SEX ADDICTION

Is NOT a "MYTH" When Neuroscience Keeps the Score

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> One myth, which we believe is the most damaging untruth about sex addiction therapy is that Certified Sex Addiction Therapists use or respect reparative therapy (Blevins et al., 2016, p. 14). This is patently false. CSATs receive their training through the International Institute for Trauma and Addiction Professionals (IITAP), which neither ascribes to, promote, employ nor remotely countenances any form of reparative "therapy" (https://www.iitap.com/about/).

This article aims to update the psychotherapy community on the sex addiction model, highlight neuroscientific research supporting its addiction paradigm, and dispel myths about sex addiction therapy. Unfounded critiques claim that the very concepts of "sex addiction" and "porn addiction"—let alone therapies aimed at alleviating pain associated with these conditions actually harm our clients.

It is not uncommon for those untrained in the treatment of sex addiction to make uninformed, and even false, statements regarding assessment and therapeutic modalities provided by Certified Sex Addiction Therapists (CSATs). Typically, outdated behavioral arguments or accusations of homophobia and pathologizing non-normative sexual practices fuel their complaints. Rather than study the neurobiological science supporting the view of sex addiction (like other dependencies) as a chronic disease of the brain, they dismiss solid research into its neuropsychological roots and make inaccurate allegations about treatments used by sex addiction specialists. Thus the present authors believe it is vital for the profession, and the public, to understand neurologically informed sex addiction theory as well as its sex-positive, relationality-based therapeutic protocols.

One myth, which we believe is the most damaging untruth about sex addiction therapy is that Certified Sex Addiction Therapists use or respect reparative therapy (Blevins et al., 2016, p. 14). This is patently false. CSATs receive their training through the International Institute for Trauma and Addiction Professionals (IITAP), which neither ascribes to, promote, employ nor remotely countenances any form of reparative "therapy" (https://www.iitap.com/about/). Certainly, some *non*-CSAT therapists have co-opted the term *sex addiction* to lure clients into reparative therapy, and some *non*-CSAT therapists shame and judge sexually compulsive individuals. Inexpert and uncredentialed as sex addiction therapists, these clinicians have indeed mislabeled (and mistreated) clients with nonconforming attractions. Yet as noted, IITAP and CSATs neither support nor condone such destructive practices. They adamantly believe in and uphold California law and IITAP ethics, both of which correctly state that reparative therapy is unethical and illegal. A second myth purports that individuals are deemed sex addicts based on their sexual orientation, with homosexuals as the likeliest targets. In fact, individuals of *any* orientation may display symptoms of sexual addiction, and would be so diagnosed based on their self-report and a comprehensive, careful assessment process.

Some detractors of the sex addiction model also maintain a third myth that sex addiction therapists demand clients' participation in a 12-Step program and rely on those groups as the be-all and end-all of treatment. In truth, though, not all CSATs encourage, and none require, attendance at 12-Step meetings as part of treatment (Carnes, 2000, p. 10). This is so precisely because CSATs commit to value each individual's form of sexuality, while certain 12-Step programs present discriminatory and repressive ideologies or environments. And although most 12-Step program participants appear to strengthen their attachment capacities as they get their needs met relationally through the interactive regulation of a caring group (Smith & Tonigan, 2009), sex addiction therapy hardly ends with 12-Step work. Each client works with his or her therapist to complete a thorough assessment, design a comprehensive treatment plan tailored to the client's goals, and establish supportive structures that facilitate long-term and profound recovery.

These points alone disprove a fourth myth that CSATs' protocol includes shaming and scolding individuals who struggle with sexual preoccupation. Far from the pleasurable, creative and relational sexuality (of any stripe) toward which sex addiction therapy guides the client, sexual preoccupation is marked by moderate to severe dissociation, frequently accompanied by ego-dystonia, dysphoria, rigidity, and isolation. Sex addicts expend most of their energy replaying past (often traumatic) sexual experiences or fantasizing about future (repetitive or compensatory) ones, often to the point of disabling function in—and certainly enjoyment of—their personal or professional lives. The hallmark compulsivity characteristic of sexual preoccupation keeps it from being at all equivalent to even the most intense healthy sexual interest and behavior.

The need to make such subtle distinctions requires CSATs to undergo rigorous specialized training and to maintain ongoing recertification. Many CSATs are also Certified Sex Therapists (CST), usually through the American Association of Sex Educators, Counselors, and Therapists (AASECT). Additionally, they study new work in the neurobiology of addiction; the manifold aspects and range of human sexuality; the role of trauma and its impact on sexuality; attachment and affect regulation theory; and family-of-origin issues. CSATs also receive extensive training on the Sexual Dependency

Inventory 4.0 (SDI 4.0) assessment instrument, which includes the Sex Addiction Screening Test (SAST). The SDI 4.0 is the most comprehensive, validated, broadband measure of potentially problematic sexual behaviors and preoccupations available (Green, 2016, p. 126). Two renowned psychometricians largely modeled this tool on the Minnesota Multiphasic Personality Inventory's (MMPI) psychometric analysis, evaluating it with standard and field-tested indices (Green, 2016). Yet CSATs use it only in conjunction with the client's self-report and a structured interview process—*never* as the sole indicator.

CSAT clinicians are also educated about alternative sexual lifestyles and are trained to avoid labeling a client a "sex addict" simply because her or his arousal template includes nonconforming behaviors such as kink/fetishes, BDSM, or other practices (Hopkins et al., 2015). Only if a client presents with sexual behavior—alternative or ordinary—that troubles *him or her* are practices explored and assessed. More importantly, this investigation aims to measure the problematic nature *not of the sexual acts themselves*, but of their *compulsive use*. Recovery from sex addiction never means "repairing" erotic minorities from their sexual preferences. A fifth myth is that the sex addiction model is sex-negative, puritanical, anti-pleasure, and accepting only of narrowly normative heterosexual coitus, is a flat-out falsehood. Precisely to the contrary, the sex addiction model is a sex-positive one with the goal of helping each client discover, delight in, and fully express *his or her* preferred sex life (Bercaw & Bercaw, 2010; Katehakis, 2010; Weiss, 2016).

Sex addiction therapists agree with sexologists that sexual activity greatly benefits physical health. Sex addiction therapists do not judge clients as having the "wrong kind" of or "too much" sex. What does concern us, however, is the increasing number of adolescents, adults, and couples who seek our services because of sexual behavior *they* find problematic personally, professionally, financially and, in some cases, legally. Those without proper training routinely miss the point of sex addiction treatment—not to pathologize individuals with varied types or degrees of sexuality but rather, to assess and treat

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individuals who report, *of their own accord*, indicators consistent with the addiction model.

Science-Based Debate and Consensus on Sex Addiction

Having dispelled the mythic objections to the concept and field of sex addiction, we may explore the science-based debate concerning its nature and treatment, which sex addiction naysayers deny, dismiss, or simply don't know. Of course, we recognize that for the past several decades, well-informed researchers and practitioners have disagreed vehemently, as scientists do, about the definition and the very existence of compulsive sexual behavior or sex addiction. But that serious debate inspired groundbreaking neuroscientific research which, in turn, has produced a body of neurophysiological data that explain the identical brain and nervous system mechanisms at work in both behavioral and substance addictions. This new knowledge "has engendered a maturation in understanding the role of the mesolimbic dopaminergic reward pathways in both drug and natural [behavioral] addictions" (Hilton, 2013, p. 2). In 2011, the American Society of Addiction Medicine (ASAM) formulated a more accurate definition of any addiction—one that incorporates current neuroscientific findings—as "a brain disease affecting memory systems, reward pathways, and motivation" (Retrieved from http://www.asam.org/for-the-public/definition-of-addiction, 2013). ASAM confidently applies this updated definition informed by brain research to both substances and process addictions (explicitly including sex and gambling), based on the commonality of the reward brain pathways involved in both types. ASAM comprises medical doctors whose qualifications entail specific training in addiction treatment, pharmacology, board certification and clinical experience. However, inexpert detractors of the sex addiction concept reject ASAM's competence to determine that sex (or gambling, or overeating) addiction is a biological disorder like substance addiction.

These critics correctly note that while ASAM has acknowledged sex addiction as a brain disease similar to substance addictions, the *Diagnostic and Statistical Manual of Mental Disorders* has not. And they depict the *DSM* as the final arbiter of the reality of a given addiction (or of any disorder). But this portrayal entirely mistakes the scope and function of the *DSM*. The *DSM* is a valuable field guide based on observation but not on the etiology or essence of conditions. Opponents of the concept of sex addiction misrepresent the *DSM*'s real purpose, claiming that it is the ultimate authority of which disorders are "real." And they carefully omit any mention of the *DSM*'s long delay in recognizing alcoholism as an addictive disorder. But as Jabr (2013) reminds us, "No one knows whether the disorders in the *DSM* are real... The NIMH is not in any way saying that clinicians should stop using the *DSM*, but it does think that the *DSM* has constrained research."

Various researchers have proposed different theories and names for problematic sexual behavior for possible inclusion in the *DSM* throughout the last four decades. These include Hypersexuality (Orford, 1978); Sex Addiction (Carnes, 1983, 1991, 2005); Sexual Addiction (Goodman, 1998a, 1998b); Hypersexuality Disorder (Stein, Black, & Shapira, 2001); Nonparaphilic Compulsive Sexual Disorder (Coleman, Raymond, & McBean, 2003); and Hypersexual Disorder (Kafka, 2010). Problematic sexual behavior, with its various theories and subsequent titles, has continued to be subject to proposed diagnostic criteria. A meta-analysis by Carnes, Hopkins and Green (2014) revealed, "When the literature is distilled from an atheoretical perspective, a number of consistencies emerge despite controversy in proposed etiology" (p. 2). Indeed, regardless of the theory or label a researcher used for problematic sexual behavior, most agreed on the fundamental diagnostic criteria marking it as an addiction:

- Continuation of behavior despite knowledge of having persistent or recurrent social, financial, psychological, or physical problems that are caused or exacerbated by the behavior;
- Recurrent failure (pattern) to resist sexual impulses to engage in a specific sexual behavior;
- Persistent desire or unsuccessful efforts to stop, to reduce, or to control behaviors;
- Preoccupation with the behavior or preparatory activities;
- Frequent engaging in the behavior when expected to fulfill occupational, domestic, or social obligations;
- Frequent engaging in the behaviors to a greater extent than intended;
- Inordinate amount of time spent obtaining sex, being sexual, or recovering from sexual experiences; and
- Giving up or limiting social, occupational, or recreational activities because of the sexual behavior

All researchers agreed that individuals with sexual addiction—as with any addiction—continue their behavior despite awareness of resulting social, financial, psychological, or physical problems (p. 2); most researchers agreed on five additional criteria.

To test for addiction-like brain involvement in problematic sexual behavior, Voon et al. (2014) compared the neural correlates of sexual-cue

reactivity in individuals displaying indicators of sexual compulsivity with those of individuals not displaying them. They found that the level of cue reactivity "relates importantly to clinically relevant aspects of substance-use disorders. For example, heightened cue reactivity is associated with relapse" (p. 1). The study also strongly suggested that "neural differences in processing of sexual-cue reactivity were identified in [compulsive sexual behaviors] subjects in regions previously implicated in drug-cue reactivity studies" (p. 1).

Similarly, in a study conducted at the Max Planck Institute in Germany, Kühn and Gallinat (2014) discovered a "significant association between reported pornography hours per week and gray matter volume in the right caudate...[F]unctional connectivity of the right caudate to the left dorsolateral left putamen cortex was negatively associated with hours of pornography consumption" (p. 827). This finding of atresia (shrinkage) in the striatum in participants with porn addiction is also evident in persons with drug or other substance addictions.

Contrary to the claims in an article recently published in *The Therapist* (Blevins et al., 2016), the 2015 EEG investigation by Prause, Steele, Staley, Sabatinelli, and Hajcak supports the porn addiction model. The study reported higher EEG readings (P300) in subjects than in controls when both groups were exposed to pornographic photos. A higher P300 occurs when addicts are exposed to cues (such as images) related to their addiction. In addition, the researchers found greater cue-reactivity (brain activation) for porn, and less desire for partnered sex (pornstudycritiques.com, 2013, p. 1). Five peer-reviewed analyses by neuroscientists and medical doctors, including that of Kühn and Gallinat (2014), concur that the work of Prause and others in fact suggests the validity of the porn addiction model (pornstudycritiques.com, 2015).

In the last decade, researchers and mental health professionals have worked diligently to improve the efficacy of sex addiction treatment based on the neurophysiological addiction paradigm. To do so they had to resolve etiological and diagnostic problems and integrate a research-based model. The resulting theoretical construct—that all addictions, whether substance or process (i.e., gambling, overeating, overspending, or sex), are developmental self-regulation disorders triggered by neurobiological deficits from early relational (attachment) trauma—informs cutting-edge addiction treatments. This understanding means that sex addiction treatment must weave together neuroscientific knowledge with genuine therapeutic connection if it is to nourish the client's self-acceptance and relational capacities.

In *Sex Addiction as Affect Dysregulation* (2016), Katehakis describes her relation-based psychotherapy for sex addiction (including pornography addiction), now used by many CSATs. With a foreword by researcher and neuropsychoanalyst Allen Schore, the manual presents more than 800 sources validating the approach to ego-dystonic, compulsive hypersexual behavior as a neurobiologically based process addiction. Katehakis's protocol combines neurophysiological findings with best practices in interpersonal psychology—a relation-based treatment integrating

CBT/ART (affect regulation theory) with neurobiological research on attachment, complex trauma treatment, and affect regulation. Its aim is to guide the sex addiction therapist in helping the client realize a free, joyous, and connected sexuality into her or his life. This holistic model incorporates the body, brain, and mind, which allows the client to resolve past trauma and experience—sometimes for the first time—pleasurable, self-nurturing, and relational sexuality.

It is difficult to ignore the growing weight of evidence from cellular and molecular biology and neuroscience—the fundamentals of brain research—unless one is biased or willfully uninformed. Those who accuse sex addiction therapists of using their specialty to patrol traditional moral boundaries propound a flawed argument. Sex addiction therapy is not driven by crabbed, superficial judgmentalism. On the contrary, it treats sexual compulsivity as a brain disease whose behavioral manifestations hobble the client sexually, socially, relationally, and emotionally—and holds that denying or minimizing such suffering is the greatest immorality of all. The root of sex (as of most) addiction is underlying neurobiological damage, not the outward acts that result from it. As rigorous research from the biological sciences becomes increasingly accessible to professionals and the public, we can more accurately assess and relieve those struggling with all types of addictions, including sex. It is our belief that these controversies will resolve over time as neurobiology, not mythology, keeps the score.

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