Untangling the web of sex addiction

With his books *Untangling the Web: Sex Porn and Fantasy Obsession in the Internet Age* (2006); *Cruise Control: Understanding Sex Addiction in Gay Men* (2005); *Cybersex Exposed: Simple Fantasy or Obsession* (2001), as well as with a multitude of appearances in nationally broadcast television programs, Robert Weiss appears to have cornered the evolving marketplace for the diagnosis and treatment of sexual and addictive disorders. Mr. Weiss, a social worker (MSW), certified addictions specialist (CAS) and the principal and clinical director of the Beverly Hills-based Sexual Recovery Institute, has risen to national prominence in various media by promoting himself as an expert on the assessment and treatment of "sex addiction," a disorder which cannot be found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) but nevertheless has gained increased attention within the past decade. The current theoretical basis of sex addiction and the foundation of Weiss's work are rooted in the writings and treatment programs of Patrick Carnes, Ph.D., who holds the professional designation of CAS but whose doctorate is in counselor education and organizational development. Dr. Carnes is the author of 11 books centering on addiction and recovery issues and has developed a therapeutic modality for treating sexual compulsion based on a study of 1,000 recovering addicts. It is on this work that Robert Weiss has built his paradigmatic etiology, assessment and treatment of sexually addictive disorders. In order to promote his books and his treatment programs, Mr. Weiss regularly holds seminars, workshops and participates in conferences on sex addiction targeted toward mental health professionals. The seminar attended by this writer was held during a period of six hours and encompassed theory, etiology, treatment modality and some case histories within the field of sex addiction. What follows is a summary of the various issues presented as well as a brief commentary.

Diagnosis

In the paradigm at hand, "sex addiction" is viewed as a stand-alone diagnosis. It is not a moral stance or a part of a religious belief system; nor is it a sign or symptom of underlying mental illness, a fetish, sexual offending, sociopathy, sex negativity or a clear signal that a relationship must end. The criteria for sex addiction closely parallel guidelines for assessing substance abuse, alcoholism and compulsive gambling.

The syndrome borrows from the characteristics of such addictions in that it demands the presence of loss of control, continuation despite adverse consequences, and obsession or preoccupation. In greater detail, the 10 behavioral factors defining sex addiction would be:

1. Recurrent failure to resist sexual impulses
2. Engaging in behavior longer than intended
3. Desire to reduce behavior
4. Inordinate amounts of time spent on the activity
5. Preoccupation with a particular sexual behavior or preparatory activities
6. Engaging in the behavior when expected to fulfill academic/professional/domestic tasks
7. Continuation despite social/financial/health problems
8. Need to increase intensity/frequency
9. Reduction of social activities where sex is more important
10. Distress, anxiety, restlessness or irritability if unable to change the behavior.

It is this writer's opinion that these criteria are standard in defining addiction to alcohol, illegal substances and gambling, but may be problematic when diagnosing "sex addiction." Many studies have pointed out that the stage of "falling in love" has a clear basis in the hypothalamic region of the brain, where low levels of serotonin and high levels of dopamine can create aberrant or unusual behavior in those who are in the midst of a romantic and/or sexual infatuation. Falling and rising serotonin levels can contribute to actual psychic distress, in which the individual may make statements such as "I can't live without him/her," or "I will die if I can't see him/her again." If a separation occurs, dopamine levels plunge and the individual experiences a psychological reaction analogous to an addict who is abruptly left without the substance of choice. This has been acknowledged by mainstream psychologists, neurobiologists and psychiatrists and is considered evolutionarily normative, as the underlying objective is for two individuals to spend a significant time together to procreate. Hence, it is not unusual for many of these criteria to apply to infatuated individuals of both genders and all ages. If judging strictly by these criteria, many adolescents or even those who find themselves "falling in love" during later years could be classified as "sex addicts."

It is not unusual for the newly coupled of all sexual orientations to spend days in bed exploring their mutual sexuality and foregoing alimentation, personal hygiene, social obligations or professional duties.
While expecting the paradigm to exempt such individuals from this syndrome, this writer was surprised and confounded by a statement made by Mr. Weiss during the lecture; he clearly indicated that even non-addicted individuals are sometimes having "too much sex" and that "perhaps they should stop for a while to see how it feels." It therefore appears that Mr. Weiss may have a personal agenda that goes beyond defining a syndrome and indeed, this particular statement struck this writer as rather "sex negative," despite the assertion to the contrary.

But there are other, more insidious consequences of the proliferation of this construct among the general population. In its ever-increasing quest to sell advertising space and to draw attention to new issues and problems, media has seized upon the opportunity to disseminate yet another disorder designated to alarm the already sex-panicked population – not just in the United States, but in countries that hold the U.S. as a model for social and psychological development. Sex addiction is suddenly ubiquitous and something to be feared, at least according to popular magazines and television shows. Conversely, if the concept of "sex addiction" gains more foothold, much as the term "addict" has become an appendage to various forms of deepened preoccupation – e g. "love addict," etc. – several things may occur: a) the term "addict" will lose its significance and become diluted, thereby obscuring the gravity of real addiction; b) parents will label their children's healthy sexual exploration as addictive and begin to seek treatment for something which is healthy, natural and developmentally desirable; and c) the diagnosis may obscure deeper and medically recognized disorders such as Major Depressive Disorder, Bipolar Disorder or delusional disorders, to mention a few. It is then up to the CAS counselor to ferret out a differential diagnosis, with the danger that if the counselor is intent on labeling the client with "sex addiction," other important diagnoses may be overlooked. In fact, there are already 12-step groups with titles such as Sex and Love Addicts Anonymous (SLAA) where predominantly females who would do very well in individual therapy for depression, PTSD, etc. are trying to process their disorders through programs that praise aversion to a biologic function rather than embracing sexual activity as something healthy, desirable and part of a holistic recovery.

The “Primary Carnes criteria” for a sexually addictive activity are that they must be shameful, secretive, abusive, and void of relatedness to the individual. As to the behaviors exhibited by sex addicts, Mr. Weiss lists them as follows:

a) Compulsive masturbation with or without Pornography
b) Anonymous Sex
c) Prostitutes, Escorts and “Sensual Massage”
d) Multiple Simultaneous Affairs or a Repeated Pattern
e) Cybersex – with our without “hooking up”
f) Fusing Drug Abuse and Sexual Bingeing [*sic*]
g) Obsessive Cruising, Objectification, Flirtation
h) For Some: Exhibitionism, Voyeurism, Abuse of Power – Sexual Boundary Violations

During this enumeration, Mr. Weiss clarified the various behaviors without quoting any sources or scientific basis. Among the more objectionable statements was the gross and unprofessional generalization that “prostitutes are drug-seeking.” This type of judgmental assertion in front of approximately 80 psychotherapists, most of who do not specialize in sexology or sex therapy, may be highly irresponsible in that it contains erroneous information, stigmatizes an already marginalized population, and is clearly intended to shame both commercial sex workers and those who make use of their services. It also confirms and entrenches any stereotypical bias that therapists who are not generally in contact with prostitutes may have, since the statement comes from a putative clinician who has been informed by statistical data on sexuality. On the heels of this clearly sex-negative comment, Mr. Weiss proceeded to enumerate the venues where the addictive behavior was practiced. Gay males frequented bathhouses, sex clubs and bars, engaged in online hook-ups and had anonymous sex in public and/or one-night stands, whereas heterosexual males chose strip clubs, massage parlors, bars, adult bookstores, and online hook-ups where anonymous sex with female-born females such as prostitutes or “massage girls” and/or transsexuals occurred.

In terms of male-female addict differences, 80% of those who present for treatment are male. The relational focus differs between the two genders, in that females are less visual and more relational in their seeking. Without any further explanation, Mr. Weiss offered that women are intrinsically more relational and therefore more exhibitionistic. This flies in the face of the male as the stereotypical "flasher," although this variable was never fully explicated. Other issues have indeed been confirmed in the sexological literature, such as the greater cultural shame that exists for females who participate in "sexual exploits," and that women who "act out" sexually tend to have more trauma and unfortunately fewer options for help. Mr. Weiss again seized upon the construct of the female commercial sex worker as a victim of the disorder, and stated that female sexual addicts are more likely to be able to make a living at sexual acting out. Although this carries a grain of truth in terms of earning power – most clients of female sex workers are heterosexual males willing to pay considerably more for sexual encounters than their homosexual counterparts – the conflation of prostitution and damaged individuals carries an underlying hypothesis presented as fact. This writer, who has a long professional history of interacting with commercial sex workers, has yet to come upon a prostitute who is also a sex addict. On the other hand, addiction to making large sums of untaxed money may be a factor, but in that case our entire capitalist system has created a world class of pecuniary addicts who populate the highest echelons of industry in the United States, not just the trenches of every-day, middle-class sex workers. As a final coda to this segment of the seminar, Mr. Weiss finished with the highly generalized observations that "men are more likely to act out with sex or overt aggression evoking intensity," whereas women are more likely to "act inward with self-harm, eating disorders and pathological caretaking and evoking despair." This last sentence may lend a grain of truth to the possibility that "sex addiction" as a concept borrows so heavily from other addictive behaviors, that eating disorders and aggressive behaviors also become part of this confusing syndrome with rather indistinct diagnostic boundaries.

Etiology

In his latest book *Untangling the Web,* Mr. Weiss has had the co-writing assistance of Jennifer Schneider, M.D., Ph.D., a physician certified in Internal Medicine, Addiction Medicine and Pain Management. It may be possible that she has contributed the specific information on etiology in that particular volume. When asked by this writer to identify the specific biological substrate of addiction, Mr. Weiss responded that he is "a clinician" and would only briefly mention the physiological factors responsible for addictive behavior. He then presented the current sexual addiction etiology that includes genetic components such as affect management, personality type and mood stability, in addition to early environmental stressors such as "emotional neglect and abandonment" – that is, an interactionist perspective of genetic predisposition with environmental influences. He briefly touched on neurotransmitter activity in the hypothalamic region and the adrenal glands although not expressing it as such; a simple list of biochemical substances was offered, which included serotonin, dopamine, adrenaline and endorphins. Descriptions of brain structures responsible for these substances such as the hypothalamus, the pituitary and the amygdala were omitted from the presentation. To this, some overarching psychodynamic constructs from personality theories were added, namely the concept of "Covert Incest – Narcissism of the Caretaker" and family-of-origin rules suggesting extreme sexual rigidity and/or the absence of demonstrated sexual boundaries. It was unclear if these psychodynamic factors were firmly cemented in the sex addiction paradigm. Mr. Weiss firmly stated that sex addiction is first and foremost an attachment disorder, and that the need for attachment connection in the face of rejection – presumably from the primary caregiver in early years – contributes to a narcissistic character pathology that renders the affected individual incapable of forming deeper human connections. In going deeper into the matter, Mr. Weiss proposed the development of the inauthentic, i.e. "shamed Self," where a primary genetic inability to contain affect is compounded by familial shame and an experience of abuse, all of which would lead the individual to conclude that he or she is better off by not becoming dependent on anyone for getting his or her needs met. The primary caregiver denies the primary narcissism of the infant and the child is often shamed.

The child begins to feel defective; the shame comes about as dependency needs are denied or subverted and the child turns upon himself or herself as being the problem. In Weiss's theory, early attachment disturbances appear to be a key root cause of both narcissism and sexual addiction. Compulsivity and obsession offer relief from the pain and rage of the disrupted self in those too defended to find comfort in "healthy" relatedness. The compulsive behaviors eventually take on a life of their own. Mr. Weiss also quoted from Alice Miller's book *The Drama of the Gifted Child* (1981) and from his personal life, in which he freely admitted to his own narcissism as the child of a bipolar mother as well as his role as a patient of psychoanalysis for 23 years. He then proceeded to explicate the link between the narcissistic injury and sex addiction as "the narcissistic personality being defended against further abandonment and rejection by maintaining the illusion of control," in which the individual dissociates from "need states" and dependency through fantasy, arousal and addiction. The survival methods used to suppress or mimic dependency needs by the narcissistically injured addict are thus evidenced in behavioral or substance addictions, pathological care taking and codependency, thrill seeking and high risk activities, objectification of self and others, dissociation and fantasy, or rage and abuse. The addict does not learn about or from emotions, and quickly learns to disavow his or her needfulness. Coping skills which evolve within the addict provide self-soothing, distraction from any problem, have a certain calming effect and also offer stimulation, all in the absence of having integrated more stability of the Self. The survival methods learned in childhood by the narcissist who expresses them within the addictive frame can contain seduction, manipulation, feigned passivity, a desire to create emotional "drama," and unhealthy parenting behavior.

Clinical manifestations

In focusing on cybersex, i.e. sexual stimulation with the help of computers and the Internet, Mr. Weiss acknowledged that the accessibility, affordability, anonymity and normalization of using the Internet have contributed to the proliferation of sexually addictive behavior primarily in males, but also to a lesser extent in females who use the Internet for slightly different purposes such as sexual chatting or "hooking up."

This writer is well aware of the evolutionary mechanism of visual processing of sexual cues that is highly evolved in males; hence the wide distribution of erotic and pornographic images that may contribute to behavior defined as compulsive. It is also this writer's belief that the emphasis on narcissistic injury for the development of compulsive behavior is far too exaggerated, and that there needs to be no narcissistic trauma to a person in order to become sexually compulsive. In terms of the stress-diathesis theory, a brain that has developed under prolonged, stressful conditions may secrete excess amounts of cortisol and hence become vulnerable to self-soothing mechanisms such as compulsive masturbation or other sexual behaviors. But that the character pathology is rooted in narcissism alone may be a complete fallacy and should not be relied upon by any treatment professional, whether psychologist, sexologist or sex counselor. For accuracy's sake, personality disorders such as borderline, histrionic and even avoidant personality disorders may not only qualify, but may have their own specific etiologies which could well become connected to sex addiction, depending on one's view of the trajectory of the disorder. This in itself posits the question about a tenuous connection between character pathology and sexual compulsivity.

As for the self-reports of the addicts, Mr. Weiss describes their arousal affect as "being in the bubble, the trance, or spacing out." Physiological signs of arousal include increased heart rate, shallow breathing, perspiration, reduced intellectual functioning, and a "rush" or an "intensity feeling." The result of the behavior itself produces affect regulation, stimulation, excitement and escape from intolerable external and internal stressors. The orgasm serves as the "reset" button and will render the individual at the numbing point of the sexual addiction or "shame cycle." This specific sequence of events appears to borrow from the sequential process of the domestic violence cycle, with affect and behavior linked to an initial fantasy, followed by rituals executed to engage in the behavior; the acting out of the behavior and the subsequent release; and a numbing feeling related to shame, blame or guilt; depression or self-hatred as follow-up emotions, to which fantasy and the repetition of the cycle will serve as temporary palliatives. While this writer is in agreement of the description of the psycho-physiological manifestations of affect regulation in the addict and the shame cycle, many of the descriptive feeling states provided by the addicts can also be found in the psychologist Mihály Csíkszentmihályi's concept of "flow" (1990). In his many years of research on the topic, Csikszentmihályi's

theory states that individuals are most content when they are in a state of flow, a condition of complete absorption with the activity or the situation itself. The flow condition is an optimal state of intrinsic motivation, where the person is fully immersed in what he or she is doing. This state is is characterized by a feeling of great freedom, enjoyment, fulfillment, and skill, during which time and space and basic physical needs may be ignored. The difference would be that after the activity is concluded, the non-pathological individual who experiences flow would feel stimulated and euthymic, whereas the sex addict would feel shame and regret. With this in mind, however, one wonders: if sexuality in itself were not so stigmatized or circumscribed and if certain sexual activities *and the time spent engaging in them* would be labeled as sex-positive rather than shameful, wrong or disordered – would the individual experience the same negative cyclical phenomenon? If parents, schools and subsequently the dyadic sexual unit would allow for unlimited exploration of sex, with the underlying dynamic that *any* sexual activity, as long as consensual and collaborative could be enjoyed by both parties – would the need for sexual variety be construed as defective?

In many cultures and human situations, that which is prohibited becomes all the more desirable. If males and females came to the table with sexually open and positive minds, would some of these behaviors be labeled as negative? Or compulsive? Would the individual get into a psychologically compulsive feedback system if there were no forbidden aspect to the matter? Perhaps – but certainly to a much lesser extent than in today's sexually paranoic climate – since some behaviors would not be labeled as shameful or abnormal. An individual who, despite psychological setbacks in early life, would be able to engage in open and reciprocated explorative sexuality, free from stigma and the initial taint of "shame," would clearly run a lesser risk of engaging in compulsively sexual behavior since the aspect of secrecy would be removed. And, since Mr. Weiss has stated, "adultery is the keeping of sexual secrets," the level of deception would decrease dramatically, since there would be no reason to conceal sexual habits from a partner. From a sexological treatment perspective, sexual anorexia within the couple, regardless of sexual orientation or age, can lead to frustration and compulsive behaviors. The sexologist in his or her function as a sex educator would do well by helping clients to break this logjam and free both parties to explore and engage with one another, rather

than further cementing withdrawal from healthy behaviors, as is evidenced in the following section on the treatment of those labeled sexually compulsive.

Treatment considerations and protocol

Upon closer examination, the consequences of engaging in compulsive cybersex largely parallel the sequelae of substance abuse, gambling and other addictions as follows:

1. Loss of time for work, family, recreation
2. Family violence and relationship loss
3. Loss of job because of cybersex at work
4. Guilt and shame due to keeping secrets
5. Loss of interest in sex with spouse or partner
6. Increased preoccupation with sex
7. Increased objectification of all people
8. Lost sense of self
9. Increased interest in deviant sex
10. Arrest of illegal online sex
11. Escalation to off-line sex

An initial evaluation should include a bio-psychosocial assessment, complete with psychiatric assessment; the taking of a psychosexual history, including assessing for arrests and offender behavior; determining spousal considerations and/or domestic violence, and the partner or spouse's knowledge of the individual's "acting out." According to Mr. Weiss, treatment should be "coercive by design." Oftentimes, sex addicts do not self-refer – there may be a precipitating legal, financial or emotional crisis. Treatment is behavioral and encompasses a contract for "sexual sobriety," homework, and accountability to the therapist and others. Treatment must also be "confrontational" and the individual must "earn" therapist approval. Establishing a trusting relationship with the therapist is the primary goal, however, trust is more likely gained initially through the individual respecting the therapist rather than through mutual affection. Mr. Weiss believes that part of building a relationship with someone narcissistic necessitates containment and boundaries. The sex addict who may display sincerity will do so only to gain control of the process and manipulate the therapist. This

manipulation is evidenced in the countertransference often experienced by the treating clinician, who may minimize or unconsciously collude with the individual in terms of normalizing the behavior. A period of complete sexual abstinence is contracted for and no sequential harm reduction is allowed. Mr. Weiss points out that part of this restriction is to raise the individual's anxiety to see what the behavior has cost him or her in terms of relational currency.

Throughout the treatment protocol, the individual sets the pace for the progression to more psychodynamic work; those who meet agreements, follow directions and stop "acting out," earn the more intimate relationship and praise from the therapist. As for treatment errors, there are many pitfalls: not addressing the sexual behavior as the primary treatment focus; not utilizing psychological testing where indicated; minimizing the depth of the betrayal, grief and rage of the spouse or partner; underestimating adverse consequences of the sexual behavior; and not holding clients accountable for their lapses in treatment. Paradoxically, Mr. Weiss repeatedly asserted that he believes in "healthy shame," despite his earlier statement of shame reduction as an integral part of the treatment protocol. The role of the therapist is to confront, contain and intervene; to promote structure and encourage resources; to provide hope and to normalize through interpretation and understanding – which may be what Mr. Weiss equates with shame reduction.

In terms of doing work with the aggrieved spouse, treatment appears to focus on normalizing feelings and provide hope, in addition to educating him or her about the disease of addiction and the recovery process. Disclosure – when, where and how occupy a great extent of the spousal treatment protocol. Classic couples therapy is contraindicated and the therapist is not to become the primary treatment professional for both the addict and the spouse. It is up to the addict to disclose the behavior to the spouse, and he or she must do so immediately if the "acting out" occurred with someone familiar to the spouse, if there are potential STD or health issues, and if other family members or children have been involved or are at risk. Staggered disclosure where the addict reveals some, but not all information, is discouraged. Addicts who have intense fears of shame may first deny everything and then disclose additional information, with the result that the

other party is repeatedly impacted and becomes additionally traumatized by the process itself. To help the addicted individual, disclosures are written and rehearsed.

Mr. Weiss does offer some statistics on disclosure outcome: despite the pain of experiencing disclosure, 81% of partners felt that disclosure was the proper course, and in retrospect, 96% felt that disclosure was proper (Corley& Schneider, 2002). Disclosure is contraindicated when the couple is going to separate or divorce, or when the spouse actively denies disclosure information; in addition, the disclosure process is monitored so that the addict is not disclosing out of anger, exhibitionism or to sadistically hurt the partner with the information. Disclosure is also discouraged when the addict is found to "dump" the sexual history on the partner to assuage guilt or seek forgiveness. Finally, the addict is given the task to provide a complete list of secrets and lies told to the spouse, as well as a complete sexual timeline or history that is processed in individual or group therapy. This list may include number of contacts, dates and frequencies of occurrences; types of acting out; money spent; arrests; diseases; names of sex partners, and time spent on sexual activities measured in weeks, months and years. The partner then needs to tolerate the partner's anger and pain in living without forgiveness for a certain time, but also learn how to get support for the recovery outside the primary relationship, in order not to burden the partner and allow him or her to heal.

Concluding comments

This writer agrees with the majority of statements made by Mr. Weiss in terms of the biological substrates of addiction and how to address the chemical imbalance of dopamine which is the neurotransmitter most often implicated in lack of impulse control. As a psychotherapist with considerable experience in treating character disorders, however, it is difficult to believe that an impulse control disorder has its unquestionable roots in a specific character pathology – particularly in such a distinct personality constellation as Narcissistic Personality Disorder. The danger in accepting these theories of etiology, lock stock and barrel, may obscure more serious mental disorders, e.g. depression, bipolar disorder or paranoid schizophrenia. It is also evident

from the treatment program at the Sexual Recovery Institute that Mr. Weiss and his therapists do not automatically refer individuals for psychiatric evaluations unless necessary. It is this writer's belief that *any* clinical syndrome with such a heavy biological substrate should be addressed by a medical professional, in conjunction with "talk therapy."
Oftentimes, the robust response obtained from medications may largely attenuate any obsessions and compulsions, and this was not adequately emphasized in the seminar. In discussing the treatment protocol, however, the aspect of shame was a prominent factor. The oxymoron "healthy shame" was used on numerous occasions and it was obvious that Mr. Weiss enjoyed conferring this particular brand of therapeutic intervention onto his clients. Therefore, it was all the more disconcerting to listen to Mr. Weiss, who in his demonstratively contemptuous tone of voice denigrated sex workers, pornography, and various sex organizations, all of which perform a valuable function in our society. Despite his overt statement of not being "sex negative," this was precisely the overwhelming sentiment that permeated the seminar. Mr. Weiss did separate cybersex users into recreational, at-risk, or addicted/compulsive users, but the difference between the three types was never fully elucidated. The judgmental tone of voice when describing "hooker review sites," hiring prostitutes to perform live sex acts on command, or engaging in real-time one-on-one masturbation, may subtly – or overtly – steer a mental health professional with limited sexological knowledge to pathologize what clearly are normal and also enjoyable behaviors and activities. Hence, a recreational cybersex user may be defined as at-risk, which could have disastrous therapeutic consequences. What may be a healthy and interesting diversion for a client could be stamped by the therapist as deleterious and pathological, with the result that the individual goes underground with the behavior to avoid the shame of enjoying his or her predilection in the open. The risk with this diagnosis is that it may spill over onto a population heretofore not deemed at risk.

According to Carnes, 3-5% of the population has a problem with compulsive sexuality. Were this figure to increase, it may be due to our conceptualization of the problem and the pasting of a diagnosis *du jour* onto a client, much like the "false memory syndrome" which was responsible for ruining so many lives during the backlash of the sexually repressed decades immediately before the advent of the Internet. It is therefore highly unlikely

that this therapist and sexologist ever will adopt the extreme and shame-based treatment protocol that characterizes the end-all, be-all of the already questionable and diffuse diagnosis of “sex addiction.”