, 1998] that brings with it a characteristic set of symptoms, these include, among others, loneliness, low self esteem, boundary ambiguity, grandiosity, boredom, chronic envy, and the need for admiration [Kernberg, 1986, p246]. Roles are taken to mask the inner sense of self and behaviours are adopted to medicate the inner sense of discomfort and neediness that accompanies narcissistic damage. The Church of England clergy who were consulted about causation [Birchard 2000] located sexual misconduct primarily in this symptomology: the neediness, loneliness, and experienced stress of the clergy. Later in-depth interviews carried out with clergy sexual abusers seemed to confirm this same combination of factors in the causation of sexual abuse.

A number of writers have alluded to the relationship between narcissistic damage and the exercise of ministry [Benyei, 1998, Brocke and Lukens, 1989, Hands, 1992, Muse 1992, Steinke, 1989]. Recent research at the University of Northern Colorado supports this view but also notes that high levels of narcissism characterise abusing and non-abusing clergy [Francis and Baldo, 1998]. What seems to have gone largely un-noticed is the fact that religious behaviour and sexual behaviour can both be used to medicate the pain and distress of narcissistic wounding [Booth, 1991]. William James in **Varieties of Religious of Experience** [1902], using different language, authoritatively suggests such a process. More or less how this works can be explained by an exploration of the cycles of offending and/or the cycles of addiction considered later in this chapter.

It seems that some people with high levels of narcissistic damage utilise religious behaviour and other behaviours, including sexual behaviour, to mask and medicate the pain and shame of such damage. It is this combination, taken together or working alternatively, that helps to explain the incongruity of the high levels of sexually abusive behaviour within the church. Such people, who are often high performers and very capable in every way, then occupy roles that render them vulnerable to sexually abusing others. They are then given no proper support or supervision and no awareness training or, for that matter, any other training in relationships, sexuality or human development.

## **Risks in the Role**

Sexual abuse in the church has its origins and causation not only in the psychology of the individual but also in the power, nature and construction of ministry. The pastoral role is normally accorded high levels of moral authority but, also as it is practiced, brings with it stress and boundary ambiguity.

The exercise of ministry is fraught with dual roles, boundary overlaps, and indistinct demarcations. The same person can ask you for money, join you for dinner, sit with you in grief, take your children swimming, lead you in worship and join you for coffee when you are home alone. The boundaries are blurred between the ministerial office and personal friendship, between the house as personal space or as a tool of ministry, between the conversation at the pub as recreation or as evangelism.

The Oxford Diocese handbook **The Greatness of the Trust** [1996, p5] emphasises this point,

The greatest dangers are the failure to recognize proper boundaries and a misunderstanding of the nature of pastoral relationships.

In a clergy focus group on this subject conducted in 1999 there was considerable and inconclusive discussion on the indistinguishable boundaries between professional and non-professional relationships [Birchard, 1999 p65]. The problems of blurred boundaries was emphasised as not a 'grey area' but with even greater complexity, 'varying shades of grey'. This is described ethically and professionally in the following [Gonsiorek, 1995 p154],

Clergy roles are inherently more complex and fraught with boundary strains...Health care professionals generally have much more circumscribed roles. In fact, some health care professions, such as psychology, consider such a complex role to be inherently unethical, because of dual relationships. In effect...the extraordinary diversity of roles that clergy routinely play are simply impossible to manage appropriately, because of boundary strains.

The maintenance and occupation of multiple roles in ministry has a long tradition and other options are probably not viable but, nevertheless, it is important to realize that this, significantly, contributes to the susceptibility of church leaders and clergy to breaches of trust [Birchard, 2000]. This is sympathetically recognized in *Sex in the Parish* [Lebacqz and Barton, 1991, p45],

The loneliness of the clergy, the close relationships they enter, the fact that they have intimate access to people's homes and bedrooms, the privacy and isolation of their own office settings—all these factors can be conducive to sexual desire and can contribute to the temptation to act on that desire.

The possibility, and indeed probability, of sexual abuse in the church is clearly connected, in part, to the boundary blurring role ambiguity associated with traditional manifestations of Christian ministry.

In research with clergy of the Church of England almost all of the clergy interviewed or polled took the view that the vulnerability of the clergy to sexual misconduct is connected to the levels of stress associated with ministerial office. Andrew Irvine [1997] writing on clergy stress emphasises two important points: first of all the high level of stress and secondly the source of stress in confusion, secrecy, role ambiguity, and the conflict between the demands of

individual authenticity and the requirements of public office. Additionally, church leaders experience isolation and the often the absence of solicitous support. Where can these people honestly take problematic issues of sexuality? All the Roman Catholic clergy interviewed stressed this point without exception [Birchard, 2002]. As the issues move into the arena of sexuality and the margins of misconduct, the stress is increased and the potential for misconduct increases in tandem.

It is important for us to understand that the aetiology of sexual abuse in the church is associated not only with the individual psychology and vulnerability of the abuser to perpetrating acts of abuse but that there are serious contributing components inherent in the expectations of day-to-day ministry. None of this is written to excuse but rather to explain and clarify.

### **Institutional Failure**

In addition to role of theological concepts and traditions of belief examined in the section on theology that provide a conducive context for sexual abuse there are a number of ecclesiological factors that seem to directly contribute to the aetiology of sexual abuse in the church.

In a letter to the Editor about the Clifford William's affair [**The Guardian**, 27<sup>th</sup> October 1997] Margaret Kennedy of the Minister and Clergy Sexual Abuse Survivors Group called for the church to have 'policies to challenge similar and abusive predatory behaviour'. In research done with Church of England clergy on this subject, Birchard [1999, p87] took the view that factors of



institutional failure and negligence were seriously responsible for the problem of sexual abuse in the church. These factors included the following:

- Absence of awareness training
- Absence of pastoral care, supervision, accountability of the pastors
- Absence of Codes of Professional Ethics
- Absence of an adequate theology of sexuality
- Sexism endemic in the church
- A culture of silence and secrecy.

In research done with Roman Catholic clergy sex offenders [Birchard, 2002] the offenders themselves were unanimous in their view that the absence of awareness training and the absence on teaching on issues of human development contribute to the problems of sexual misconduct in the church. Of the Church of England clergy who responded to a survey on causation, 91% attributed significant causation to the absence of awareness training in theological colleges, as well as in other places of continuing ministerial education. Similarly, in other parts of this same research, causation was tied, over and over again, to the absence of awareness training, the absence of pastoral care, and the absence of supervision.

Penny Jamieson writing from an Anglican perspective in, **Living on the Edge** [1997] identifies the culture of secrecy and the 'circle of silence' as especially conducive to sexual abuse in the church. Richard Sipe [1995] makes the same point in his book on sexual abuse in the Roman Catholic Church.

Others writers confirm this view [Fortune, 1989, Irvine, 1997] and this view is consistent with the findings of the **Report on Harassment and Abuse in the Methodist Church** [1997].

We have observed a tendency for the hierarchies of both the Roman Catholic Church and the Church of England to deflect attention from this institutional failure by focusing responsibility on the individual members of the pastorate. This loses track of the fact that such people were chosen by the institution, formed and trained by the institution, and commissioned to minister in a system of oversight and care designed and supported by the institution. We would be concerned if church hierarchies and other bodies of leadership tried to scapegoat the pastorate in an attempt to deflect blame away from the shortcomings of the senior leadership and the governing bodies of the church.

### **Typology and Cycles of Sexual Abuse**

It will help us to understand sexual abuse in the church if we look at a typology of offending and at several of the models that have been developed by theoreticians and clinicians to describe the phenomenology that lies behind abuse, sexual addiction and offending. There is only space to outline briefly these cycles, but this will help us to understand the inter-connections between the six attributed causative factors and treatment design and prevention.

The Centre for the Prevention of Sexual and Domestic Violence, in its literature, roughly divided sexual offenders into two types: the 'wanderer' and the 'predator' [1992]. These are self-explanatory categories. 'Predator' would

signify an exploitative pattern of sexual behaviour, involving differentials of power that is pathological, cyclical, re-current, and enduring. The 'wanderer' is characterised as someone who wanders into sexual misconduct almost by accident, more out of naiveté and vulnerability than out of any deep-seated repetitive pathology. In an interview in **Leadership** magazine, Bud Palmer says [Winter, 1988, p16] that 'for most of us in local church ministry, sexual temptation doesn't come painted in the lurid tones of a vamp. It comes in the quiet, gentle relationships a pastor has with people he truly loves.' This same view was echoed in a focus group of Church of England clergy [Birchard, 1998]. One of the participants talked about 'almost slipping unawares into a relationship with whom one is working'.

Many professional codes of conduct restrict or preclude sexual and romantic relationships with clients or others for whom one is professionally responsible. For example, the Code of Conduct and Practice of the British Association for Sexual and Relationship Therapy never allows a sexual or marital relationship between a therapist and client under any circumstances or at any time in the future. In church life, by contrast, it is almost customary to expect an unmarried curate to court the churchwarden's daughter or the schoolmistress or to find a wife from the village. One of the clergy focus groups took the view that it was entirely proper for a clergyperson to court a member of the congregation [Birchard, 1998]. This perspective was noted and promoted by Lebacqz and Barton [1991, 128],

...we have ample evidence from our own circle of friends and acquaintances to suggest that it can and does happen that pastor and parishioner can meet as equals, become romantically and sexually involved, and enter solid and committed relationships.

At the time of their writing, Karen Lebacqz was Professor of Christian Ethics at Berkeley and Ronald Barton the Associate Conference Minister for the United Church of Christ in San Francisco. Clearly this issue of clergy courtship raises important ethical questions and signals the need for practical policies of care and supervision. For example, in the Episcopal Church in the Diocese of New York a priest is required to make a private but official declaration of an intention to courtship to an appropriate Diocesan authority if the person is a member of his or her congregation. This applies to same gender as well as cross gender relationships. The point of this process is to bring the relationship to responsible knowledge. Other churches could devise similar approaches adapted to their own ecclesial structure. Abuse operates in circumstances of secrecy and silence. If we accept that it is ethically correct for a church leader to be in a developing romantic and sexual relationship with a member of the church, which is the nature of courtship, then there needs to be some way of protecting both parties and excepting this behaviour from designation as sexual abuse. This is especially true since not all courtships have a happy, or mutually desired, outcome.

There are a number of 'models of understanding' and 'cycles of behaviour' that we can call upon to help further our understanding of sexual abuse. Four of these are evaluated, criticized and knit together in new work by Tony Ward [in press], Professor of Forensic Psychology, University of Melbourne. His

own 'good lives' model of offender treatment has much to commend it to the church as it tailors offender treatment to the needs of the individual. It moves offender treatment beyond containment to problem resolution and the supportive development of fulfilling life styles.

Because of limited space only three 'cycles of sexual behaviour' will be described in this paper. These are cited to aid an understanding of the process that lies behind abusive sexual behaviour: the first is the 'cycle of offending' developed by Wolf [1984] and described and developed further by Joe Sullivan [2002], the second outlined by David Finkelhor [1984] and discussed in Tony Ward's [in press] new essay and the third, the cycle of addiction outlined by Patrick Carnes. Wolf's work is at the centre of most cognitive-behavioural sex offender treatment programmes [Sullivan, 2002]. It is self-explanatory and relatively simple to understand therefore it is shown here in diagram form [fig. 2] without further comment. Finkelhor's work, which explores motivational causation, has also been strategic in the development of offender treatment and significantly underpins much rehabilitation work [fig. 3]. Carnes' work has been strategic in the development of our understanding sexual addiction and sexual compulsivity [fig. 4]. It is important to remember that sexual abuse may involve adults or children, and that, not all sexual addiction is abuse and that not all abuse is addiction.

## **Four-Preconditions Model of Sexual Abuse**

This model was developed by David Finkelhor to address previous shortcomings in theory development and to provide a more comprehensive framework to explain child sexual abuse. He suggests that all factors relating to child sexual abuse can be grouped as contributing to one of four preconditions. All four need to be met before abuse occurs [Finkelhor, 1984, p54]:

1. A potential offender needed to have some motivation to abuse a child sexually.
2. The potential offender had to overcome internal inhibitions against acting on that motivation.
3. The potential offender had to overcome external impediments to committing sexual abuse.
4. The potential offender or some other factor had to undermine or overcome a child's possible resistance to sexual abuse.

Motivation might include such things as arrested emotional development, re-enactment, narcissistic identification, and inappropriate patterns of arousal. Internal disinhibitors could include alcohol use, impulse disorders, or the failure of incest inhibition mechanisms in family dynamics. He lists as examples of external disinhibitors: an absent mother, social isolation, lack of supervision, unusual opportunities to be alone with the child. Factors cited in overcoming the child's resistance include coercion, unusual trust between the child and the offender, insecurity and deprivation. In summarizing this model Finkelhor [1984, p68] writes,

Sexual abuse is a problem with causes and explanations. Many of these we do not fully understand. The four pre-conditions model is open-ended; new findings and new ideas can be added to it. By having given some structure to what is already known, this model enables us to use that knowledge.

These four pre-conditions interact with the six attributed causes, discussed earlier in this chapter, and provide the 'filler' for the four pre-conditions.

### The Addictive System

Patrick Carnes in *Out of the Shadows* [1983] outlines a cycle of addiction that operates in alternating rhythms of control and release. It is set in a faulty belief system that supports impaired thinking and operates with a four-phase cycle of preoccupation, ritualization, sexual compulsivity, and despair. The lives of addicts, he says, become immersed in this control-release cycle. Carnes later writes that [1991, p105] 'when in the process of sexual acting out there is a total absorption in the behaviour, a numbing of all judgments and expectations'. The cycle is driven by shame and shame is the principal by-product of narcissistic damage. Carnes writes again as follows [1991, p67]

The addict's intense emotional pain is transformed into pleasure during the preoccupation and ritualization stages, becoming euphoria during the fleeting moments of sexual release. However, following the climax experience, the addict plummets into shame and despair more deeply with each repetition of the cycle. Isolation also increases.

Once the behaviour is completed, or that part of the cycle exhausted, then there is a period of control, characterized by avoidance and doing good, until a sense of need or entitlement sets off the next stage of the cycle [fig.5]. These cycles can operate at frequent and infrequent intervals and they can operate systemically in conjunction with family members or chosen others [Fossum and Mason, 1989].

This conceptual model seems especially important for understanding sexual abuse in the church because it helps explain the juxtaposition of the two apparently incompatible behaviours: sexual abuse and religious service. It is likely that in many of the cases of abuse in the church, sexual and religious behaviours alternate in this repeating cycle of control and release. This is the same structure as the binge–purge cycle characteristic of eating disorders. From the interviews done with clergy offenders [Birchard, 2002] it is clear that the sexual abuse committed by these men always followed this pattern. Sexual episodes, over which there is often denial, justification, profound shame, great fear, and ultimately despair were followed by zealous commitments to hard work, abstinence, devotion, service and righteousness. Eventually a sense of need or entitlement would emerge, internal and external inhibitors would be overcome and the cycle would begin again.

About such cycles of abuse and circles of addiction, perhaps there is much to learn from Augustine,

The enemy had my power of willing in his clutches, and from it had forged a chain to bind me. The truth is that disordered lust springs from a perverted will; when lust is pandered to, a habit is formed; when the habit is not checked, it hardens into a compulsion. These were interlinking rings forming what I have described as a chain, and my harsh servitude used it to keep me under duress. [Boulding, 1997 p192]

His knowledge of the nature of addiction and offending, his imagery of the chains of habituation, addiction, and slavery, and his experience of its resolution in the paradox of powerlessness, suggests that we should read the Confessions again, with fresh eyes.



## **Review and Summary**

Current thinking would accept that sexual abuse in the church is not just about sex. When committed by a church leader against a staff member or a church member, it is an abuse of power and violates the duty of care and conditions of trust implicit in the pastoral relationship. Marie Fortune [1994] describes this, not just as a misuse of power, but also as a violation of role, an exploitation of the vulnerable, and as an act that, because of the differential of power, precludes meaningful consent.

Other professional organisations have very clear codes of ethics that not only clearly delineate such behaviour as unethical but also provide appropriate training, supervision, and structure to minimise the potential for abuse. There is no suggestion in the literature, or in our knowledge of current practice, that it is possible to test for a 'potential to abuse' and thus to create a screening system for the church.

The three major factors that account for sexual misconduct in the church seem to be the personal problems of the church leader, especially problems that somehow seek both a religious and a sexual solution, aspects of ministerial service that render vulnerability to sexual misconduct, and the ignorant and inattentive character of the institution. Any of these taken alone might predispose a man or woman to such behaviour, but all taken together have created the multitude of pastoral problems and reactive media explosions we see happening all around us.

The high levels of sexual abuse in the church can be explained, in summary, by this combination: vulnerable people with sexual and personal problems in positions of power, functioning in multiple roles, in stressful jobs with much boundary ambiguity, working with other people, often vulnerable and needy and without boundaries, in an organisation without training or supervision, in an ecclesiastical culture dominated by systemic sexual shame and pandemic secrecy.

### **Recommendations for Prevention from this Research on Causation**

- Training in human sexuality, relationships and human development in theological colleges and in seminaries and in continuing ministerial education
- Awareness training in colleges and in programmes of continuing ministerial education
- Provisions for the equivalence of 'supervision' for those working in pastoral care as a requirement for the continuation of ministry
- Provision of therapeutic resources accessible for those with individual psychological/sexual problems in line with other 'employee assistance' programmes
- Increased 'pastoral care' for those involved in ministerial function
- Additional investigations into a functional theology of sexuality and human relationships that can incorporate the distinctive features of

modern society, including patterns of courtship, marriage, and the diversity of domestic units

- An end to the culture of silence and secrecy that surrounds many aspects of ministry and church life
- The development of a clear Code of Professional Ethics applicable to church members in positions of leadership
- Promotion of 12 Step Sexual Recovery Programmes and other behavioural regimes to facilitate change and foster healthy relationships

In the literature and in recent research [Birchard 2000/2002], awareness training and training in issues of sexuality, development, and human relationships were given as the number one priority in the future prevention sexual abuse in the church.

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*Four-preconditions model of sexual abuse*

Figure 3. D. Finkelhor, 'A clinical application' (1986) and adapted by Joe Sullivan

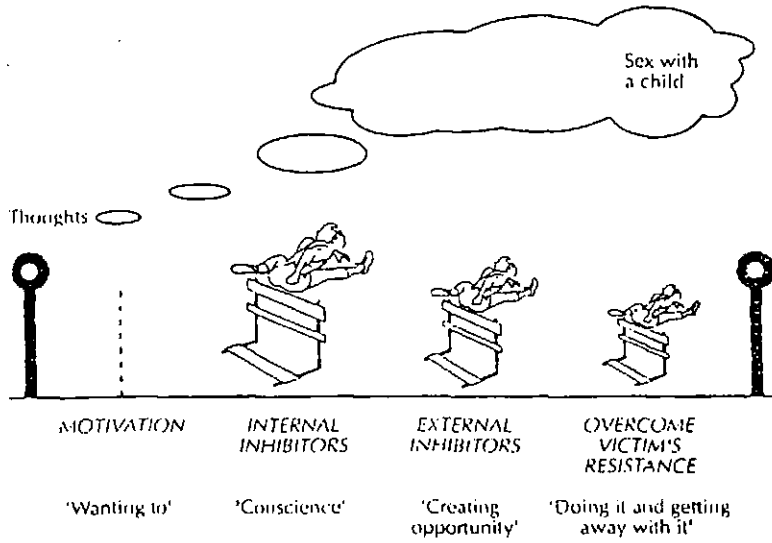
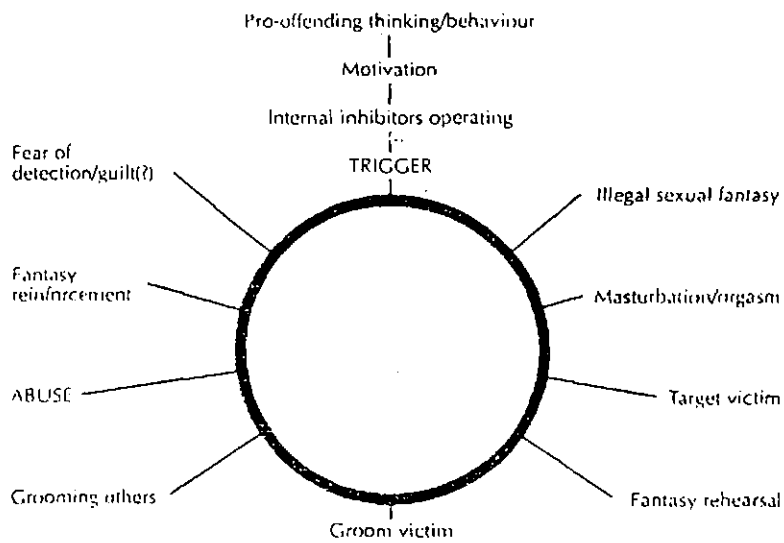


Figure 2. S. Wolf, 'The cycle of offending' (1984)



*The addictive system*

Figure 4. P. Carnes, 'The addictive system' (*Out of the Shadows*, 1983)

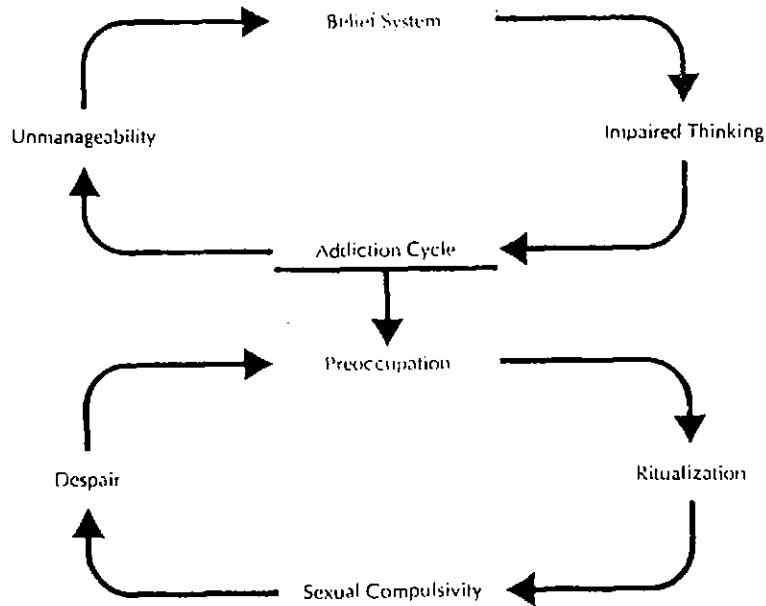
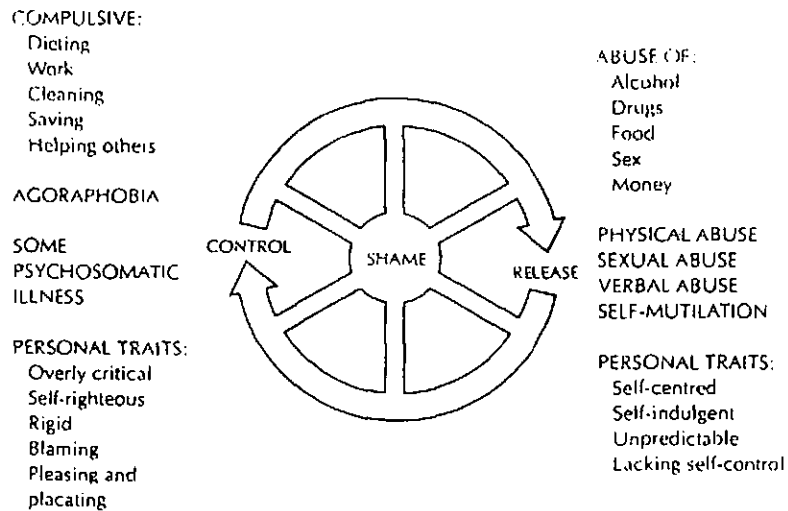


Figure 5. M. Fossum and M. Mason, 'The shame-bound cycle' (*Facing Shame*, 1986)





## **Appendix H**

### **Contents:**

**The Third Product—**

**Researching Sensitive and Distressing Topics**

**Product 3**

**Researching Sensitive and Distressing Topics**

UKCP Inaugural Research Conference  
University of Surrey  
Wednesday 29<sup>th</sup> May 2002

As part of a doctoral research programme jointly sponsored by the Metanoia Institute and Middlesex University, I am developing a modular training unit to teach psychotherapists and counsellors to assess and work with the problems of sexual addiction and compulsivity. This module could stand alone or within a programme of continuing professional education, or it could be integrated into an existing counselling curriculum. It will be constructed in such a way as to recognise the growing role of Internet pornography in addictive compulsive patterning. This is a professional studies academic programme with an expectation of a product-orientated outcome rather than the preparation of a traditional dissertation destined for the library and not the work place.

I had intended, before the current project, to research the relationship between religious behaviour, sexual behaviour and sexual offending. After four months of indecision and distress, I set this to one side to develop this other work, the teaching and training programme on sexual and romantic addiction. This is of more interest to me and, I believe, of wider benefit to the community. The other research was leading professionally away from my main areas of clinical interest. I also made that decision because I found the other research distressing and disturbing.

The data for the earlier project was to come from interviews with paedophile Roman Catholic priests and those who specialise in working with offenders. What had seemed feasible in the environment of the classroom became depressing and distressing in the field. This paper is an examination of some of the implications and consequences of handling painful, sensitive,

distressing, and, potentially explosive, subjects in the pursuit of the twin goals of academic and clinical research.

The distress began at the end of last year, and the first of this year, as I began to interview offenders and those who work with them. These are the relevant extracts from my research journal:

Monday 7<sup>th</sup> January 2002

'In typing up the interview with RW I am very aware of his anxiety and a sense of contagious shame that extends from him to me and I feel that I am bordering on nothing less than despair.'

The entry is followed by reflective notes under the following headings, 'heuristic and reflexive', 'hermeneutics and phenomenology', and 'social construction'.

Tuesday 8<sup>th</sup> January 2002

'I am experiencing feelings of paranoia and a sense of contamination. I have been exposed to a culture of fear.'

Wednesday 9<sup>th</sup> January 2002

'I keep having dreams of being victimised and at the mercy of predators which I connect to the nature of the research. I woke up feeling angry and trapped.'

Sunday 13<sup>th</sup> January 2002

'I had two bad dreams last night, one about breaking china and another about a woman falling to her death on a roller coaster. This feels like it is about an encounter with evil. This is about a confrontation with evil, the ordinariness and all pervasiveness of evil in the human condition.'

Similar entries follow throughout the timetable of the interview process. During this period I began to drink too much and became vulnerable to old, and long abandoned, addictive compulsive patterns. Over four months I discussed this 'toxic leakage' into the rest of my life with my academic advisor, clinical supervisor and personal therapist. Eventually the way forward crystallised at

conference where I was giving a paper on sexual addiction and the Internet. The transition became complete when I discussed the future of the work I was doing then with the head of the London Marriage Guidance Council. I quote him, 'such a change represents the creative movement of the heuristic process'. This paper grows out of that 'creative movement' and is, thus, an exploration into some of the particular characteristics and requirements that can accompany heuristic qualitative research when the research, and particularly the data gathering, is associated with sensitive issues, distressing behaviours and/or high levels of fear, opprobrium and social anxiety.

The experience of 'distress' is subjective and cannot be made by others or necessarily predicted in advance. Sexual abuse is not the only distressing or sensational topic likely to come into the researchers remit. For some researchers it might be work with drug addicts, abortion, terminal illness, domestic violence or crime. A staff member at the Medical Foundation for the Treatment of Victims of Torture reported a similar experience to me in the preparation of his own doctoral dissertation. His research, 'Mind and Body: The Treatment of the Suquelae of Torture Using a Combined Somatic and Psychological Approach' was a qualitative case study analysis of important but disturbing material. What may seem manageable in the classroom can feel much less clinical and much more personal in the field or in the consulting room.

In my experience, research with sensitive and distressing topics has a possible impact at six interconnected levels:

- Academic
- Administrative
- Ethical
- Political
- Professional
- Personal

Sieber and Stanley [1988, p49] define 'socially sensitive' research as research 'in which there are potential social consequences or implications, either directly for the participants or for the class of individuals represented in the research'. In this case, the consequences and implications were mostly for the researcher and grew out of the research journey and the heuristic and reflexive nature of the qualitative process.

### **Academic**

Working with sensitive and stigmatising topics has a number of potential effects upon reception and location within an academic environment and within the academic community. This is particularly true at entrance level and for the novice researcher and when the research constitutes a debut into an academic community.

Having begun to establish a reputation as a psychotherapist with an interest in addiction, I began to notice that the new research was subtly altering my reputation to someone who is interested and experienced in the field of

paedophilia. Even at an early stage, I had been booked for a workshop on 'Men, Religion and Offending' and asked to join a national working party on sexual abuse in the church. Next came an invitation to a conference in the United States on working with paedophile offenders. While this 'establishment of reputation' would be true of any directional development in research, it seems to me, that this is more pronounced in the case of research that explores the extreme. The extreme, stigmatising and sensational make it more memorable and invite speculation and comment. This is especially true of a 'product orientated' dissertation that requires, for example, the preparation and publication of books or journal articles as part of the academic outcome. In degree programmes that require a traditional dissertation, the actual subject matter of the dissertation may not so extensively determine academic repute because the dissertation often sits, unpublished and unread, in the recesses of a university library.

Research that is proposed and seems reasonable in an academic environment can become unexpectedly and unforeseeably problematic once in the field. As my diaries show, discomfort set in only at the beginning of the interviews when I was exposed to the horrific content of the material and working on the deeply depressing interface with the tragedy of my informants. The distress was multi-factored and involved not only the nature and history of the people interviewed, the character of the stories told, but included repeated winter visits to the dismal physical setting of secure accommodation. All this was set in the wider context of a media outcry and moral panic that spilled over into my interviews, both here and in Ireland. While interviewing

participants in one establishment, the security of the setting was invaded by vigilantes with cameras. I had to remain locked in the building until it was judged that I might not be mistaken for an offender and that it might be safe for me to leave un-harassed, un-followed and un-photographed.

Fear and shame have been primary feelings experienced in the process of research. I felt shame that I would be perceived by the Academic Committee to have chosen badly, to be lacking in resolve, to be a person without academic substance. I became aware that when I read the emails of my tutor, before choosing to change the direction and character of the research, that I experienced them as cheerful and helpful. Once I made the decision to change, I projected unfriendly feelings onto these emails. As far as I can see, they do not, in words, vary from the ones before.

The levels of fear and shame that accompanied the academic character of this research extended more widely into my professional and personal life. The important thing for a researcher to bear in mind is that the affect of the participants, in this case the toxic fear and shame of the interviewees and those who work with them, had the power to leak into academic, as well as the professional and personal life of this researcher.



## **Administrative**

Research with sensitive and distressing topics and research into areas of social opprobrium can bring with it extra, onerous and time consuming administrative requirements. These include, among others, a need for more long term planning, unexpected administrative difficulties and special issues of confidentiality.

In the first place, I found it difficult to access my participants. The institutions that work with sexual offenders are discrete, cautious and have high levels of security. Phone numbers were unlisted, calls screened, and access to decision-makers slow and difficult. I had to plan carefully, deliberately target and cultivate contacts and build credibility over a two-year period. It was a case of strategically targeting people of influence and courting the gatekeepers. Because of the difficulty of access, longer lead-in times are required and exceptionally careful preparation is necessary. It is also important for the researcher to 'snowball' contacts, to use one gatekeeper to set up connections and appointments with other gatekeepers.

Given the highly confidential and even sensational nature of the taped material, I soon realised that there needed to be exceptional commitments to confidentiality. For example, I could never leave my computer, notes or briefcase in my car or the window open in my ground floor study. For extra security, tapes and notes were transferred to specially designed double-lock filing cabinets. In working with sensitive material any security breach, however

unlikely, will bring with it risk and fear to the participants and heavy criticism to the researcher.

The long-term timetable had been built upon the expectation that my secretary would type up the interviews. Once I had begun to do the interviews, it became clear to me that the recorded data would have been too distressing and disturbing for her to hear. I would have to do the transcription and typing myself. This would add four or five unplanned extra weeks to the research timetable.

### **Ethical**

All research projects raise 'ethical, moral, and political questions' [Renzetti and Lee, 1993, p14]. In addition to the special administrative considerations of doing research with sensitive and distressing topics, there are also special ethical considerations. The topic of sexuality raises, its own right, a set of ethical issues and has to be dealt with in a sensitive way.

Renzetti and Lee [1993] emphasise the importance of the following: privacy, confidentiality, safety, respect, consent, and the avoidance of deception. The Council for International Organisations of Medical Sciences had the following guideline for maintaining ethical standards in sensitive research especially around sexual issues: respect for persons, beneficence, non-maleficence and justice [Ringheim, 1995]. I found four major areas that required attention: confidentiality, the issue of free and informed consent, the problem of psychological harm/benefit, and the problem of 'unacceptable truth'.

The principle of confidentiality is one of only three principles that appear 'without exception' [Kimmel, 1988, p88] in American and European codes for psychological research. I have already delineated the extra administrative security provisions to double-insure the confidentiality that needs to be put in place while working with sensitive material. It is also important to clearly state, to your participants, the context and the limitations of confidentiality, especially working with paedophile offenders where there is a possibility that the content of the interview might disclose previously unknown offences. Knowledge of some behaviour might be required for disclosure by law or by a code of professional conduct. The confidentiality contract between the researcher and the research participant requires good clarity and appropriate wording.

Most of my research was done with men living in secure residential accommodation. Davison and Stuart argue [1975] that it is not possible to do ethical research in an involuntary and coercive setting. Ethical questions can be very complex and sometimes there are no clear and obvious answers. In this case, although the accommodation was secure the men in residence were there on an optional basis. The voluntary nature of the research participation was made abundantly clear. Even so, it was obvious to me that non-participation would have been common knowledge through out the institution. This could not help but to affect judgements and perceptions. While these interviews took place in an inherently coercive setting, it seems to me, that this was within an acceptable context and I was grateful that participation was experienced and reported by my informants as positive and beneficial.

While recognizing that it is important not to harm my participants, the purpose of the project was to gain information to prevent my participants from harming other people. This is recognised in **Research Methods in Clinical and Counselling Psychology** [Barker, Pistrang, and Elliott 1994],

In general, research should not harm the participants. However, some people may freely consent to suffer harm for the greater good of humanity...there is a trade-off between any harm caused to the participants and the potential gain to humanity from the knowledge acquired.

In the preparation for my schedule of interviews I was able to call a meeting of all my prospective clergy participants and address them as a group, answer questions and invite them to participate. At the end of the questions one man in the group agreed to participate. He said, 'I can't change the harm I have done but this is the least I can do to put something back'. All the other men agreed and all of them volunteered to participate. Given the sensitive and disturbing nature of the material that could emerge with each interview, plenty of time was left over at the end of each interview for a full debriefing. In every case, I had reports from my participants that they had found the interview therapeutically helpful and that it had been, for them, an act of repair, restitution, and reparation. The ethical implications of this process, and it may well be the same in working with other types of participants, is that the actual research creates a sense of benefit, especially, where participants have been stigmatised or have experienced isolation and opprobrium.

Another ethical dilemma that emerged from the project came not from the format or the participants but from the outcomes of the study and the general public. I call this the problem of 'unacceptable truth'. It became clear to me that the high level of public outrage around the issue of sexual abuse in the Roman Catholic Church had created an environment where some views were acceptable and other views were not acceptable. Seiber and Stanley [1988] make this point in this way,

'society will enthusiastically embrace ideas that suits it and that will be done irrespective of the validity of the application or the validity of the research'.

There are transient orthodoxies in the charged world of strong feelings, abuse, allegation, counter-allegation, vigilantes, and public protest. According to Jenkins [1996, p152] concern over child abuse has followed a cyclical pattern alternating between extravagant claims with far-reaching legislation until the public grows sceptical and the 'crusade' itself becomes seen to be the problem. He cites this as the pattern with the sex-offender panics in the United States of America in the 1930's and 1940's. In the 1970's it was widely held that single incidents of sexual abuse did little lasting harm and at least one authoritative text is quoted saying that 'Early sexual contacts do not appear to have harmful effects on many children *unless the family, legal authorities or society reacts negatively*' [Jenkins, 1996, p88] [italics in the original]. This view would not be acceptable now. It could not be promoted even if it were established as an incontrovertible fact. There is thus an additional heightened ethical difficulty—the problem of 'unacceptable truths', in the conduct and publication of sensitive and distressing research in the coercive context of a time of moral panic.

## **Political**

There are other important political issues to consider in the process of researching sensitive or controversial subjects, particularly in climates of social concern or in times of moral panic. These may include having to handle, harness, or avoid media interest, respond to personal criticism and unfriendly scrutiny, recognise problems of prejudice and exercise vigilance and dexterity in fielding potential legal and political issues.

Whatever the preferences of the researcher, sensational subjects are attractive to the media and invite press interest. This may have advantages for the researcher. It may create an advantageous public perception around the career of the researcher or clinician. To be seen as an advisor to the stars or a confidant to royalty might well have a generous impact on career development and clinical or academic reputation and therefore client demand. However, if the subject is unpopular, the opposite is likely with the consequences in reverse. When the residential treatment centre was under siege by vigilantes and press photographers I became very aware that my concern to understand causation could be presented to the public not as explanation but as justification. This would not have had a welcome effect on public standing, academic reputation, or my clinical referral system. It was this kind of interpretative controversy that enveloped Cherie Blair in the media response to her comments on suicide bombings—explanation was taken, probably deliberately, by the press and her political enemies—as justification.

It also has seemed to me that hostile methodological scrutiny and even deliberate misrepresentation of the work are more likely when doing research on sensitive and distressing topics. The competition for funding or reputation creates an environment where it can be economically advantageous for those with one view to criticise and attack those with another competing view. Similarly with subjects that generate strong feelings, either positive or negative, research findings and statistical information will be taken up or ignored to suit different political agendas. This is potentially true of all research but I believe that this is especially problematic for researchers investigating sensitive, controversial or distressing topics.

Those who research extreme subjects and socially marginal groups need to remember that research outcomes have the capacity to generate prejudice as well as reveal truth. I became aware that the publication of my research into Roman Catholic paedophile offending would have the power to contribute to the generation of additional prejudice against the clergy and the church. Just to write about this subject tarnishes reputations and inflames the potentials of prejudice. Most of the men I interviewed were Irish and from a culture and time quite different from our own. I have wondered to myself how much prejudice came into play in the assessment, treatment, and evaluation of such men. In writing a paper on sexual misconduct in the Church of England, I was aware of my own prejudice operating, in that instance to protect the church from insinuation and attack. Issues of prejudice come into play with all research but when researching areas of controversy and sensational subjects

the ethical and political implications of prejudice are more far-reaching and of greater consequence.

Sensational and sensitive topics, by their nature, may be circled by special legal requirements that require the attention of the researcher. In the case of my own research, I was concerned about the requirements of disclosure in relationship to the material given to me in the interview. What if I were made aware of an offence that had not come to light to others? What exactly were the legal requirements? What would be required under the Code of Ethics and Practice of my professional body? Attention to the law and to codes of practice will need to be heightened in researching issues of controversy. In cases of sexual abuse in the Republic of Ireland there is a tariff of compensation paid depending upon the nature and level of the abuse. It becomes in the financial interest of the victim to have been badly abused and to have suffered greatly. This point highlights the complex and consequential legal nature of some kinds of behaviours that the researcher may research. This is particularly true where documents, statistics, and outcomes might be cited in a court of law or in other circumstances involving custody, settlement or compensation.

### **Professional**

In counselling and psychotherapy research, it is not absolutely possible, right or desirable to separate out the academic, professional and the personal. However, I have done so in this paper for conceptual clarity and ease of organisation. The professional problems that emerged for me were connected



with the requirements of immersion, conflicts of empathy and the heuristic character of psychotherapy research.

There were a number of lesser problems attached to my status as a novice researcher that should be noted by other novice researchers investigating sensitive or sensational subjects. The first is to recognise that those working with such topics can experience a kind of 'professional contamination'. One can become 'the odd one' and can suffer an alteration or imputation of reputation. I found myself characterised as 'the one interested paedophilia' rather than 'the one interested in prevention'. Doctoral studies can create the professional identity of the researcher. I found that my professional identity had begun to conform to the topic. I am not especially interested in paedophilia or sexual offending as an end product. I am primarily interested in the generic process that, I believe, lies behind the majority of these behaviours. I found this shift of professional reputation undesirable and unwelcome.

I have come to the view that research with sensitive subjects, or subjects with the capacity to contaminate the researcher, should be 'department anchored'. By 'department anchored' I mean commissioned and held by an organisation rather than by the individual and/or lone researcher. This takes the speculation and media attention off the researcher. It allows the researcher to be supported and grounded, and to hand over public inter-face to an impersonal organisation. I noticed that when the residential treatment centre was attacked, all responsibility was directed away from the sponsoring

organisation and individual staff members and handed over to the Home Office. This anchored the work outside the work itself.

Qualitative research uses empathy as a major heuristic tool and many qualitative researchers regard participant empowerment as a legitimate, even central, purpose of the research [Stiles and Stanley, 1988]. Client empathy is central to the psychotherapist's task and essential for the creation and development of the therapeutic alliance. Our academic and clinical tradition has grown out of medicine and this places the primary duty of care to be towards the client rather than to a third party. I found myself in 'empathy competition', a contest between the capacity to feel empathy for the perpetrator, who is seen, and the requirement to feel empathy for the victim, who is unseen. Worst of all, I found that my empathy for the offender [necessary to the qualitative process] was being characterised by others as an absence of empathy for the victim. This was made worse because much of the offender treatment world, at least that based in the prison system and the probation service, takes the view that psychotherapy is not helpful in the treatment of offenders. It might even make it worse. This, it was suggested, inclines to make a psychotherapeutic approach 'well meaning' but, in effect, complicit in offender behaviour. I understand that this view of psychotherapy is the prevailing view and that this has determined some aspects of the Home Office funding policy for intervention and treatment. During this research I observed in myself many disturbances of empathy and empathy competition and I found this to be exacerbated by the political and professional agenda of others.

Stiles [1993, p604] writing in **Clinical Psychology Review** made the point that 'in contrast to the idealised detachment sometimes advocated in received-view research, qualitative research seems facilitated by immersion in the material'. McLeod [2001, p6] prescribes the necessary foundation for the qualitative researcher as 'becoming a knower'. The single most difficult aspect for me of this research was the expectation and requirement of immersion in the qualitative process. I had to hear distressing material, not once, not twice, but over and over again. I would hear it at the time of the interview. I would hear it again on the tape, sometimes two or three times more, because of the way a transcription machine works, and then read it over and over again in the analysis process. I found it distressing to hear once but I was unprepared for its cumulative impact. Other researchers working on sensitive and distressing topics would do well to make provision to minimise this effect. The research is important, but for me, it is not my first priority and it is not right at this stage of my own development. I will say more about immersion in the next section.

### **Personal**

The literature on qualitative research emphasises the importance of protecting the well being of the research participants. There is not much on protecting the researcher. There is an emphasis on the use of the self as the principal tool of the researcher, however, I did not come across mainstream material for prospective researchers warning them that research material has the capacity to enter, in a disturbing way, into the personal process of the researcher. The requirement for immersion exacerbated my sense of personal

contamination. This was made worse by what I call 'the incongruity of the lyrical requirement' and the way in which the research activated some of my own inner psychological scripting.

The principal issue is that the primary components of heuristic qualitative psychotherapy research: immersion, ethnography, hermeneutics, and reflexivity are the same components that allow leakage from the professional back into the personal, the psychological equivalent of stomach acid reflux. In the same way as the heuristic process affects the nature of the research, so too, does the research affect the nature of the researcher. It is the heuristic nature of qualitative psychotherapy research that brings the leakage as well as the insights to bear.

Strauss and Corbin [1998] in **Basics of Qualitative Research** describe the process of qualitative research as 'like a piece of music' and Moustakas [1990], in particular, waxes lyrical, and becomes poetic, in his descriptions of the heuristic contribution required of the qualitative researcher. I found this lyricism incongruous and inimical to my own research. Delightful and inspiring as it might be in many research projects, it sets an inappropriate and discouraging tone for those doing qualitative research into the sensitive, distressing and disturbing.

I am clear that shame and the shame of public opprobrium are the most powerful scripts that operate in my inner world of feeling and thinking. Shame, in particular, I experience as involuntary and excruciating and when

activated it seems to have a life of its own. In my family of origin and in the community of my adolescent formation, sexuality was both sought after and experienced shamefully. Although the issues are different, I experienced this research as an activator of my own shame, as shame by association.

Shame has a contagious nature. People can feel shame when they see someone else acting in a shameful way, especially, if others think that they are somehow associated with the shameful person. This is what I think happened to me. Whenever anyone would ask my research topic they would grimace and look away in disgust. I suspect that this registered in me, in an involuntary place, that I was shameful and disgusting. It is not logical but I think that somehow this research project, dealing with maximum sexual shame and maximum social opprobrium, activated powerful inner scripts and that now account for my distress and disturbance. Other researchers working in different but equally distressing and disturbing areas or interest ought to be mindful of the capacity of the subject matter to engage their own archaic memories and deeply imbedded scripts.

## **Recommendations**

In addition to that the recommendations and 'good advice' that are implicit in the text I would like to highlight the following points:

- Perhaps as a novice researcher avoid sensitive and distressing research topics.
- Do not choose sensitive and distressing topics unless you are willing to undergo media scrutiny and public identification.
- The willingness to quit and the willingness to continue are choices of equal value.
- Create a peer support team that can meet with you as a group on a regular basis to interpret, support, challenge, and create perspective.
- If you are indecisive about the continuation of your work, take advice from the experts and set a time-limited reflection period and a decision-making timetable.

Most important of all, if you decide to quit, the next day you will have wished you had decided to stay, and, if you decide to stay, the next day you will have wished you had decided to quit.

## **Conclusion**

People have assumed when I talk about the sensitive and distressing nature of the subject matter that I mean I have met wicked monsters and heard horrendous tales of the unimaginably vile. This has not been true. Two quite different and unexpected things have upset me in this study. The first has

been the reality of the goodness of these men, and these acts excepted, their commitment to service, the reality of their faith and the confusion, deep suffering, profound despair and hopeless nature of their circumstances. The second has been a recognition of the similarities between the psychology of the offender and the psychology of the crusader [Firman and Gila, 1997]. The yearning that creates and drives the offender seems, to me, to be the same yearning that drives the crusader— both are driven by the need to matter and the dread of non-being. The child abuser and the 'abuser abuser' share a common psychological profile, only the end product is different. To understand this is to understand something of the nature of evil.

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## **Appendix I**

### **Contents:**

#### **The Fourth Product—**

**A Training Programme for Psychotherapists,  
Counsellors and Health Care Professionals to  
Work with Sexual Addiction and Compulsivity  
with Special Reference to Internet Sexual  
Addiction**

**Product 4**

**A Training Programme for Psychotherapists,  
Counsellors and Health Care Professionals to Work  
with Sexual Addiction and Compulsivity with Special  
Reference to Internet Sexual Addiction**

## **A Training Programme for Psychotherapists Counsellors and Health Care Professionals to Work with Sexual Addiction and Compulsivity with Special Reference to the Internet**

This treatment and training programme is an amalgamation from the work of psychotherapists who have clinical experience of narcissistic damage, psychologists who have especially researched shame and the other affects associated with shame, and from practitioners and researchers who have published work on sexual addiction and compulsivity. The programme has incorporated concepts and treatment techniques drawn from research on the care and treatment of sexual offenders. Although this training programme is directed towards the treatment of sexual addiction it is relevant to other addictive processes.

### **Rationale**

Research indicates that sexual addiction is a problem that is little recognised and understood in this country. To date there has been no specific training available to practitioners to help them identify and understand this behaviour and to respond in clinically appropriate ways [Birchard, 2003].

### **Objectives**

The key objectives of this training programme are:

- To explain and describe the phenomenon of sexual addiction
- To explain the aetiology of sexual addiction
- To explore the nature of shame and its role in the addictive process
- To enable therapist to better work with sexual addiction
- To explore sexual addiction and the Internet
- To provide therapists with conceptual knowledge to better inform their involvement in public discussion

The primary goal is to provide a suitable programme of training for psychotherapists and psychosexual therapists to work with clients who present with the problems of sexual addiction and compulsivity.

### **Teaching Strategies**

This training programme includes the following teaching interventions:

- Tutor input
- Small group discussion
- Video
- Computer projection
- Plenary sessions
- Drawing and craft work
- Case study
- Working in pairs and triplets
- Group ceremonial activity
- Handouts
- OHP transparencies
- Advance reading material

### **Sexual Addiction and Offender Treatment**

The concept of sexual addiction clearly has implications for those who work in the field of offender treatment. The creation of successful interventions for sexual addiction has the capacity to provide a treatment programme for potential offenders, pre-offenders and to assist others in relapse prevention. Some people inhabit a shadowy world of 'near offending' and such a programme of treatment could prevent a drift into offending. Anyone who has offended once and wants to stop, or come near to offending and wants to stop, has no where to go to get help because the social consequences are so dire. Therefore, the 'borderline offender' has nowhere to turn and no help available. The provision of such a programme of treatment could arrest

behavioural patterns that could otherwise, driven by loneliness and shame, evolve into escalating patterns and/or patterns of more serious offending.

### **Sexual Addiction and the Internet**

This programme of training has also been developed to equip the growing problem of Internet sexual addiction. Research done in the United States indicates that this is an increasing problem [Carnes et al, 2001]. British psychosexual psychotherapists share this view [Birchard, 2003].

### **Wider Treatment Applications**

This training programme is also targeted to equip therapists and counsellors to work with sexual addiction. It would also be useful to help social workers, probation officers, nurses, and other health care workers to understand and effectively respond to sexual addiction. The programme is primarily designed to treat self-referred clients who self-identify as sex addicts.

### **The Format**

The material in this training programme is organised into nine units, each unit lasts approximately one and a half hours. The introduction is built around the video **Addicted to Sex** [MacFarland, 1999]. The video provides real life examples of the phenomenon. The remainder of the programme, through the formal presentations and the experiential work, explores a generic process that lies behind both the outworking of the behaviour and the proposed strategy of treatment.

Each unit contains a formal presentation a number of experiential options. The formal 'taught' part of the presentation is important because at this stage few people are aware of the material and there is little literature easily accessible in the United Kingdom. With the exception of the introductory unit, which last 2 hours, all other units last approximately 1.5 hours. The total teaching time, including the experiential component, will be 14 hours. An overall introduction and an introduction to each day and a concluding activity are included in the total time.

In advance of the first module all participants should receive three papers downloaded from the website of the National Committee on Sexual Addiction and Compulsivity. These papers are preparatory reading and cover the following three topics: Sexual Addiction, Cybersex and the Consequences of Sexual Addiction. Participants can download these directly from the website [www.ncsac.org](http://www.ncsac.org).

It is an advantage if the presenter is an addict in recovery or is trained in the treatment of addiction and, in particular, sexual addiction. Alternatively a recovering addict could be invited to share something of his/her own experience with participants. The feedback from participants in the pilot project suggests that appropriate 'tutor disclosure' of personal process provides a place for participants to feel sufficiently safe to disclose their own processes in the experiential exercises [Birchard, 2003].

## **Ethical and Professional Issues**

This teaching module deals with sensitive and sometimes distressing material. It is important to provide for the emotional safety of all participants. Therefore particular attention must be given to an agreed collaborative confidentiality policy and to opportunities for de-briefing as well as the provision of external psychotherapeutic support if this is required.

### Training Unit Flow Chart

In advance

Unit One: Introduction



Day One  
The Problem

Unit 2: Sexual Addiction



Unit 3: Narcissistic Damage



Unit 4: Shame



Unit 5: Internet

Day Two  
The Solution

Unit 6: Getting Started



Unit 7: Making Progress



Unit 8: Creating Momentum



Unit 9: Moving On

Fig. 6 Training Unit Flow Chart



## **Unit 1 Introduction to the Training Programme and to the Concept of Sexual Addiction**

### **Rationale**

This module introduces participants to one another, to the presenter, to the phenomena of sexual addiction and to the concept of 'Good Lives' [Ward, in press]. The tutor introduces him/herself and talks both about the outer career and his/her inner process. The experiential exercise is designed to break the ice and introduce participants to one another and to provide material for the last unit of the whole programme 'Reconstructing the Self and Creating Good Lives'. The experiential exercise has been chosen for its emphasis on success, achievement, and well-being and therefore for its potential capacity to lend affirmation and positivity to the launch of the training programme.

The video shows a group of self-identified sex addicts and a smaller number of professional addiction counsellors in conversation with the camera. In other words, it shows real people talking about real problems. By the end of the first unit all participants will have begun to know each other and to know the tutor and will have heard first hand accounts of the nature and impact of sexual addiction. The video is especially useful in that it presents first hand accounts of the problem and it does so with clarity, feeling and candour.

### **Aims and Objectives**

- An overview of the programme
- See and hear the 'felt' experience of the addict
- A global introduction to the phenomena of sexual addiction
- An introduction to the 'good lives' model [Ward, in press]
- Meet each other
- Begin to get to know the presenter/tutor

## **Sequence**

- Tutors Input
- Experiential
- Video
- Plenary

### **Presenter's Personal Story**

[Outer story and inner story]

Ending with an explanation of some aspect Ward's primary 'goods' as experienced by the tutor.

Introduction to the three categories of primary goods [Ward, in press]

[Appendix]

### **Experiential:**

Discuss in triplets the things that make life worthwhile for you, that give you joy and create meaning and significance for you with particular reference to the 'good lives' [Ward, in press] concept of the requirements for human fulfilment. Then convene back into the larger group. The various expressions of these categories as personally experienced are called out and listed on the flip chart. These are set aside and saved for the final experiential session.

Introduction to video **Addicted to Sex** [3 / 5 minutes]

**Video 'Addicted to Sex'** [Black and White, 58 minutes]

Questions, Discussion, Summary, Conclusion

## **Unit 2 Sexual Addiction**

### **Rationale**

The purpose of this unit is to teach formally on sexual addiction. This teaching will include definitions of addiction, the distinction between substance and process addictions, the characteristics of addictions, definitions of sexual addiction drawing on Carnes [1991] and Goodman [1998], an outline of DSM IV and the place of sexual addiction in this system of classification. The section will illustrate sexual addiction and will draw on examples from recent writing and great world literature. The section ends with an introduction to the current debate over addiction and addiction nomenclature.

### **Aims and Objectives**

- To learn the basic definitions of sexual addiction
- To understand the characteristics of sexual addiction
- Familiarization with the work of Patrick Carnes and Aviel Goodman
- Knowledge of DSM IV in relationship to sexual addiction
- Basic understanding of the controversy over definitions and nomenclature

### **Sequence**

- Tutor Input
- Experiential Work
- Plenary

Content for this unit can be found in the appendix.

## **Experiential**

A] A rerun of the early parts of the video that focus on the addict's behaviour to provide a useful introduction to a discussion on sexual addiction.

B] A small group discussion to be arranged, built around clinical experience of behaviours similar to the ones in the video.

C] If the course facilitator knows anyone in sexual addiction recovery, that person could be invited to talk about his/her experience of sexual addiction with the course participants. This could also be placed in the introductory session in addition or instead of the video.

D] If the course facilitator knows a psychotherapist or other professional who works in the field of addiction recovery, that person could be invited to share his/her experience of sexual addiction with the course participants. This could also be placed in the introductory session in addition to the video.

Questions, Discussion, Summary, Conclusion

## **Unit 3 The Aetiology of Sexual Addiction / Narcissistic Damage**

### **Rationale**

The purpose of this section is to introduce participants to the concept of narcissistic damage and to explain that addiction is a response to narcissistic damage. The experiential section at the end of this unit is designed to allow participants to reflect on their own experience of such damage and to reflect on the outcome of these patterns in their own process.

### **Aims and Objectives**

- Learn about the aetiology of sexual addiction
- Know definitions and descriptions of narcissistic damage
- Become familiar with other characteristics, affects, and outcomes of narcissistic damage
- Understand adapting and masking behaviours
- Introduce the concept of the sexual arousal template
- Explain the concept of covert sexuality

### **Sequence**

- Tutor Input
- Experiential Work
- Plenary

Content for this unit can be found in the appendix.

### **Experiential**

Option C is the preferred option.

A] In small groups discuss the concept of narcissistic damage.

B] In small groups discuss clinical examples of 'covert sexualization'.

C] Work alone to create a representation of your personal experience of the inner and outer self, using C4 envelopes, the characteristics of the inner self are written or drawn on the inside of the envelope and the projected outer self or the behavioural mask is drawn on the outside of the envelope. Share in confidence what has been drawn and why with one other person.

Questions, Discussion, Summary, Conclusion

## **Unit 4 Shame**

### **Rationale**

The previous unit was an exploration of the aetiology of sexual addiction in narcissistic damage. This unit explores 'shame' as the principal outcome of narcissistic damage and as the major driver of addiction and sexual addiction in particular. The experiential section at the end of this unit is designed to bring home to participants the idea that addiction is about the medication of the self—experienced painfully and as unacceptable.

### **Aims and Objectives**

- Understand of the etymology of the word 'shame', the language of shame and the connection between shame and non-being
- Understand the concept of chronic / toxic shame
- Understand 'shame binds' and 'shame scripts'
- Insights into shame and social marginalization
- Understand the socially useful function of shame
- Reflections on the distinction between shame and guilt

### **Sequence**

- Tutor input
- Experiential
- Plenary

Content for this unit can be found in the appendix.

## **Experiential**

a] Explore a major personal event of deep shame and share that with another person. The other person will act as therapist and will listen, track, empathize, and summarise but not interrupt or otherwise comment. Work in Pairs.

b] Make a list of substances and behaviours that you use to medicate shame and other aspects of painful reality and put them in order of preference / insert this into your envelope. Work first alone and then share what you have done and why in triplets. The purpose of this exercise is to illustrate how we use substances and internal processes to medicate inner feeling states.

Questions, Discussion, Summary, Conclusion



## **Unit 5 Sexual Addiction and the Internet**

### **Rationale**

Modern technology has brought with it a widespread use of the Internet for sexual and romantic activities [Cooper, 2000, 2002]. To date the impact of this activity has been little explored. The research [Greenfield, 1999] suggests that sexually addictive use of the Internet is an increasing problem. This unit explores some of the distinctive characteristics of the Internet in relation to sexual and romantic addiction and suggests practical strategies for client use to self protect against the behaviour. It introduces reflections on the impact of the Internet on child and adolescent sexual development as well as its impact on already formed adult functioning.

### **Aims and objectives**

- Define and describe Internet sexual addiction and cybersex
- Knowledge of different sexual and romantic usages
- Recognition of the signs of problematic usage
- Knowledge of the distinctive features of Internet sexual addiction
- Knowledge of the criteria for the assessment of problematic behaviour
- Understand the possible impact on marriage and relationships
- Outline the role of fantasy in romantic use of the Internet
- Provide a client implemented strategy to reduce usage
- Explore the impact of the Internet on sexual development
- Explore the use of the Internet to access recovery resources

### **Sequence**

- Tutor input
- Experiential
- Plenary

Content for this unit can be found in the appendix.

## **Experiential**

A] In small groups discuss your experience of the Internet either personally or in your experience of work with clients.

B] Using a computer and projector access sexually explicit sites and chat rooms to show the range and nature of the material and the ease of site access. Include sexual recovery sites and sites that promote filtering devices to automatically exclude access to sexually explicit sites. Discuss in groups.

Questions, Discussion, Summary, Conclusion

## **Unit 6 Creating a Strategy of Treatment and Getting Started**

### **Rationale**

The previous four units were designed to explain and explore the problem of sexual addiction. The next units have been designed to explain the therapeutic tasks that are proposed in working with sexually addicted clients. Although these tasks have been assembled in sequence, it should be recognised that tasks should be targeted in response to client need and that there can be movement between tasks as well as a return to tasks already done as required.

This section includes general observations on the nature of the therapeutic relationship and the importance of one-to-one psychotherapy in the treatment of sexual addiction [Cames, 1991, Goodman 1998]. Recognising that therapists come from different modalities, it seeks to build on the concept, especially in the early stages of treatment, of the therapist as 'recovery facilitator'. Supportive psychotherapy is better in the early stages of recovery. Explorative psychotherapy is more useful once behaviour and affect have stabilised. This section also explores the nature and sequencing of affect and behavioural change. Attention should also be given to alerting practitioners to the possibilities of secondary trauma when working with this client category [Clarke and Roger, 2002, Straker, 1993].

The first five tasks:

- Making an assessment
- Challenging denial
- Identifying cognitive distortions
- Psycho-education
- Family of Origin Work

The rationale for starting with an assessment is self-evident but it must be noted that effective treatment requires a detailed sexual and relationship and addiction history. The need to challenge denial will be predicated on the nature and content of the behaviour and the client's self-assessment. The concept of cognitive distortions is introduced at an early stage. Cognitive distortions left unchallenged are cognitive distortions confirmed. Psycho-education is the encouragement and promotion of a programme of appropriate client-centred education. The importance of 'Family of Origin' work is to build a sense of an 'understandable self', the 'plausible story' [Butler, 1999], a narration of the self, as the self has been built over time. This work reduces shame, strengthens the sense of self and provides important information that will be needed to understand the cycle of addiction.

### **Aims and Objectives**

- Reflect on the role of the therapist in general and consider issues of transference and counter-transference
- Alert therapists to the possibility of secondary traumatising
- Understand the role of the therapist as recovery facilitator
- Recognise stages in behavioural change
- Emphasize the importance of immediately stopping dangerous behaviours and behaviours that harm other people
- Consider factors that indicate a favourable prognosis
- Introduce the concept of first and second order change
- Consider the skills and requirements of each of the five tasks

## **Sequence**

- Tutor input
- Experiential
- Plenary

Content for this section can be found in the appendix

## **Experiential**

A] Make a tree of life and then share the tree of life with one other person.

B] Make a time line and then share it with one other person

C] Make a list of your own cognitive distortions and then against each one write a new message.

D] In small groups discuss the required information components of a sexual relationship and addiction history

Questions, Discussion, Summary, Conclusion

## **Unit 7 Making Progress**

### **Rationale**

This section continues to explain client / therapists tasks that are important for a successful recovery. These include

- Connecting to a culture of recovery
- Making a sex plan
- Establishing abstinence
- Shame Reduction

To connect to a culture of recovery means to become involved and committed to a sexual recovery group. Without such an involvement the prognosis of a successful outcome is very poor [Carnes, 1991]. The purpose of the 'sex plan' is to help the client learn to discriminate between behaviours; to discern which ones contribute to his/her sense of well being and which do not. The clarity thus provided helps to facilitate change and recovery. A temporary abstinence contract usually gives a sexually addicted client additional clarity, reveals core issues, and enhances the client's self-worth. With the enhancement of self worth comes the reduction of shame. Toxic shame is the oxygen of the addictive fire and therefore shame reduction and shame externalisation is an essential part of a programme of successful recovery. Shame reduction is greatly facilitated by connecting to a culture of recovery.

### **Aims and Objectives**

- To give participants information about sexual recovery groups and to discuss involvement
- To learn how to make a 'sex plan'
- To consider the idea of an abstinence contract
- Teach about the nature of shame and shame reduction techniques
- To consider Carnes [1991] distinction between healthy and unhealthy sexuality

## **Sequence**

- Tutor input
- Experiential
- Plenary

Content for this section can be found in the appendix.

## **Experiential**

A] Make a trauma egg and then explain your trauma egg to a colleague who will act as therapist. The function of the colleague is to listen, track, empathise, and to summarise what has been heard.

B] Working in pairs, share one experience of traumatic shame with a colleague. The function of the colleague is to listen, track, empathise, and to summarise what has been heard.

C] Discuss the distinction between 'healthy' and 'unhealthy' sexuality [Cames, 1991].

Questions, Discussion, Summary, Conclusion

## **Unit 8 Creating Momentum**

### **Rationale**

This section explores three tasks of recovery:

- Understanding and applying the cycle of addiction
- Making a recovery plan
- Developing spirituality

The primary goal of this unit is to explain the cyclical nature of the addiction process and to train therapists to be able to apply an understanding of the cycle to the unique circumstances of individual clients. An understanding of the cycle of addiction is a major component in helping a client learn how to exit the cycle before the addiction begins to take over. Associated with the creation of an individualised 'cycle of addiction' there are two other therapist-client activities that can facilitate early stage recovery: the creation of a tailor made 'recovery plan' and the creation of a written relapse prevention plan. Much of the content and emphasis on the 'cycle of addiction' has been taken and adapted from models of offender treatment [Bays and Freeman-Longo, 1989].

A section on the importance of the development of a functioning spirituality is also included in this section. This section has been included because much of the literature on addiction recovery takes the view that the development of a 'client appropriate' functioning spirituality is an important factor in recovery. The 'admission of powerlessness', although paradoxical, seems to have the capacity to allow the recovering addict to step outside the inter-active quality of the 'control / release cycle' [Fossum and Mason, 1986].



## **Aims and Objectives**

- Understand and learn to apply the concept of a 'cycle of addiction' to facilitate client awareness and recovery
- Work with clients to make a personal recovery plan
- Work with clients to make a relapse prevention plan
- Understand the role of 'spirituality' in addiction recovery

## **Sequence**

- Tutor input
- Experiential
- Plenary

Content for this section can be found in the appendix

## **Experiential**

A] Work in pairs and discuss a case study. Pay particular attention to the cycle of addiction. Report back your observations to the larger group.

B] In small groups explore the role of 'spirituality' in your own life.

Questions, Discussion, Summary, Conclusion

## **Unit 9      Moving On**

### **Rationale**

This unit is concerned with the process of inner repair and the acquisition of 'goods' to give value and meaning to the recovering addict and to replace the inner need and repair internal distress. Addiction covers and medicates a 'hole' in the centre of the person. When the addiction is taken away there is still a 'hole'. The rationale behind this section is the deep work of repair and re-learning that must take place so that clients can begin to acquire a good quality of life. There is little incentive to stop acting out sexually if the outcome is to continue to experience the emptiness shame and loneliness that explains and drives the addiction in the first place.

This section therefore focuses on the two tasks

- Re-constructing the Self
- Creating Good Lives

The treatment process can be notionally divided into two inter-connected processes: leaving behind one set of behaviour and affects and seeking to take on new affects and new ways of being. In many ways this second part of the process is more difficult than the first. It is easier to stop doing what you know than to start doing what you do not know. It is here that the therapist returns to the more traditional psychoanalytic, psychodynamic, and psychotherapeutic goals traditionally associated with the profession.

The role of the therapist in this treatment plan has been described as both educational and relational. The relational character of the work is highly

sacramental in that 'it is a sign that effects what it signifies'. One-to-one psychotherapy is a journey into trust, intimacy, negotiation, honesty, communication, and the beginning of the restoration of attachment and the meeting of attachment needs. The role of therapist is, among other things, to engage in a process of attentive listening in such a way as to initiate or reengage the process of empathetic attunement with the self of the client. This process works towards the repair of the impairments that created the original damage. This is the work of 'relational repair' that exists alongside the provision of interpretations, hypotheses, strategies, formulations and cognitive behavioural exercises.

The concluding ceremony of celebration is designed to complete the workshop on an affirmative note and, at the same time, to create an experience of affirmation that in itself illustrates a feeling of well being associated with addiction recovery.

### **Aims and objectives**

- Reflections on the function of the therapist
- Reflections on the relational role of the psychotherapist
- Application of the 'good lives' model to therapeutic strategies [Ward, in press]
- Creation of a targeted approach to client future building
- To create a participative experience of well being

### **Sequence**

- Tutor supported introduction
- Experiential
- Tutor supported summary
- Experiential

Content for this section can be found in the appendix

## **Experiential**

The trainer goes through the 'things that make life worthwhile' list from the previous session and locates it in the various good life categories and then facilitates a discussion about the things that give meaning and well being to life and how these can be encouraged for the client in the therapeutic environment.

Questions, Discussion, Summary, Conclusion

## **Experiential**

### **Concluding Ceremony of Celebration and Affirmation**

The room is arranged as a circle of chairs with a single chair in the middle. Each participant is given a sheet of labels. One person sits in a chair in the centre of the room, all the other participants write on a label a word or two of how they have experienced the other person positively. Then each participant comes forward and speaks it to the person and places the label somewhere on that person. After all participants have done this the person returns to the circle and another participant comes to the central chair and the process is repeated until all members have had a chance to take the central chair. The experience is one of being covered in affirmation.

**The End**

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Co-dependents Anonymous	<a href="http://www.codependents.org">www.codependents.org</a>
Recovery Online	<a href="http://www.onlinerecovery.org">www.onlinerecovery.org</a>
Sex Addicts Anonymous	<a href="http://www.sexaa.org">www.sexaa.org</a>
Sexual Addiction Resources	<a href="http://www.sexhelp.org">www.sexhelp.org</a>
Sexual Compulsives Anonymous	<a href="http://www.sca-recovery.org">www.sca-recovery.org</a>
Recovering Couples Anonymous	<a href="http://www.recovering-couples.org">www.recovering-couples.org</a>
Cocaine Anonymous	<a href="http://www.ca.org">www.ca.org</a>
Sex and Love Addicts Anonymous	<a href="http://www.slaafwas.org">www.slaafwas.org</a>
National Council for Sexual Addiction and Compulsivity	<a href="http://www.ncsac.org">www.ncsac.org</a>

All Internet references correct as of 2<sup>nd</sup> November 2002

## **Appendix to the Training Manual**

## **Preparatory Tutorial Notes**

**The notes contained in this appendix have been prepared to ease and facilitate tutor preparation.**

**The material draws heavily on Carnes [1991], Goodman [1998], Twelve Step recovery groups, theoreticians and practitioners as well from clinical practice.**

## **Unit 1 Introduction to the Training Programme and the Concept of Sexual Addiction**

This is a summary of the things that human beings need to feel good [Ward, in press]

### **'Good Lives'**

Ward [in press] suggests that human beings have a number of natural needs that when they are sufficiently met the individual has a 'good life'. He categorises these as follows:

#### **Primary goods for the body:**

Sex, food, water, warmth, sleep, and a healthy functioning of the body as a whole

#### **Primary goods for the self:**

Autonomy, relatedness, and competence

[Relatedness: intimacy, understanding, empathy, support, sexual pleasure, sharing]

#### **Primary goods for social life:**

Social support, family life, meaningful work opportunities, access to recreational activities

A conception of 'good lives' should be based on these three classes of primary goods and specify the forms they will take in each persons life plan.'

## **Unit 2 Sexual Addiction**

### **Definitions**

#### **Based on World Health Organisation**

'A pathological relationship with a mood altering substance [or process] with harmful or life-threatening consequences'

#### **Firman and Gila [1997]**

'Addictions are not simply habits or talks casually gathered over the course of living, they are desperate strategies by which we avoid the unimaginable terror of non-being.'

#### **Griffin-Shelley, [1991]**

'As we become more and more familiar with addictive disorders, we are better able to see the similarities between drug addicts and alcoholics, heroin addicts and smokers, sex and love addicts and food addicts, over-workers and the over religious.'

#### **Milkman and Suderworth [1987]**

Three basic types of neurochemistry

A] Arousal Addictions—compulsive gambling, stimulant drugs, sex, high-risk behaviours

B] Satiation Addictions—compulsive overeating, alcohol and depressant drugs

C] Fantasy Addictions—including psychedelics, marijuana, and artistic and mystic preoccupations

#### **Stern [1998]**

A 'rush' of anger or joy,  
a perceived flooding of light,  
an accelerating sequence of thoughts,  
an unmeasurable wave of feeling evoked by music, and a shot of narcotics  
can all feel like 'rushes'.

They all share similar envelopes of neural firings, although in different parts of the nervous system.

## **Goodman [1998]**

Sexual addiction is characterised by 'the individual is not reliably able to control the sexual behaviour and the sexual behaviour has significant harmful consequences but continues despite these consequences.'

## **Carnes [1991]**

### **10 Signs of Sexual Addiction**

- 1 Pattern of out of control behaviour
- 2 Severe consequences
- 3 Inability to stop in spite of harmful consequences
- 4 persistent pursuit of high risk and self destructive behaviours
- 5 on-going effort to limit behaviours
- 6 sexual obsession and fantasy as a primary coping strategy
- 7 increasing amounts because the current level is not enough
- 8 severe mood changes around sex
- 9 inordinate amounts of time obtaining, using, recovering from sexual exp
- 10 neglect of important social, occupational, and recreational activities

Typically begins in adolescence  
Narrowing of repertoire  
Experienced as a craving  
Tendency to relapse  
Relates to other areas of clients life

### **11 Behaviour Types of Sexual Addiction**

- 1 Fantasy Sex [obsessing, preparing, seductive atmosphere kept but not acted upon]
- 2 Seductive Role Sex [using seduction, hustling]
- 3 Anonymous Sex [cruising areas, one night stands]
- 4 Paying for Sex [phone calls, saunas, escorts]
- 5 Trading Sex [swapping videos, receiving money or drugs for sexual activity]
- 6 Voyeuristic Sex [videos, pole dancing clubs, peeping, sexualising others in public places]
- 7 Exhibitionist Sex [flashing, inappropriate clothes, nudist club for sex]
- 8 Intrusive Sex [indecent liberties, professional misconduct]
- 9 Pain Exchange [receiving or giving harm or pain to increase the sensation]
- 10 Object Sex [masturbating with objects, cross-dressing to add to pleasure, sex with animals]
- 11 Sex with Children [inappropriate information, exposing children to adults having sex etc]

These are not 'per se' sexual addictions but rather sexual addiction tends to fall into these categories of behaviour.

### **Functions of Sexual Addiction**

Response to loneliness  
Associated with isolation and disconnection  
Tension release  
Soporific  
Window of oblivion  
Defending against intolerable affect  
Warding off dread  
Response to feelings of fragmentation

### **Cycle of Addiction [Lasser, 1992] Fig. 7**

### **Schneider and Irons [1996]**

### **DSM IV and Sexual Addiction**

Sexual Addiction not in DSM IV

DSM IV

Sexual Disorders are divided as follows:

#### **Sexual Dysfunctions**

Hypoactive sexual disorder  
Sexual arousal disorders  
Orgasmic disorders  
Sexual pain disorders  
Secondary and other sexual dysfunctions  
Sexual disorder not otherwise specified

#### **Paraphilias**

Recurrent intense sexual urges fantasies or behaviour that involve unusual objects, activities, situations, that occur over 6 months and cause significant distress or impairment of social, occupational, or other important areas of functioning

#### **Gender Identity Disorders**

NOS [Sexual Disorder Not Otherwise Specified] is used to code sexual disorders not listed. It includes three examples one of which is 'distress about a pattern of sexual relationships involving a succession of lovers who are experienced by the individual as things to be used'.

## **Experiential**

Sexual recovery fellowships are listed in United Kingdom directory enquires and all have websites. It would be possible to ring and ask if there is anyone willing to come and speak.



## **Unit 3 The Aetiology of Sexual Addiction / Narcissistic Damage**

### **Goodman [1998]**

Narcissistic Damage— enduring affect, cognitive, behavioural, relational patterns, laid down in the formation of the self and carried on into adult functioning that are inflexible, maladaptive, and cause either significant impairment or subjective distress.

[Based on DSM-III-R definitions for 'character' and 'pathology']

### **Alice Miller [1987] Narcissistic Damage**

- Created in the family of origin
- It is an accommodation to parental needs
- Emptiness and loneliness
- Anomie
- Grandiosity
- Lost feelings
- Compulsion to control

### **Otto Kernberg [1986] Narcissistic Damage**

- Grandiose fantasies
- Feeling inferior
- Over-dependence on admiration
- Boredom
- Emptiness
- Striving for wealth, brilliance, or power
- Lack of a capacity for empathetic understanding
- Chronic uncertainty
- Dissatisfaction with self
- Exploitation and ruthlessness
- Chronic intense envy
- Defences against chronic intense envy

### **Aviel Goodman [1998]**

Goodman suggests that there are usually high levels of 'covert sexuality' in the family of origin of the sex addict.

## Unit 4 Shame

### An Introductory Illustration of Shame

#### Jenny's Story from Anonymous, A., [1987] **Hope and Recovery**

I became so compulsive about masturbating that I'd inflict pain upon myself in order to have an orgasm. My addiction was worse than ever, but I felt that I had no reason to change my behaviour. I believed that I had done such terrible things in the past that I didn't matter and I certainly didn't matter and I certainly didn't deserve to be in relationship with anyone ever again. I now see that my addiction was actually fed by the shame that I felt about my sexual behaviour....Over a period of time I had been hospitalised for various 'accidents', but no one ever questioned me about them. Eventually I found that I needed even more physical pain in order to achieve an orgasm, and I resorted to self-flagellation, electric shock, and burning myself while I masturbated.

#### **Kaufman [1989] References to Shame**

- 'Shame is the affect of inferiority'
- 'No other affect is more central to the development of the identity'
- 'Shame is felt as an inner torment'
- 'Shame is a wound made from the inside, dividing us from ourselves and others'
- 'It is the most poignant experience of the self by the self, whether felt as the humiliation of cowardice, or in the sense of failure to cope successfully with a challenge'
- 'Phenomenologically, to feel shame is to feel seen in a painfully diminished sense'

#### **Sartre [1956] References to Shame**

- 'I am ashamed of what I am'
- 'Moved by jealousy curiosity or vice I have just glued my ear to the door and looked through the keyhole but all of a sudden I hear footsteps in the hall. Someone is looking at me.'

#### **Kaufman [1989] References to Shame**

Shame generates two kinds of scripts:

Defending Scripts:

- Rage
- Contempt
- Blame
- Deprecation Humour

**Identity Scripts:**

**Self-blame**

**Comparison making**

**Self-contempt**

**Re-enactment scenarios**

**Disowning of the self**

**Splitting**

## **Unit 5 Sexual Addiction and the Internet**

### **The Internet is Powered by the 'Triple A Engine' [Cooper, 2002]**

- Access
- Affordability
- Anonymity

### **Eight Distinctive Characteristics of Internet Pornography**

Availability

Immediacy

Specificity

Singularity

Secrecy

Anonymity

Rehearsal

Fantasy

[This list is taken from various sources]

### **Carnes et al [2001]**

#### **What is Cybersex?**

Accessing online pornography, video, chat rooms and text stories

Real time with a fantasy partner

#### **Statistics [Carnes 2001]**

January 1999 19,542, 710 visits per month to the top 5 pay sites

98,527,275 to the top free sites

17% Internet users report problems with sex on line

70% e-porn weekdays between 9:00 and 5:00

100,000 sites selling sex not including chat rooms etc

200 sites added per day

Cooper. Research on 19,265 Internet users found that 8.5% were sexually compulsive or addictive

60% of all visits are sexually connected

28,000 sites \$1 billion

3<sup>rd</sup> largest economic sector

software/computers rank first

Biggest porn shop in the world

## **Ten Criteria of Problematic On-line Behaviour [Carnes 2001]**

1. Preoccupation
2. Frequency [more than intended]
3. Unsuccessful attempt to control or cutback
4. Restlessness and irritability when attempting to stop or limit
5. Using Internet sex to escape from loneliness, helplessness, guilt, worry
6. Searching for more and more intensity
7. Lying to family members, therapists, or others to conceal
8. Committing illegal acts
9. Jeopardizing relationships, job, or educational opportunities
10. Incurring significant financial consequences

## **Carnes et al [2001]**

### **The Arousal Template and the Internet**

The arousal template is formed by:

Physiology, biology, genetics  
Culture, religious and ethnic background  
Family history  
Experiences of physical, emotional, sexual abuse or exploitation, if any  
General life experiences  
Sexual and relationship history

Implications of the Internet for the arousal template

Triggering the arousal template  
Identifying the triggers  
Connection between arousal and childhood abuse  
Hierarchy of arousing activities and situations  
Usually the goal is not intercourse but the 'erotic moment'

The Internet can become part of a person's arousal template  
It can provide the 'erotic moment' i.e. chat rooms for women, intrigue, manipulation, seduction, and power

Most of us have part of our sexuality that lies unacknowledged and unexplored and the Internet offers a way for that to happen  
For the majority of people arousal templates have a spontaneity and flexibility

Carnes [2001] reports templates being altered by the Internet  
One of the distinctive features of the Internet is that it is possible to have an orgasm at the time of watching so sexual activity and orgasm become closely linked

Cybersex allows people to 'mainline' sex whenever they want it

## **The Internet as an aid to Addiction Recovery**

Recovery websites

Online sexual recovery meetings

Recovery resources

Books, tapes, and questionnaires

Diagnostic tools for clinicians and self-assessment tools for clients

Contact details of sexual recovery fellowships and local meetings

## **Unit 6 Creating a Strategy of Treatment and Getting Started**

The role of the therapist as recovery facilitator

### **Goodman [1998]**

The importance of the therapist in recovery

Supportive psychotherapy better in early stages of recovery and then exploratory psychotherapy more useful once behaviour and affect has stabilised

### **Changing For Good [Prochaska et al, 1995]**

Six stages of change

Pre-contemplation

Contemplation

Preparation

Taking Action

Maintenance

Relapse

### **Stages of recovery [Carnes, 1991]**

Developing stage

Crisis and decision

Shock

Grief

Repair

Growth

### **Four stage recovery process [Goodman, 1991]**

Initial behaviour modification

Stabilisation of the behaviour and affect

Character healing

Self-Renewal

### **Carnes et al [2001]**

First and second order change

## **Prognosis [Goodman 1998]**

Illness factors indicating a less good prognosis

Early age of on-set  
High frequency of behaviour  
Concomitant use of drugs and alcohol  
Absence of anxiety or guilt

Recovery Support Factors

Stable job  
Stable primary relationship  
Supportive social network  
Availability of appropriate sexual outlets

## **Making an Assessment**

Use evaluative and diagnostic questionnaires to assess and to filter denial. Cames has a number of such tools available on his website [[www.sexhelp.com](http://www.sexhelp.com)]. There are other books and web sites on sexual addiction.

Assessment might include the following:

- Inter-generational history, including the history of addiction in the family
- An understanding of the family system and its characteristic dynamic
- Birth history
- Earliest sexual memories and experiences
- All recollected sexual and quasi-sexual memories before puberty
- Any experiences of abuse and molestation
- Toilet training memories
- Childhood experiences of punishment and discipline
- Memories of family nakedness
- History of masturbation
- Use of pornography or other images
- Family / school / church attitudes to sexuality
- Experience of the onset of menarche and attitudes to menstruation
- History of same gender experiences and attitudes about such experiences
- History of opposite gender experiences and attitudes about such experiences
- Sexual preference and attitudes about sexual preference
- First 'full' sexual experience with a partner appropriate to one's orientation



- Experiences contrary to one's sexual preference
- Content of sexual fantasy life especially that accompanying masturbation
- Sexual and relationship patterns up to the current
- Current patterns of sexual behaviour
- Current relationship [history, character and status]
- The nature, content, intensity and scale of sexually addictive patterns of current behaviour

## **Challenging Denial**

There is a tendency for addicts to minimise, obfuscate and deny the nature, extent, frequency and consequences of their sexual addiction. This is the outcome of splitting and a by-product of shame.

It is appropriate and essential that the therapist assist the client to explore and examine whether and how this process of denial might be operating in his/her own life. If clients are to attempt and achieve recovery they need an accurate picture of the real and potential consequences of such behaviour. However, the therapist must exercise the greatest care in handling this process.

Experiential tools for use with clients to challenge denial and give the client a more accurate picture especially of the consequences of the behaviour.

Tool One:

Ask the client to make a list of harmful consequences, real and potential, that are an outcome of his/her sexual addiction. Such a list may include

- Financial
- Domestic and Relationship
- Parenting Impairments
- Employment
- Health
- Life Goals

Tool Two:

Ask the client to write out a 'what if' sequence of the realisation of the fantasy. For example in working with a client who sexually exhibits in public places ask the client to write out events to the completion of the act and then to continue with the consequences.

## **Cognitive Distortions**

In addition to denial, addiction has associated with it, the employment of a range of cognitive distortions. Part of the task of a therapist working with this client group is to help the client to understand this as a 'normal part to the disease' and to identify this process as it operates in the client's own life. In a sense, not to identify and challenge a cognitive distortion is to collude with the client in its validity and application to the client's circumstances.

Some main types of cognitive distortions associated with the behaviour

Denial	It didn't happen
Rationalisation	It did happen but it was the last time
Justification	It did happen but it wasn't my fault
Minimalization	It did happen but there was no real harm done
Excuses	It did happen but I was drunk
Blame	It did happen but she shouldn't dress that way

Therapeutic groups are particularly useful for their capacity to identify and challenge such distortions. One of the useful functions of a sponsor in Twelve Step Recovery is to provide another voice to identify and challenge cognitive distortion.

Tools:

Many therapeutic books suggest that the old negative messages should be identified and replaced by other messages. Suggest that the client write out all the negative messages and then write replacement messages. The replacement messages are then written on flash cards and rehearsed during the day or put on tapes and listened to on a regular basis.

## **Psycho-educational Work**

In the treatment of addiction, therapists have a psycho-educational function. In institutional treatment centres for drug and alcohol addiction this process is often in the formal lectures and explanatory videos and with the recommendation of appropriate reading. However this part of the work can be integrated into the therapeutic environment or at specific times set aside to provide information. This can also be done with the provision of a recommended reading list, appropriate website addresses, the lending of suitable videos, and suggestions for attendance at appropriate Twelve Step Groups where available.

## Tools

It is often helpful to suggest that the client starts to use a journal and reflective writing as a therapeutic tool. Sexual Compulsive Anonymous, a mostly gay sexual recovery programme, lists the use of the reflective journal as a 'tool of recovery' and describes the reflective journal as a 'portable therapist'.

Therapists may practice keeping such a journal and they may propose to clients, intent upon sexual recovery, that such an activity would aid the process of addiction recovery.

## Family of Origin

Butler [1999] quoting Frank [1986] suggests that one of the functions of the therapist is to collaborate with the client 'to create a plausible story to make the symptoms more benign and to help restore morale'.

It also helps create a sense of self-history.

## Tools

Suggest that the client make a Tree of Life [Butler, 1999]. This exercise invites individuals to explore their current life situation by exploring their route to it and their aspirations regarding it. Allow both positive and negative factors.

Roots = childhood and family of origin

Trunk = environmental opportunities and constraints

Branches = friends and current relationships

Leaves = individual's own personality, feelings and emotions

Unripe fruit = current appraisal of performance and satisfaction in it

Ripe fruit = where they would like to be in the future

An alternative to this is a 'Life Line' or 'Time Line'. This is a linear version of the same concept, although the Life Line concentrates mostly on understanding the relationship of current behaviours to early life experiences of shame and abuse. The time line will include experiences of shame and trauma and experiences of powerlessness in relationship to the addiction.

## **Unit 7 Making Progress**

Connecting to a culture of recovery

Making a sex plan

Establishing abstinence

Shame Reduction

### **Culture of Recovery**

Normally this means an involvement in a Twelve Step Recovery programme.

Groups currently meeting in the United Kingdom include:

Sex Addicts Anonymous

Sex and Love Addicts Anonymous

Sexaholics Anonymous

Sexual Compulsives Anonymous

### **Goodman [1998]**

Emphasizes the importance of group work

In groups people learn to make meaningful connections with others

To turn to people in times of need rather than to the addiction

### **Groups allow**

Experiencing a chance to help others

Shame reduction

Learning from others

Acceptance

Recognition that 'I am not the only one'

Learning by identification

Development of altruism

Instillation of hope

### **Characteristics Twelve Step Groups**

Free of charge

Round the clock support

Worldwide network

Coherent framework of approach

Foster honesty with the self

Offer a non-judgemental, non-dogmatic, spiritual foundation

Non-professional

## **Carnes [1991]**

### **Twelve Step Recovery Groups**

Encourages honesty

Decreases isolation

Shame reduction

Acceptance

Information from others

Sharing of vulnerability

Reduces self-judgement

### **12 Steps of Sex Addicts Anonymous**

1. We admitted we were powerless over our sexual addiction—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked God to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take a personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of his will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to others and to practice these principles in all our affairs.

Adapted from the Twelve Steps of Alcoholic Anonymous with permission of AA World Services Inc., New York, N.Y.

## **Making a sex plan**

The purpose is to:

Create awareness and clarity

Lay a foundation for abstinence-based behaviour

To help distinguish between healthy and unhealthy sexuality

Making a sex plan:

To make a sex plan is to work with a client to clarify what sexual behaviours he/she wishes to include and exclude from his/her life. This is normally done by drawing three concentric circles, labelling the inner circle 'okay' the middle circle, uncertain ['slippery'] and the outer circle 'not okay'. The client is then asked to consider which behaviours to put where and to avoid the behaviour in the outer circle. This interacts with decisions about abstinence, sobriety and celibacy and with a clarification of the distinction between 'healthy' and 'unhealthy' sexuality.

## **Establishing Abstinence / Sobriety [Carnes 1991]**

Some of the outcomes to be derived from abstinence:

Provides clarity and builds self-esteem

Need to address other addictive processes and substances

May require a time of complete withdrawal

Allows for empowerment

Brings to the forefront primary affect

Creates energy and momentum

An abstinence contract:

Should be limited in length of time

Should be reviewed regularly

The impact of withdrawal should be noted and explored

Advise of withdrawal symptoms:

Fatigue, anger, sleeplessness, depression, anxiety

## **Distinctions between healthy and unhealthy sexuality [Carnes, 1991]**

### **Addictive**

Feels shameful  
Illicit, stolen, exploitative  
Compromises values  
Draws on fear for excitement  
Re-enacts childhood abuse  
Disconnects from oneself  
Creates a world of unreality  
Self-destructive and dangerous  
Uses conquest and power  
**Seductive**  
Serves to medicate  
Is dishonest  
Becomes routine  
Requires a double life  
Is grim and joyless  
Demands perfection

### **Healthy**

Adds to self-esteem  
Has no victims  
Deepens meaning  
Uses vulnerability for excitement  
Cultivates a sense of being an adult  
Furthers a sense of self  
Expands reality  
Relies on safety  
Mutual and intimate  
Takes responsibility for needs  
May bring legitimate suffering  
Originates in integrity  
Presents challenges  
Integrates authentic parts of the self  
Is fun and playful  
Accepts the imperfect

### **Shame Reduction**

Shame acts as the oxygen to the addictive process so shame reduction work is important to the recovery process. Such work involves the identification and externalisation of shame in therapy and group work and is one of the principal spin-offs of such work.

Tools:

Specific techniques to work to change and reduce shame can be introduced. Including the 'trauma egg' [Earle and Earle, 1995]. Fig. 8.

## **Unit 8 Creating Momentum**

Understanding and Applying the Cycle of Addiction  
Making a Recovery Plan  
Relapse Prevention  
Spirituality

### **The Addictive Cycle [Carnes, 1991]**

The Four Main Components

Preoccupation  
Ritualization  
Compulsive sexual behaviour  
Unmanageability and Despair

### **Understanding the Cycle of Addiction**

For the sex addict, compulsive sexual behaviour has been the defensive mechanism used to handle 'stress, loneliness, anger, unexpressed fears and feelings.'

The cycle of addiction has the following characteristics:

It is habitual  
It involves a collapsed concertina of responses  
Much of the cycle is out of awareness  
It seems automatic to the addict

### **Bays and Freeman-Longo [1989]**

Fig. 9.

### **Based on Bays and Freeman-Longo [1989]**

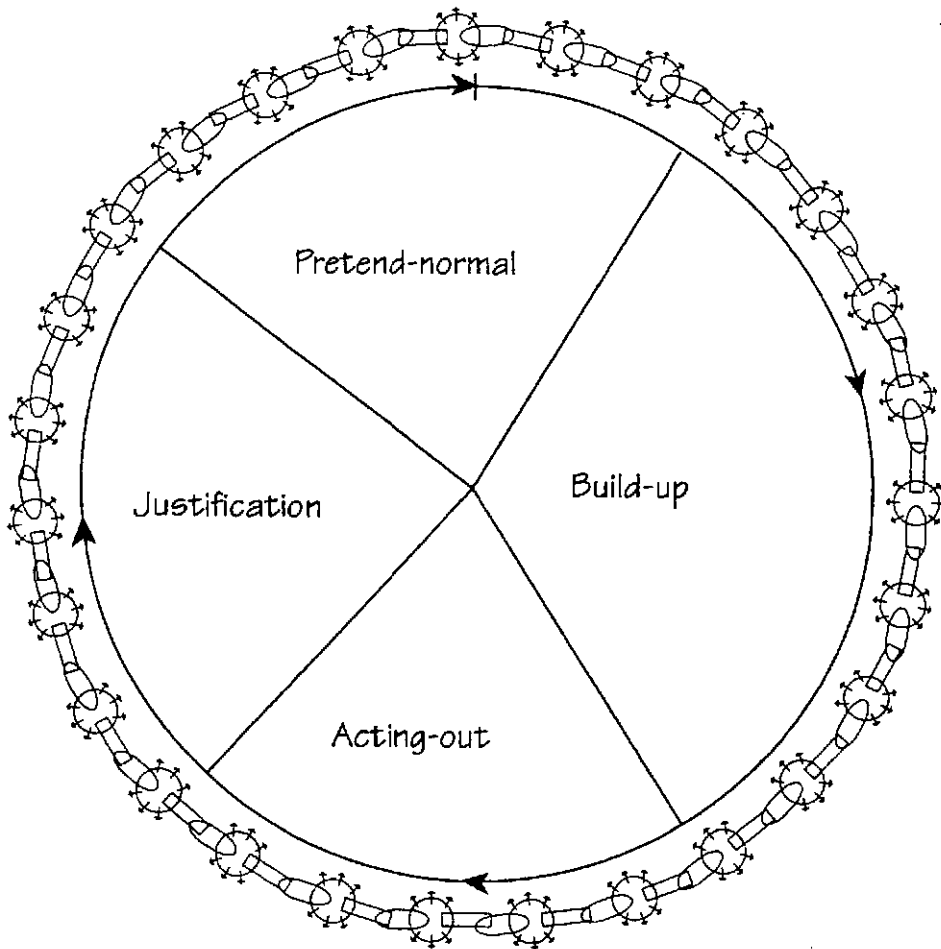
Fig. 10.

In working with such clients, it is important to:

Go through each clients cycle as with a video camera  
Remember to emphasize that early exit is the best prevention strategy  
The client must learn to identify feeling states that create vulnerability



## Cycle of Sexual Addiction based on Cycle of Sexual Offending



**Fig. 9 Bays and Freeman-Longo [1989]**

# Linear Version of Cycle of Addiction Based on Cycle of Sexual Offending

## Cycle of Addiction

Based on Laume Bays 'Why did I do it again?'

Pretend normal  
Build up  
Acting out  
Justification

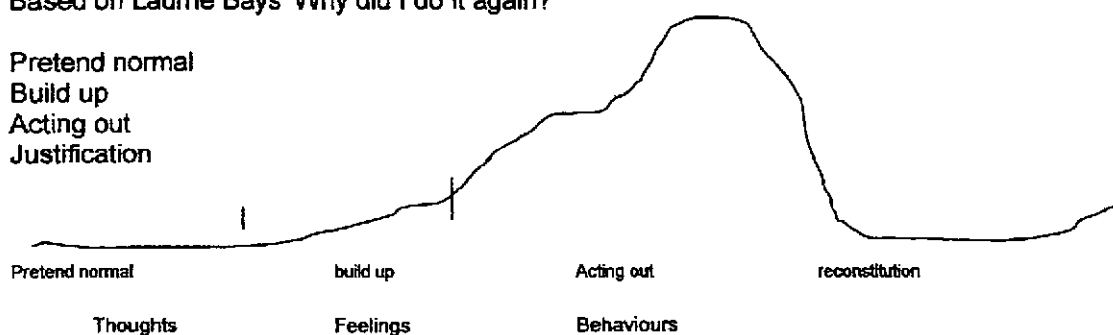


Fig. 10

## **Understanding the Control / Release Cycle**

Based on Fossum and Mason [1986]

Fig. 11

This cycle has the following characteristics:

An acting in / acting out component

An interconnection between the two sides of the cycle

The cycle can be intergenerational

Importance of getting off the cycle rather than moving to the control side

## **Understanding and working on suds**

A SUD is a 'seemingly unimportant decision'. It is important to explain and emphasize to clients how avoiding suds can prevent the cycle from gathering momentum. It allows an exit from the cycle more easily and more surely.

## **A written recovery plan might include**

Directed reading

Identification of appropriate 12 Step meetings

An action plan to attend 12 Step meetings

Amount and type of therapy

Goals and objectives in therapy

Active decisions to

## **A written relapse prevention plan might include**

Regular therapy

Written plan of action in the case of relapse

Get to a meeting

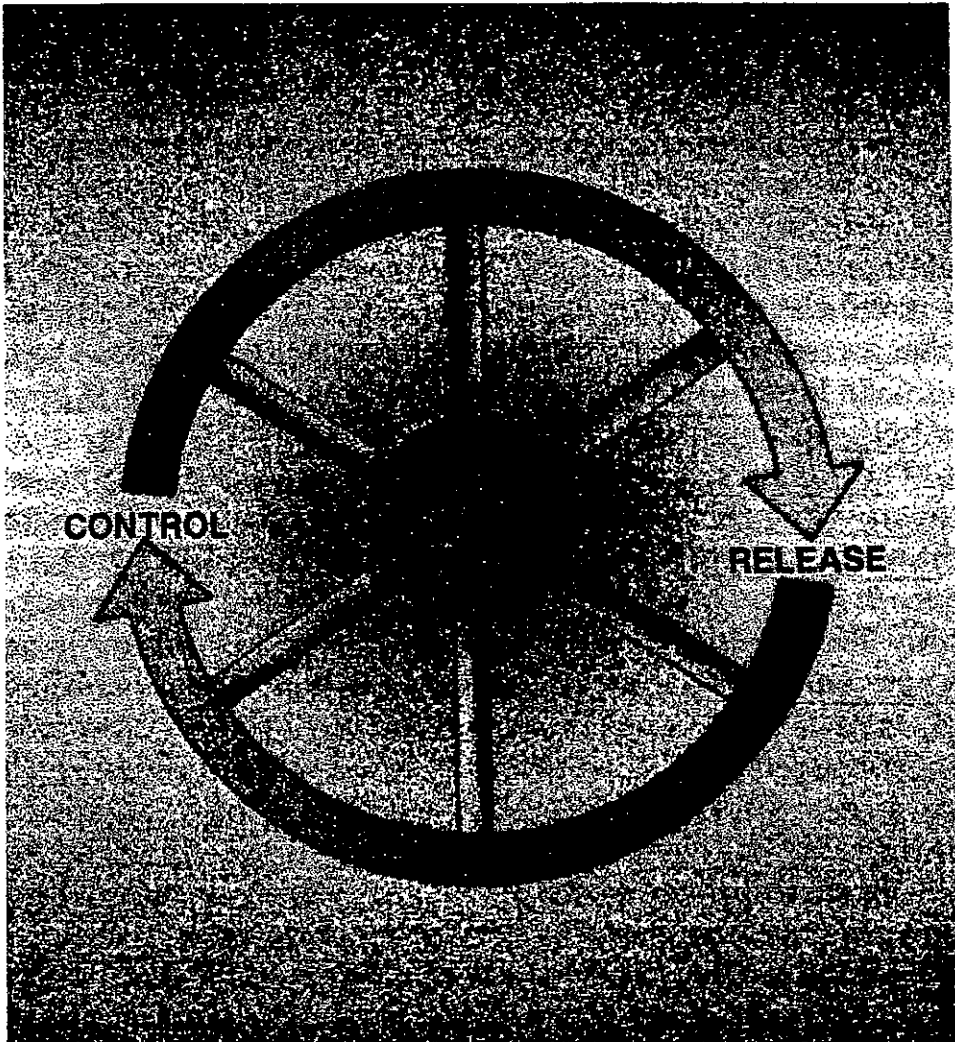
Tell someone

Use Of the serenity prayer

## **Development of a Personal Spirituality**

Work with client for the identification and development of the client's personal spirituality.

**Alternating Control / Release Cycle  
Characteristic of Addiction**



**Fig. 11 Fossum and Mason [1986]**

## **Unit 9 Moving On**

Reconstructing the Self  
Creating Good Lives

**Psychodynamic psychotherapy has the following goals—  
[Goodman, 1998]**

- Enhance self-regulation
- Foster capacity for meaningful interpersonal connections
- Facilitating healthy means of managing affects, getting needs met, resolving inner conflicts, and getting needs met

**Major goal:**

People with addictive disorders are typically not aware of any connection between behavioural states and the underlying affect states, therefore a key element is to engage them in a paradigm shift from the behavioural urge is a 'force in itself' to becoming interested in that which the behavioural urge is an indication.

**Cognitive behavioural techniques can be helpful—**

- Skill training [communication, assertiveness, anger management, stress management, relaxation training, cognitive re-structuring, life style regeneration]

**Social skills considerations include**

- Physical integrity, financial viability, meaningful work, life style balance, exercise and nutrition, and building supportive friendships

Here the goal is to work with clients to take actions that create a better quality life. This means, in effect, the creation of a tailored made work-package for each client

Summary of Ward [in press] as for Unit 1

Human beings have and are naturally inclined towards the following goods for body, self, and social life.

**Primary goods for the body:**

Sex, food, water, warmth, sleep, and a healthy functioning of the body as a whole

**Primary goods for the self:**

Autonomy, relatedness, and competence

Relatedness: intimacy, understanding, empathy, support, sexual pleasure, sharing

**Primary goods for social life:**

Social support, family life, meaningful work opportunities, access to recreational

'A conception of the good lives should be based on these three classes of primary goods and specify the forms they will take in each persons life plan.'

This strategy proposes the creation of specially prepared life plan for each client that is based on acquisitions of some of the three primary goods.

## **Appendix J**

### **Contents:**

**The First Product Revised—**

**‘The Snake and the Seraph’**

**Accepted for Publication by Counselling  
Psychology Quarterly**

**'The Snake and the Seraph'—  
Sexual Addiction and Religious Behaviour**

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## **'The Snake and the Seraph'— Sexual Addiction and Religious Behaviour**

### **Abstract:**

The purpose of this article is to explore the relationship between sexual misconduct and religious vocation. Drawing on clinical and ministerial experience the article suggests that most sexual misconduct among religious officials is a combination of sexual addiction and religious behaviour acting as interconnected responses to narcissistic damage. It goes on to outline a reciprocal inter-locking cyclical pattern of behaviour and suggests a treatment strategy that prioritises four tasks: psycho-education, group work, family of origin exploration, and facilitating access to the components of a good quality of life.

## **'The Snake and the Seraph'— Sexual Addiction and Religious Behaviour**

### **Introduction**

A great deal has been published and broadcast over the past few years on sexual misconduct in religious organisations. There is evidence that religious officials have higher rates of sexual misconduct than other caring professionals [Birchard 2000, Carnes 1987, **Leadership** 1988, Grenze and Bell 1995, Francis and Baldo 1998, Fortune 1989, Sipe 1995]. Sexual misconduct among religious officials is usually a combination of sexual addiction and religious behaviour acting together as interconnected responses to narcissistic damage [Birchard, 2000, **Time for Action**, 2002]

### **Sexual Addiction**

Sexual addiction is defined as an on-going pattern of sexual behaviour which has three principal characteristics: an inability to reliably stop the behaviour, a continuation of the behaviour in spite of potential and/or actual harmful consequences, and a preoccupative or obsessive quality to the pursuit of the behaviour [Carnes and Wilson, 2002].

Most authorities agree that the phenomenon of sexual addiction exists [Keane, 2002]. Some practitioners [Cooper and Marcus 2002] prefer 'sexual compulsivity' as an alternative descriptive term. A debate about appropriate nomenclature is on-going. The most powerful and sustained criticism of the concept of sexual addiction is social constructionist and argues that the concept of sexual addiction and other emerging 'discourses of addiction' [Keane, 2002] treat 'overwhelming erotic desire as a virulent disease'. Keane

[2002] suggests, like Levine and Troiden [1988] that the expansion of addiction discourse pathologises such behaviour and the 'addict' thus becomes one in need of intervention and medical and psychological services. However the application of an addiction model to our understanding of this behaviour has enabled counsellors and psychotherapists to treat the problem with some success [Cames, 1991, Carnes and Adams, 2002].

### **Examples of the Behaviour**

Sexual addiction is not about any one type of behaviour but rather it is "a syndrome in which some form of sexual behaviour relates to and affects an individual's life in such a manner as to accord with the definition of addiction" [Goodman 1998 p234]. One addict described his experience in this way [Anonymous 1986 p200],

But going to the strip joints in Boston's Combat Zone, peering in windows, compulsive masturbation, and eventually exhibitionism were not 'cheating' on my wife... I would spend spring and summer nights exhibiting myself, masturbating, drinking, peering in windows, and gradually getting sicker.

The behaviour is experienced as unmanageable, chaotic, relentless and unstoppable. It takes up inordinate amounts of time, interferes with the rest of life, is unsafe and unsatisfying and, sometimes, anti-social or criminal. It is experienced as relentless and unstoppable.

Another example is from a case study. Liam was an older married man with three children who was in a recovery programme for drug addiction. His 'acting out' patterns involved anonymous unprotected receptive oral sex in public places with, sometimes, many men in one evening. The major issue

behind the other issues was a sense that he was, in his words, “addicted to sex that degrades”. He experienced powerlessness and unmanageability. Given the health risks and the other dangers involved, the word ‘addiction’ seems, to me, aptly to describe the ‘locked in’ repetitive character of his behaviour. He was in despair, with suicidal ideation, and overwhelmed by shame. However great his resolve, the behaviour was unstoppable. [Names and details have been changed.]

### **The Functions and Consequences of Sexual Addiction**

Sexual behaviours are used addictively to control painful affect, to avoid feelings of loneliness, and to ward off the dread of non-being. Once the behaviour begins, he/she is out of pain and out of reality for the duration of the episode. A tunnel closes around the addict and nothing exists and nothing much matters but the pursuit of the behaviour. However bad life seems after the behaviour—loneliness, anxiety, and shame are banished for the duration.

But the behaviour has harmful consequences for the individual. The feelings of shame and low self-worth are compounded by the behaviours themselves and contribute to cycles of self-hatred and contempt. The behaviour disturbs family life, affects careers and public office, creates accidents, drives people to suicide, can be associated with crime and anti-social activity, lies behind abuse and contributes to human tragedy.

## **Narcissistic Damage**

Based on DSM-III-R definitions for character and pathology [Goodman, 1998] narcissistic damage can be defined in the following way— enduring affect, cognitive, behavioural, relational patterns, laid down in the formation of the self and carried into adult functioning that are inflexible, maladaptive, and cause either significant impairment or subjective distress.

Narcissistic damage arises out of impairments in the mechanism for the formation of the self [Stern 1998]. These are various but include problems and incompleteness in the individuation/separation stage of child development, problematic internalisation of self-regulatory functions, and abnormally high levels of aggression created by the frustration of early needs [Goodman 1998]. This is reflected not only in personality and life-style but also in internal body chemistry [Pope et al 1993]. According to Kernberg [1986] there is 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 brilliance or achievement. There is a tendency to lack empathy, to experience chronic uncertainty, and dissatisfaction with self. There is often the presence of chronic envy and defences against envy. Much the same list of features and characteristics are outlined by Miller [1987] and can be found throughout psychotherapeutic literature. The psychoanalytic concept of narcissistic damage is widely held and well documented [Morrison, 1986], its origin supported by specialist research into child development [Stern 1998].

I propose that narcissistic damage is the core issue behind all forms of addiction. The addictive process produces temporary relief from inadequacy, loneliness, inner distress, anger, shame, and other painful affects. Laaser [1991 p215] describes sexual addiction as 'used to escape feelings', 'numbing', and used for its 'narcotic like effect' and Kasl [1989 p4], as a way of 'attempting to fill an emptiness 'paradoxically' and getting hungrier and hungrier'. In effect, sexual addiction temporarily anaesthetises the deep inner feelings of low self-worth, provides windows of intensity and oblivion, and is used to forestall hopelessness and the fear of non-being [Kasl, 1989].

### **Religious Behaviour**

The sense of inner emptiness, isolation, and primal wounding that lies at the heart of addiction is the same sense of emptiness, isolation and primal wounding that takes people, not only to varieties of addictive behaviour, but to varieties of religious experience [Booth, 1991]. For some people, religious behaviour is a coping strategy to manage shame and to handle the consequences of narcissistic damage [Pattison, 2000]. In some cases it will be manifested with addictive patterns and the symptoms and behaviours of narcissism. The word 'alcoholism' has at its root the meaning in Arabic 'the desire to be whole' [**Independent of Sunday**, Sunday, 22 November 1998]. The compulsion to seek 'enlightenment', a state untouched by fragmentation and suffering is [Firman and Gila 1997] 'the drive that underpins the addictive process as a whole'. Damage repair and wholeness are available to the worshipper through faith and practice. Broucek [1991 p78] writes that a 'shame-glory complex is particularly observable in disorders of narcissism'.

He notes that the “propensity of prominent Christian preachers and evangelists to bring disgrace upon themselves [usually in connection with some sexual escapade] testifies to the power of this complex”. Griffin-Shelley [1991] emphasises that “it is not uncommon for sex and love addicts to turn to religion as a solution to their addiction”.

Other researchers have observed similarities among different addicts [Jacobs, 1997] and have alluded to religious behaviour as behaviour with similar characteristics. William James [1982, p426, first published 1902] observed in **The Varieties of Religious Experience** that the ‘snake and the seraph’ abide side by side. Religious behaviour and sexual behaviour can come from the same place. They can both be responses to narcissistic damage. This is, I believe, the key to understanding much professional misconduct and the combined appearance in clients of religious and sexual behaviours that alternate, or are perceived to be in conflict, but are held at the same time. The co-existence of these two patterns, explain splitting, create high levels of shame and requirements for secrecy, all of which fuel the processes of painful affect, low self-esteem, and self-contempt.

### **Implications for Counselling and Psychotherapy**

Because ‘it is impossible to effectively intervene in a process that you do not understand’ [Sullivan, 2002, p17], aetiological and phenomenological understanding becomes fundamental to the treatment of this disorder. Research has established the absence of, and the need for, training for

psychotherapists to work with the problems of sexual addiction [Birchard, 2003].

### **The Priorities of Treatment**

Drawing from the literature [Carnes and Adams, 2002], from my own research [Birchard, 2000, 2003], from the work done by the Churches Together in Britain and Ireland Working Party on Sexual Abuse in the Church, from clinical practice and from the experience of parish ministry, the therapeutic tasks for these clients can be divided in the following way:

#### **Recovery Facilitation:**

- Psycho-education
- Joining a Culture of Recovery

#### **Psychotherapeutic Restructuring:**

- Family of Origin and Constructing the Narrative
- Creating Good Lives

Underpinning these four priorities is the importance, for the therapist and the client, to understand the repetitive inter-linking nature of this process as cycles of alternating behaviour, each with its own reciprocal momentum.

### **Recovery facilitation**

Whatever the theoretical orientation of the treatment provider, there are a number of cognitive behavioural tasks that are required for a successful outcome. The therapists must provide a place for the client to learn about sexual addiction. This can be done by providing a mini-course at the beginning of the therapeutic process or by weaving material into the unfolding of the process. Teaching about sexual addiction is the priority because sexual



addiction is that part of the process that is most damaging and destructive to the client.

Included in the education programme, is direct teaching about the importance of group work and a priority for the client to commit and participate in a sexual addiction recovery programme. Carnes [1991] suggests, from his research, that most recovering sex addicts relapse unless there is an involvement in a culture of recovery. For most clients this will, in effect, mean that they will access and commit to a 12-step sexual recovery programme. Most of these in the United Kingdom are London based, but not entirely, and new groups are opening up every day. Sexual recovery meetings are also available online. One of the recovery programmes, Sex Addicts Anonymous, has a provision for 'boundary meetings'. These are meetings specially set up to provide a programme of recovery for the clergy, medical doctors, psychotherapists, and others who need to attend meetings separate from clients, parishioners, and patients.

### **Psychotherapeutic Restructuring**

In addition to the educational and behavioural tasks proposed above, there are two additional priorities, more usually associated with conventional psychodynamic and person-centred approaches. I describe these as 'restructuring' because they are processes that are reparative on the original narcissistic damage. If the cognitive behaviour tasks are to change the behaviour, these next two tasks are meant to help change and repair the

sense of self, experienced painfully and as unacceptable, that generates the behaviour.

The first task is an exploration into the family of origin and the creation of a narrative that explains and makes sense of the client's experience. The narrative helps the client to make sense of the present. The construction of the narrative helps form and strengthen a sense of self [Butler, 1999]. The second task is the use of the therapeutic relationship to help the client bring into his or her life activities and processes that fill the 'hole' that lies at the heart of narcissistic damage. This is to use the self of the therapist to effect changes in the self of the client and to use the therapeutic relationship to create new and changed relationship templates. Furthermore, this is to help the client construct and bring into place the components of a rich and meaningful life, to fill the inner void and to replace the anaesthetizing functions of the addiction with enduring structures and sources of solace.

### **Understanding the Cyclical Link**

There are, in the literature, numerous diagrammatic illustrations on sexual addiction and on offender treatment, roughly similar, that seek to conceptualise and explain these behavioural processes [i.e. Cames 1983, Finklehor 1986, Wolf 1984]. In the process of piloting a sexual addiction treatment and training programme, participant feedback particularly endorsed the importance of an understanding of the cycles of addiction [Birchard, 2003]. Drawing from the work of Fossom and Mason [1986] who propose that addictive compulsive cycles are alternating rhythms of control and release, I take the view that sexual addiction and religious behaviour are interlinked in

# Sexual Addiction and Religious Behaviour An Interlocking Cycle

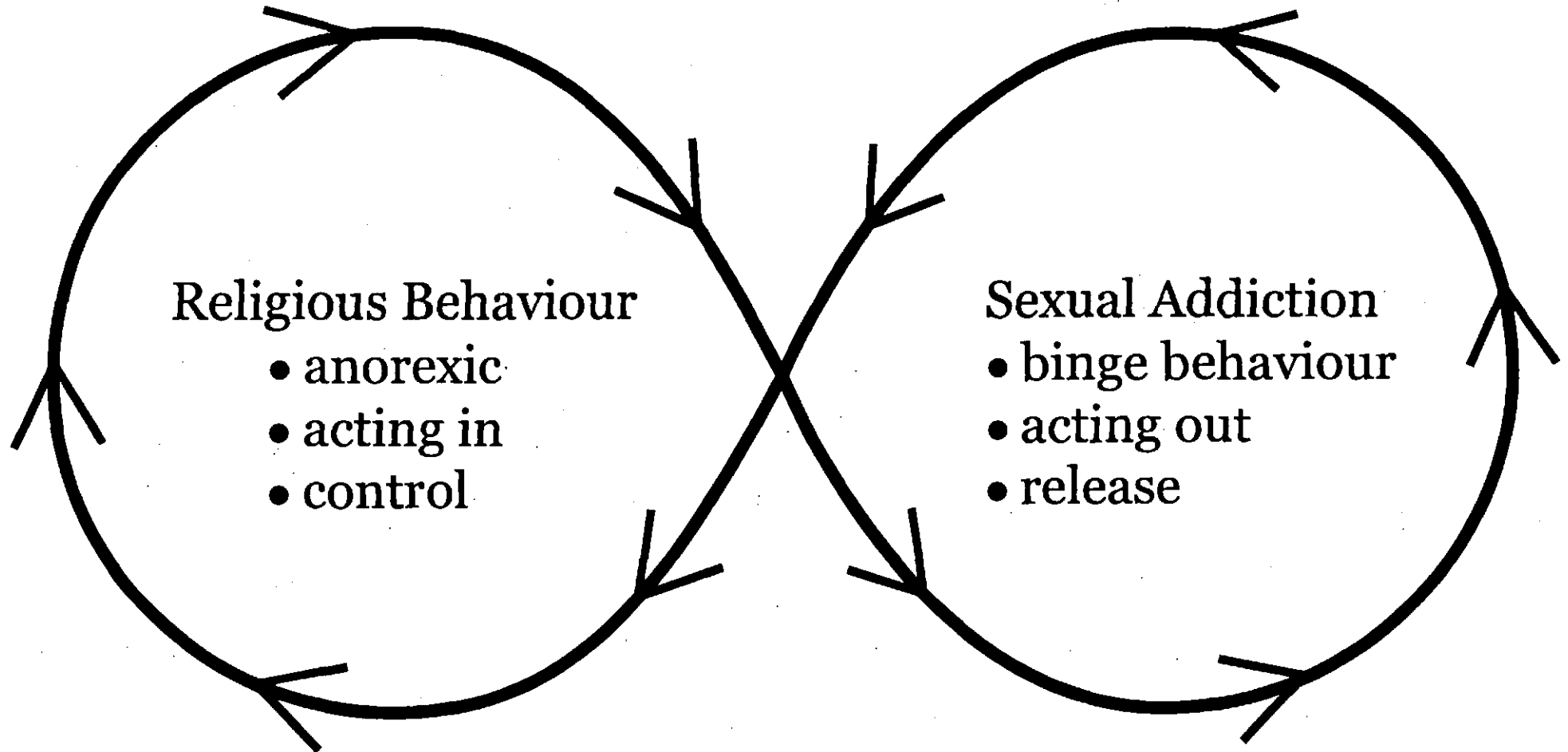


Fig. 1

that the sexual behaviour represents the release part of the cycle and the religious behaviour represents the control part of the cycle. This creates a figure-of-eight sequence of alternating interlocking behaviours rather like bulimia and anorexia. To draw from cycles of offending [Bays and Freeman-Longo, 1989], the illicit sexual behaviour is followed by a process of reconstitution. The religious behaviour makes up this reconstitution and contributes to the second part of this cycle [fig. 1]. The recognition of this factor is important. The characteristics of the religious behaviour [i.e. repentance, confession, diligence, service] actually move the client to a sense of neediness or entitlement and thus back into the sexually addictive behaviour. Unless this cycle is understood and aborted these apparently antithetical behaviours contribute to one another. It is the acceptance of the paradox of powerlessness at the heart of twelve step recovery that makes it so effective in addressing addictive compulsive disorders [Fossom and Mason 1986], effectively creating movement off of, rather than around, the cycle.

### **Summary and Conclusion**

The purpose of this article has been to examine the links between addiction, sexual addiction, and religious behaviour and to consider some of the implications of these links for intervention and treatment. But sexual abuse in the church is not just about sex. When committed by a church leader against a staff member or a church member, it is an abuse of power and violates the duty of care and conditions of trust implicit in the pastoral relationship. Fortune [1994] describes this, not just as a misuse of power, but also as a violation of

role, an exploitation of the vulnerable, and as an act that, because of the differential of power, that precludes meaningful consent.

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## **Appendix K**

### **Contents:**

#### **Outpatient Treatment Programme for Men with Addictive Compulsive Sexual Behaviours**

## Sexual Addiction Treatment Programme

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A 14-week treatment programme for men will be held at the Psychotherapy and Counselling Consultation Centre [PCCC], Regents College, Inner Circle, Regents Park, NW1 starting Wednesday 10<sup>th</sup> September 2003, 7:30 – 8:30pm. The centre is a ten-minute walk from Baker Street Station. On-street parking is available.

This programme is specially designed to facilitate recovery from distressful and unwanted addictive, compulsive, and obsessive sexual behaviours and to promote healthy behaviours of choice. The programme is based on the model developed at the San Jose Sexual and Marital Center. It is designed to complement one-to-one psychotherapy and/or to go along side 12 step recovery. Each group session will last one hour. A second programme will start on Wednesday 14<sup>th</sup> January 2004.

This treatment programme is independent of and unconnected to the School of Psychotherapy and Counselling at Regents College, and as such, is not a psychotherapeutic service provided by PCCC.

For information and/or to book an assessment ring 020 7372 3155, email [thaddeus@birchard.co.uk](mailto:thaddeus@birchard.co.uk) or write to:

The Programme Initiator  
The Medical Suite  
Bentinck Mansions  
Bentinck Street  
London  
W1U 2ER

Cost: £600 payable in four instalments of £150 per month and a deposit equal to one month only repayable on completion of the programme. The number of places is limited so early application is advised.

**Programme Initiator:** Thaddeus Birchard BA DipTh MSc  
BASRT Accredited, UKCP Registered  
Psychotherapist and Psychosexual Therapist  
Clinical Associate, Dr Patrick Cames, Meadows Institute, Phoenix, Arizona

**Co-facilitator:** John Beveridge, UKCP Registered  
Attachment-based Psychoanalytic Psychotherapist  
Trained with, and currently teaching at, the Centre for Attachment-based Psychoanalytic Psychotherapy

*This programme is suitable for differing patterns of behaviour, does not discriminate on sexual orientation, and is committed to the avoidance of oppression and the pursuit of individual dignity and well being.*

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Medical Doctors, Psychotherapists, Counsellors or other Health Care Professionals who would like more information about treatment modalities, programme orientation or sexual addiction in general please feel free to ring on 020 7372 3155. This is an evidence-based treatment programme using CORE and supplementary outcome studies. Individual referrals for one-to-one work can also be made through the Programme Initiator.

## **Sexual Addiction Treatment Programme**

Please find enclosed information about a treatment programme that I am running for men with unwanted addictive compulsive patterns of behaviour.

I have had such a programme in mind for sometime and have decided to move forward with it this autumn with a second programme to start in January 2004.

If you would like to any more information for yourself or if you would like to suggest this programme for someone else, please give me a ring on 020 7372 3155 or on the mobile 07949 244582.

Thaddeus Birchard BA DipTh MSc  
BASRT Accredited, UKCP Registered  
Psychotherapist and Psychosexual Therapist

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Thaddeus Birchard BA DipTh MSc  
BASRT Accredited, UKCP Registered  
Psychotherapist and Psychosexual Therapist

## **Treatment Programme Information**

The goal of this treatment programme is to help participants let go of unwanted addictive/compulsive sexual behaviours and to adopt new behaviours of choice. Research suggests that active participation in a group committed to recovery is an almost essential component for successful recovery. This treatment programme is meant to be complementary to individual psychotherapy and/or twelve step recovery meetings. The category sexual addiction also includes love and relationship obsessive behaviours.

The format that will be used is based on a sexual addiction treatment programme developed by Dr Al Cooper at the San Jose Sexual and Marital Centre in California. The aim of this group is solely to help people leave behind addictive compulsive sexual and romantic behaviours and to learn to live sexually healthy lives. Sexual sobriety is not a requirement for group membership.

## **Meeting Days and Times**

Every Wednesday evening from the 10<sup>th</sup> September to the 10<sup>th</sup> December with the 17<sup>th</sup> December kept as an extra evening if extra time is required.

Wednesday 10 / 17 / 24	September
Wednesday 1 / 8 / 15/ 22 / 29	October
Wednesday 5 / 12 / 19 / 26	November
Wednesday 3 / 10 / 17	December

Meeting Times: 7:30 – 8:30pm

All meetings will start and stop exactly on time.

## **Contacting the Facilitators between Sessions**

The facilitators can be contacted through the Programme Secretary Rhona Morris on 07945 244582.

## **Cost and Payment:**

Total cost £600 payable in four instalments of £150 that will be collected on the first Wednesday of each month. Late payment will be surcharged at £20 per week. A deposit of £150 is required which is only refundable on the completion of the programme. Cheques payable to Thaddeus Birchard.

## **Missed sessions**

Each person is only allowed to miss two sessions and for whatever reason and these must not be taken in succession. Should more than two sessions be missed then the whole programme has to be repeated.

## **Contact Between Sessions**

Because sexual addiction is seen as set up in 'disturbed relationships' unlike other therapy groups this programme strongly encourages contact between members before, after, and between sessions. One of the unique features of this programme is that this is felt to be so important that all members are asked to make two programme calls to group members between sessions. Each successful call will gain a rebate of £1 per two calls. To get the rebate a participant must actually talk to two different people in the programme between each session. It must be an actual conversation and not an email or telephone message. Rebates will be payable on the first Wednesday of each month.

Group members are encouraged to join together for fellowship after the meeting. There are various coffee bars, fast food restaurants, and sandwich shops around Baker Street and Baker Street Station.

## **Respectful Participation**

This treatment programme operates an equal access non-discriminatory policy and all participants are welcomed equally. All members are requested to be respectful of race, religion, gender and sexual orientation. Violent or threatening behaviour is not permitted.

Any questions, conflicts, or problems within the group, with another group member or with either facilitator should be raised within the group session for resolution.

This treatment programme is not suitable for sex offenders.

## **Problems and Complaints**

These should be raised with the facilitators immediately after the 'check in' portion of the meeting.

## **Confidentiality**

It is important that the group is a safe place for all participants and therefore in signing this information you are committing to a strict policy of confidentiality. What you see here, what you hear here, let it stay here. This commitment to confidentiality extends to our communication with family members and significant others. The only exceptions to this are those required by law: i.e. offences under the Terrorism Act of the Children Act. The facilitators also reserve the right to discuss

## **Gossip**

Gossip is to be avoided at all times. By gossip we mean critical or complaining statements, even those disguised as humour, about to third parties about a facilitator or another group member. In our experience gossip undermines morale and makes the group feel unsafe for all participants.

## **Completing the Programme**

It is very important to the well being of the individual participant and to all the members of the group that all participants see the group to its completion.

## **CORE Outcome Studies**

In order for us to be able to evaluate and improve the effectiveness of our treatment programme we ask all participants to fill in the CORE outcome questionnaire on the first Wednesday of each month. This is an anonymous confidential questionnaire that takes about 10 minutes to fill in. It asks nothing about your sexual or relationship behaviours and no one can be identified from the questionnaire. Signing that you have read this document also signifies your consent to participating in these evaluation studies.

## **First Wednesdays**

On the first Wednesday of each month participants are asked to arrive between 7:00 and 7:10 to allow 20 minutes for making payments, receiving rebates, and filling in the CORE outcome questionnaire.

## **Mobiles and Pagers**

Please make sure that pagers and mobiles are switched off during group sessions.

