PSYCHOTHERAPY NETWORKER

CASE STUDY

By Alexandra Katehakis

While the subject of Sex Addiction (SA) no longer draws snickers or skepticism, defining it precisely and treating it still puzzles most psychotherapists. Marked by compulsive, out-of-control sexual behaviors that damage every part of a person's life—work, family life, personal well-being, and love—SA makes thinking about, seeking, and getting sex the organizing principle of a person's existence. As much of an addiction as one to drugs, gambling, or alcohol, it can shred the fabric of personal life, create serious legal problems, and ruin physical health. Because sex addiction so often has roots in disordered attachment patterns, stemming from childhood abuse or neglect by parents or primary caregivers, many who have sexual addictions experience extreme difficulty forming stable, loving relationships.

As with any other addiction, the primary goal is long-term sobriety, which with these clients means noncompulsive sexual behavior. Treatment is initiated with a contract, often written, between the addict and therapist that lists specific behaviors from which the addict promises to abstain (a temporary period of complete sexual abstinence may also be required) and a 12-step recovery program. Because childhood trauma is so often implicated in SA, leaving many clients with a damaged ability to form relationships, they also need long-term intensive individual and group therapy directed at fundamental attachment issues in addition to the 12-step programs. Doing this kind of work isn't for the impatient or fainthearted. Since these clients are often terrified, hostile, or numb at the core, they're among the most challenging to treat. Doing this work, I frequently find myself required to recognize, track, and soothe my own intense physical and emotional reactions, such as fear, anger, discouragement, and the temptation to distance myself defensively in the face of powerful provocations.

Typically, I begin by having the client make a list of behaviors that are secretive, shaming, or abusive—usually focused on the behaviors that the client himself most wants to stop. Once clients have 30 days of sexual sobriety, they join a group with other self-identified sex addicts. These groups are unlike 12-steps meetings because they not only help each individual refrain from sexually destructive behaviors, but also encourage each member to engage in group interaction and psychoeducation, focus on the experience of locating feeling states in the body, and express those feelings in a safe environment.

We already know, through numerous empirical studies, that group therapy is essential for addicts of all kinds. Thanks to developments in brain science, we've begun to understand why: both the autonomic nervous system and the brain's neural wiring actually change in response to the emotions generated by regular, sustained human connections. For sexual addicts, groups are particularly important for undercutting denial and reducing shame, while offering supportive, trustworthy relationships. The groups give many of my clients their first experience of being genuinely seen and heard by others and of learning to see and hear others in turn. Through them, clients come to understand and feel how early, deep, chronic attachment wounds hobbled their capacities for connection, self-regulation, and self-awareness, all of which made them susceptible to their behavioral addictions.

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Jim, a mid-level executive in a transport company, was 34 years old when he came to see me, though he looked much older—stooped over and somewhat disheveled in appearance. He sullenly told me that he'd come into therapy only because his wife, Beth, had repeatedly discovered him looking at pornography and threatened to leave with their daughter if he didn't get help. At his first session, he was arrogant and surly, responding with peevish defensiveness to every suggestion I made. When I asked him why he was coming for treatment, he again blamed his wife, saying *she* was the problem. "All guys look at porn, I don't know what the big deal is," he barked.

"It sounds like the only problem you have is that you got caught," I responded.

Not liking my comment, Jim retorted, "You look like one of those liberal feminist types. I really don't think this is going to work."

Like many male sex addicts who come into treatment, Jim appeared to be testing me and sexualizing me—basically checking me out to see whether he could manipulate me. I usually take this kind of behavior in stride because I recognize that it's a way to create distance and maintain a sense of power and control. During our first session, he said he'd begun masturbating to pornography when he was 12 and had never stopped. With the advent of the Internet,

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his behavior escalated to a daily occurrence, usually for many hours. Sometimes he stayed on the computer all night, going to work "hung over" the next morning, and had at times masturbated to the point that his penis was raw and even bleeding. After 17 years of heavy daily drinking—often while watching porn—he'd joined AA several months earlier and was now sober. But now, he told me, he'd begun to skip AA meetings, claiming that he "didn't need to go anymore." When I confronted him about this, telling him he was still at risk of relapse, he left in a huff. I was sure that he'd never come back.

A few days later, he called, still angry, to complain about my "hurtful style," saying that he thought I was attacking him. I said I was sorry he felt upset and asked him if he wanted to talk about it. Still smarting from his wife's ultimatum and knowing he needed help, he agreed to come in for another session.

Assessing Underlying Attachment Issues

Jim's childhood attachment experiences had been anything but stable, loving, and secure. His mother was a severe alcoholic. She beat her four young sons when drunk and enraged—which was quite often. Once, after hitting Jim, who was 10 years old at the time, she locked him in the basement for several hours. Meanwhile, Jim's father stood by passively, or simply retreated to his study.

Not surprisingly, Jim had developed an ambivalent attachment style: he flipped back and forth from direly needing the attention of others to completely avoiding any contact at all. Ambivalently attached children often turn into narcissistic adults who persistently crave attention and feel deep shame when they don't get it. This combination—excessive neediness, the feeling of not being entitled to have one's needs met, and unbearable shame—doesn't make for an appealing personality style.

Jim tended to be passive-aggressive in getting his needs met—never directly asking for what he wanted, but indirectly taking it. Unable to connect in any other way with his coworkers, for example, he constantly picked fights with them and then felt victimized by their annoyance or disagreement. This would lead to anger and the desire to retaliate. Not surprisingly, he had few friends. All of his adult life, he'd used both alcohol and compulsive masturbation to pornography to make his intense feelings of need and shame go away.

Jim's inability to be assertive and his passive-aggressive response to others—a hallmark of sexual addicts—created problems with his wife. He could never stand up for himself, so he was always going behind her back to get what he wanted. This was a recreation of his relationship with his mother, in that his wife was always angry with him, repositioning him as a perpetual victim. As his therapist, I, too, experienced the impact of his shaky capacity for attachment. Early in therapy, he did what he could to recreate with *me* his relationships with his mother and wife, thus maintaining his status as a chronic victim.

I ask all my clients starting therapy to complete a Sexual Dependency Inventory (SDI)—a-200 item questionnaire with several other checklists and essay questions—that details their sexual history. Jim's SDI clearly indicated that he was a cybersex addict. It also showed me that he compulsively used pornography and masturbation as an analgesic—to numb his pain.

Next I helped Jim design his Sexual Sobriety Plan, which simply stipulated no viewing of pornography in any form and no masturbation. He agreed that, once he'd achieved six months of sexual sobriety, we'd revisit the topic of masturbation to determine whether it could be reinstated in his life. His most addictive behavior—viewing Internet pornography, or cybersex—fit perfectly with his personality: disconnected from others and dismissive of his own feelings. At this point, the only feeling Jim seemed to recognize in himself was shame. He could say, "I think I feel sad," but couldn't yet experience sadness as a body-based feeling. If any affect appeared to be arising, his jaw would visibly tighten and he'd swallow the feeling.

Impatient to move the process along, Jim expected he'd join my therapy group right away and so was unpleasantly surprised to hear that he had to "earn" entry into it. Before he could join, I said, he had to follow his Sexual Sobriety Plan for 30 days, come to individual therapy each week, check in by phone between sessions, complete homework assignments like his SDI, and further define his Sobriety Plan. This ultimately needed to encompass the destructive sexual behaviors he wanted to abstain from, a boundaries list of the behaviors that might lead to his acting out (like an argument with his wife), and a healthy list of behaviors that would support his sexual sobriety, such as attending Sex Addicts Anonymous (SAA) meetings weekly. Even when he successfully completed his month, I was worried about his joining my group. Although I knew that group therapy is crucial for SA treatment, I feared that, because of his social rigidity, it would be a struggle for him to fit in with the other males—two gay men, a film director, a Latino artist, an architecture student, and a criminal defense attorney.

I organize my groups around the use of the body as a mechanism for knowing how we feel. I start each group by asking members to check in with their bodies to locate where they might be feeling tension, upset, numbness, or excitement. Each group member then reports what he's feeling. My thinking is based

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on the neurobiological finding that experiencing and processing emotion in empathic relationships actually builds and strengthens the neural connections necessary for emotional connection with others. Typically, sex addicts never got this "training," because they had caregivers who couldn't attune to infants' needs or provide the secure attachment required for their emotional, intellectual, and behavioral growth. Their families ignored, shamed, or punished feelings, and the fear this engendered paralyzed these childrens' capacities for self-reflection and relationships.

In our therapy together, Jim's verbal pace was slow, and I had to be patient with the spaces between his spoken thoughts. I attuned to his rhythms by slowing my conversations down and paying attention to my tone of voice and how close I sat to him. I also observed physical signs of Jim's anxiety and gently pointed them out as defenses against emotion. "Jim, have you noticed that when you begin to talk about something that has meaning to you, you look at the ground and your left leg starts to shake?" He hadn't noticed his bodily expressions until I pointed them out, which initially provoked a shame reaction, as if he had been "caught" doing something wrong.

Body sensations (dry mouth and throat, constricted chest or gut, constipation or diarrhea) or perceptual disturbances (ringing in the ears or tunnel vision) may also signal defenses that turn suppressed emotions into physical dysfunctions. At first, when I queried Jim about these manifestations of anxiety in group, he said he felt "numb" and worried that he was somehow "defective." I reassured him that, for now, he needed just to notice his "numbness" without judging or trying to change it. The simple act of noticing became a mindfulness practice in and of itself, and eventually a new habit for him. In time, without my prompting, Jim could feel and describe "tightness" in his throat "choking" his words. As he learned to identify his physical tension in the novel safety of the group, his emotions gradually began to bubble up.

Lending a Capacity to Relate

Throughout the first year of our relationship, Jim tended to respond to my interventions—however tactful and diplomatic I tried to be—with anger and hurt, saying things like, "Why are you picking on me?" or "You say you care about me, but you *have* to because I pay you." This would be followed by weeks of smoldering resentment mixed with panic because he just knew I'd never want to see him again. I often had to contain my own impatience as I reflected his feelings back to him: "I know you're scared right now and that it's hard for you to believe that I care for you," I'd say. "I think your mother's abuse of you probably has a lot to do with your reaction to me right now."

Because Jim had missed normal affective maturation, I had to "lend" him my own feelings at first, saying what I felt when he was unable to: "My chest feels tight as you're telling this story. It makes me really sad." Only then would he respond to my somatic countertransference with appropriate affect, such as tears. Over time, I could see that my eye contact, tone of voice, and body language (including how far away I sat) were creating resonant changes in his brain and body, and also modeling how someone senses and reflects emotions to create human connection.

Like all sex addicts in recovery, Jim had to come to terms with the lost years of his life. As he talked about the grief and loss of his teen years—having to fend for himself emotionally, take care of his younger brother, and figure out ways to get himself through school—his eyes welled up with tears. He looked up and saw the group sitting on the edge of their seats, many—including me—with tears in their eyes as we listened. This was the first time he felt that *I* really cared about him because he *felt* me feeling with him. As I noticed new, fleeting shifts in his facial expressions, I asked what he was experiencing, where in his body he felt it, if the feeling had a shape, color, or temperature, or if that body part wanted to move. Whenever he talked about ideas or said something like "I think I'm angry," I directed him back to his body sensations.

Eventually, he was able to talk out feelings without too much defensiveness and could even begin to acknowledge the role he played in creating unpleasant interpersonal scenarios, both with others and me. Unfortunately, for many months, these moments of "insight" didn't keep him from repeating the same old patterns.

Learning to Recognize His Own Truth

My commenting on his body-based sensations helped Jim experience previously ignored emotions. Surprisingly soon, he started a meticulous "lie diary" to record and reveal his habitual untruths, especially in his strained marriage. His diary revealed minor daily lies, such as telling his wife he had to work on the weekends when he really wanted to be with friends, telling her he'd closed the garage door when he hadn't, and telling his boss that he hadn't taken his pen when he had.

More dramatically, about six months into therapy, Jim vividly revealed his extreme passive-aggressive tendencies by telling me about his regular, intense fantasies of tying women up and sexually abusing them. I was taken aback and decided to err on the side of safety. "Jim, should I be worried about your hurting me?" I asked. Genuinely surprised by my concerns, he said, "No. I've never physically harmed a woman and don't think I ever would." I realized from

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the content of his fantasy and his reaction to me how powerless he must feel around women. No wonder he couldn't stand up to Beth or his boss, but could only lie, blame others, fantasize revenge, and act out his rage by masturbating to violent pornographic images.

After several months in the group, Jim became more fluid in relating to other group members. He'd laugh with them and could take a joke aimed at him without automatically feeling shame. He began openly sharing his feelings and revealing the beatings, neglect, and pain he'd suffered as a child. He even learned how to listen to criticism without becoming paralyzed by shame. In fact, his feelings of solidarity with group members increased to the point that he became the main force for group cohesion and organized outside activities, like skeet shooting, boating, and martial arts events. He finally had age-appropriate friends with whom he could enjoy the wholesome fun he'd missed as a depressed, dissociated, and drugged adolescent desperate to escape his home.

Yet, for all his progress in the group, he remained unable to confront people or to ask for what he wanted. I felt irritated with him when he announced that he and Beth were having another baby in the midst of all their marital difficulties. Rethinking my reaction, I reframed this event as proof of the power of Jim's dream—however unlikely—of a happy family life to "correct" his painful childhood.

It took months before he admitted to himself and the group that he'd never loved Beth, but had always been afraid to say no to her—including about having another baby. Even as he made this confession, he didn't seem very upset about it, though. I was determined to focus him on his body to help him access his feelings as he considered this important truth. When he added that he felt like a "scared little lost boy," I asked him how he knew that.

"Where in your body are you feeling scared, little, and lost?" I said.

"In the middle of my body," Jim replied welling up with tears. "I've always had this emptiness in the middle, and it makes me feel scared and alone."

"I'm with you and the group is with you right now," I replied.

With that, he fell into a heap of tears. Afterward, it dawned on him that he'd never before felt any compassion for that little boy. "It felt really good to cry and to trust that none of you would humiliate me afterward," he said.

In the sessions after the realization that he could express feelings of sadness and loss in front of others and not be shamed for them, he began finally taking the risk of going further into his feelings, often reporting his body sensations without prompting. He started to experience genuine sorrow and fear, to feel his long-standing anger toward his parents, and to understand how his lifelong inability to recognize or effectively express his anger had fed his passive-aggressive actions. As his emotional awareness and confidence grew, he decided to leave Beth, although they'd spent a year in couples therapy. But deciding to leave and doing so were two different things. First, he chose to sleep in the guest room so that his wife and daughter had time to acclimate to the changes in the household. His plan was to wait for his second child to be born before moving out of the house, which he did. He was torn between abandoning his family and abandoning himself, but he and Beth eventually worked out the terms of their divorce, agreeing that she'd keep the house, he'd continue to support her financially, and that he'd be as much a part of the children's lives as possible.

Long-Term Challenges

Slips continued, of course. Once Jim browsed for pornography and "accidently" took a sleeping pill, but immediately revealed these slips to the group and was able to recognize with their feedback how self-destructive he became under stress. At another point, he declared that he was finally "tired of feeling angry all the time, but not feeling anything else." Asked to sketch what this state looked like, he drew a raw picture of himself locked in a cage and, after the session, went home and disconnected his Internet.

Interestingly, Jim now began to express positive feelings as well as negative ones: gratitude for recovery and empathy for others. He met a new woman, Ann, at work. For the first time, he noticed that he'd actually chosen someone carefully and felt that she had chosen him carefully, as well. Instead of rushing into sex, he took time to get to know her, reporting weekly on this novel experience. Having learned to feel just how unloved he'd been as a child, he could now feel his heart opening as he told about his first-time experiences of honest conversation and, eventually, healthy, caring sex with a woman. His relationship with Ann hastened the maturation begun by his increasing capacity to process emotion. In fact, Jim became remarkably at ease with his feelings—in group, he could notice when his defenses were up and report it. "I'm noticing that my arms and legs are tight. I'm going to breathe and relax and see what happens." By tracking his physical sensations and recognizing them as defenses against affect, his feelings became increasingly accessible to him. The group continued to applaud his willingness to make himself vulnerable and reported feeling closer to him as a result.

The following year, Jim was fired from his job, sorely testing his new emotional maturity. His first impulse

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was to fire up his computer and go to a porn site. Instead, he set up a flurry of social events with friends, a successful defense against falling back into the addiction trap. A year after that, Jim graduated from group, married Ann, and was rehired by his company.

Lasting Effects of Therapy

Jim still follows his Sexual Sobriety Plan to avoid addiction-triggering behaviors. He participates in 12-step meetings and a therapy group at church to "keep me accountable, because the collection of even the smallest dishonesties will lead me to destructive behaviors. I still get angry, but I don't justify my actions with excuses and lies." For the first time, he feels active interest in the feelings of others. Instead of being driven by guilt and shame, he says, he can rely on core values and a real conscience, without feeling the need to be punitive to others when they disappoint him.

He still struggles, though. Recently he was having a hard time forgiving himself for sometimes using humor at the expense of others to ease his own social discomfort. Mostly, however, he believes honesty about himself and his feelings is a source of strength, not weakness. "And," he says with deep conviction, "I'll never say to my children, 'Don't be sad.'"

Treating sexual addiction is difficult work because it almost always requires repairing early-childhood attachment trauma. Rarely do clients hang in there long enough to reap the benefits that Jim did. Often, people get "better enough" and move on, continuing their recovery in fits and starts. The occasional Jim stays on course, fighting for his right to feel whole and complete because he wants to be the person he knows he can be.

When clients like Jim show up ready to fight for their lives, I'm ready, too. He taught me to be patient, to slow down, manage my anxieties, and pay attention to my own body's cues. Together we found our way by trusting the attunement, misattunements, and repair work that created a crucible for us both to change through the other.

CASE COMMENTARY

By Joe Kort

Alexandra Katehakis does an excellent job of illustrating the standard treatment protocol in working with sexual addicts, including recommending a temporary period of abstinence, going to 12-step meetings, developing a sexual sobriety plan, identifying out-of-control sexual activities, and refraining from destructive behaviors. She recognizes that Jim has lost control over his pornography use and skillfully addresses his attachment disorder, with a particular emphasis on the use of body work.

While the addiction model offers an extremely helpful behavioral management and cognitive path to recovery, it has its drawbacks, including the pathologizing of normal eroticism. Often a therapist's discomfort or unfamiliarity with the wide variety of *normal sexual fantasies* and behaviors can lead to interventions that may not be helpful to the client. For example, I wouldn't label Jim's sexual fantasies as passive-aggressive as Katehakis did, nor would I assume that the problem is his consumption of pornography, in itself, but rather that it's his particular relationship with pornography. I'd certainly want to know much more about what he found within the pornography that caught his unconscious eye.

I attempt not to have any preconceived notions about what clients' fantasies mean, but try to be careful to ensure the meanings come from them, and not me. I'm concerned that Katehakis's focus primarily on her safety after learning about Jim's sexual fantasies of tying up and sexually abusing women made him feel uncomfortable about revealing anything more. While it's clearly important for therapists to be mindful of their personal safety with clients, in addition to the safety question, I'd have praised him for his courage in talking so openly about his fantasies, and asked more about what they meant for him. The additional questions I'd have asked are ones like: what's arousing about tying a woman up and sexually abusing her? What do you want the woman to think and feel in the fantasy? What do you think and feel toward the woman in the fantasy?

I believe the job of the clinician is to help clients crack their own erotic code and find the nonerotic themes and meanings from these details. The answers to these kinds of questions should dictate the treatment plan for Jim. Of course, it may be that Katehakis is correct and that his fantasies are about becoming empowered over a woman because he feels so disempowered in reality. For most people, sexual fantasies eroticize nonsexual conflicts in their lives. At their core, such fantasies are attempts to overcome unresolved issues from childhood.

Sexual addiction clinicians say they support *natural* sexual energy and what's healthy and normal for couples and individuals, but the question is, who decides what's natural? Too often, that's based solely on a therapist's bias and judgment, and may have little to do with what clients need or want. Condemning certain sexual expressions, while condoning others, isn't our job—it's understanding the relationship clients have to their sexual behavior, whatever it may be.

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AUTHOR'S RESPONSE

I appreciate Joe Kort's thoughtful response, especially his point that therapists must avoid "preconceived notions about what clients' fantasies mean." My earliest discussions of Jim's sexual fantasies with him, as well as my initial ethical and safety concerns, are what led to my guess that the images he liked represented a passive-aggressive, and therefore maladaptive, attempt to feel mastery over women. Later he confirmed that viewing violent pornography gave him a sense of power over women that he didn't experience in life, and a frustratingly temporary (presumably dopamine) rush. This pattern, he discovered, ultimately made him feel *less* in control and *less* capable of confronting women directly.

Another therapeutic pitfall Kort notes involves the question, "Who decides what's [sexually] natural?" Such determinations spark robust debates among sex addiction therapists and sex therapists, as does assessing when patients have "crossed the line" to using sex destructively. Answers to these questions likely depend on what side of the therapeutic aisle you sit on.

Sex addiction therapists more readily view clients' sexual behaviors as deviant, since their clients present with the pain those activities cause them and others. Many sex addicts have told me that—like any true addict—they can't stop their actions, despite negative consequences, and that these behaviors feel like a drug. Asking such clients to temporarily halt all sexual behavior isn't a condemnation of any specific sexual activity, but a recognition that it's being misused and, therefore, hurts the client or others. As Kort mentions, Jim's problem was his relationship with pornography, not pornography itself, and that he used it in an attempt to heal unresolved childhood issues. I agree with Kort that in sex addiction cases, the problem is never sex; it's the abuse of sex due to childhood trauma, and the damage done by such distortion.

Sex therapists generally take a more liberal view of sexual normalcy because of their broader client base. They collaborate with clients to discover "sex positive" behaviors that allow free expression of sexuality. Often, however, this tack becomes a harm-reduction model that skirts clients' core issues.

I strive to balance both approaches. I'm committed to supporting clients like Jim, who wish to stop using sexual behaviors destructively, but I reserve judgment about all sexual acts between consenting adults. My goal is to help people move from using sex as a weapon against themselves or their partners toward experiencing the kind of sex *they* deem both healthy and erotic.

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