Clinical Case: Sexual Addiction

Dan, a 35 year old in the high tech industry with a three year old child, requested counselling for sexual addiction saying that his wife of five years, Natalie, had discovered his frequenting massage parlours by tracking money that was unaccounted for, which had started after their child was born, and was threatening to leave the marriage unless he solved his sexual addiction.

Natalie, who was extremely distressed, had confronted him about whether or not he had resumed watching pornography also (she had discovered his chronic use of internet pornography and masturbation before their child was born). At first Dan had denied this, but in the face of her intense and persistent interrogation, he had admitted that although he had stopped watching pornography for a time after she had first confronted him, he had gradually drifted back to almost daily use which consumed up to two hours a night, leaving him tired for work the next day. His denial had added to Natalie's feelings of betrayal and mistrust.

Dan stated that he wanted to stop going to massage parlours and to give up pornography in order to save his marriage. He noted that he loved Natalie, and valued being a parent and family life. He indicated that although sex with Natalie had been good during their courtship, their sex life had waned gradually since marriage such that now they had perfunctory sex about once a week. He said he also wanted help to improve their sex life if he was successful in salvaging the marriage.

Process of Change

I explained that, although it is easy to separate from addictive sexual behavior in the immediate aftermath of a crisis, change is difficult to sustain in the long term because addictive behavior is highly reinforcing. Based on his experience relapsing in relation to on-line pornography, Dan said that he understood this. I informed him that if he wanted to overcome his addiction, it would require embarking on a process of change involving the following steps: 1) increasing motivation for change, 2) developing and implementing a Sexual Health Plan, and 3) providing help for his partner, Natalie, by including her in his treatment. Dan indicated he wanted to make a full recovery and was open to this process of change.

Step I: Increasing Motivation for Change

I started to help Dan build motivation for change by asking if it would be okay to talk about the advantages of his addictive behavior which are unconscious to some extent. Dan seemed surprised but also intrigued by the question and complied willingly. Together, we identified the following advantages:

- Experience intense sexual arousal and pleasure
- Avoid partner sex that he found repetitive and not very satisfying

- Avoid having to make an effort giving to his partner sexually (he found masturbating to pornography a convenient and easy way to focus on his own pleasure)
- Avoid the anxiety/shame of losing his erection occasionally during partner sex.
- Experience the anticipation of novelty when seeing new massage workers
- Experience the excitement of engaging in taboo behavior with massage workers
- Avoid feelings of boredom (anxiety), loneliness (emotional pain), and guilt (shame)

Dan took note when I pointed out that the advantages we had delineated helped him to avoid uncomfortable feelings and to move toward pleasurable feelings. I explained that any behavior that moves us away from uncomfortable feelings – such as anxiety, emotional pain, and shame – is a negative reinforcement, and that any behavior that moves us toward pleasurable feelings – such as arousal, anticipation, and excitement – is a positive reinforcement. I commented that addictive sexual behavior is highly reinforcing and hard to change because it helps us to regulate ourselves emotionally, but in a way that increases our suffering over time.

We then identified the following disadvantages of his addictive behavior:

- Diminished interest and occasional loss of erections in relation to partner sex
- Natalie's loss of trust and security in the marriage
- Increased conflict with Natalie
- Guilt and shame because he knew Natalie was feeling undesired and unattractive
- Guilt because his spending money on sexual services was creating financial hardship
- Risk of contracting Sexually Transmitted Infection (STI) and infecting Natalie
- Risk of family, friends, and coworkers finding out about his behavior and facing public humiliation and possibly losing his career
- Risk of losing his marriage
- Increased shame and low self-esteem
- Natalie's loss of sexual self-esteem and confidence (she was feeling undesired and rejected sexually and blamed herself as unattractive)
- Increased anxiety related to possibly losing his career and marriage
- Loss of productivity at work because of fatigue
- Waste of time that could be given to goal-directed behavior

When I asked Dan to give a percentage to the advantages and disadvantages of his addictive behavior such that the sum is 100%, he assigned 20% to the advantages and 80% to the disadvantages. I pointed out that the 20% represented a part of himself that benefited from the addiction, and that might not want to change. He conceded this was the case but said he wanted to change.

When I asked Dan how much effort he was prepared to make to change, he said, "Whatever it takes". I validated him, saying that in my experience men underestimate how difficult it is to change addictive behavior and that the more time, effort, and resources he was prepared to invest, the more likely he would experience a full recovery.

Then, I explained that when it comes to change, there is a part of us that wants to change and a part that resists change, and asked him if it would be okay to do an experiment to that in my experience is helpful in melting our resistance and strengthening our resolve to change. When Dan said he was willing, I indicated we would use a technique called "Externalizing the Resistance", in which I took the role of his negative inner voice speaking in the second person "You" and he answered back from his healthy point of view in the first person "I". An example of the ensuing dialogue is as follows:

Therapist: You should continue to engage in masturbating to on-line pornography and visiting massage workers because it creates so much intense sexual arousal and pleasure.

Dan: I need to stop because my behavior is hurting Natalie, and I don't want to lose my family.

When I asked Dan which part of him won this exchange, his negative inner voice as expressed by me (therapist) or his healthy point of view as expressed by himself, he suggested it was a draw. After we reversed roles and I modeled a stronger response for Dan to emulate, Dan responded as follows:

Dan: I agree that my addictive behavior is pleasurable and that I will miss it, but I want to find real gratification in healthy ways. Also, my addiction is costing both of us too much. My behavior is damaging Natalie's trust of me and feeling of security in the marriage, her sense of herself as an attractive, desirable woman, and her bond with me. My behavior is damaging my desire for Natalie, my self-esteem, and my being the man I want to be. If I listen to you (the negative inner voice), I will lose everything that is most precious to me.

When I asked Dan again which part of him won this exchange, he answered unequivocally that his healthy point of view had. Externalizing each of the additional advantages of sex addiction and helping Dan to rebut them decisively increased his motivation for change.

Step 2: Developing and Implementing a Sexual Health Plan

When I proposed to Dan that we work together to develop and implement a Sexual Health Plan (SHP), he was keen. I explained that in the Boundaries column he would define the sexual behaviors he wanted to stop, in the Ambivalence column the behaviors he wasn't ready to stop, and in the Health column tools he could use to refrain from crossing his boundaries. I indicated that six Sexual Health Principles would guide formulating the SHP. The Sexual Health Principles are:

- Consent (voluntary cooperation and permission)

- Nonexploitation (not leveraging one's power or control to receive sexual gratification from another person which compromises the person's ability to consent)
- Protection from HIV/STI's and unintended pregnancy
- Honesty (direct and open communication but not unlimited candidness)
- Shared Values (clarifying through talking the underlying motives, sexual standards, and meaning of specific sex acts for each person)
- Mutual Pleasure (prioritizing the giving/receiving of pleasure).

In discussion, Dan realized that his addictive sexual behavior to some extent violated all but the first principle, consent. He acknowledged that his paying for sex with massage workers was exploitative because he was using the power of his high status and income as leverage for sexual gratification with women who likely wouldn't choose to service him sexually if they didn't have low income/status. He admitted guiltily that at times he violated the principle of protection by having intercourse without a condom with sex workers. He accepted that his deceit with Natalie violated the principle of honesty. He concurred that he violated the principle of shared values by not talking with sex workers or very much with Natalie to clarify the motivation and meaning of sex. Finally, he conceded that he violated the principle of mutual pleasure with sex workers and to some extent with Natalie because often he was more focused on his own pleasure than hers.

After acknowledging Dan for the courage to evaluate his sexual behavior in light of the Sexual Health Principles, I handed him a writing pad and pen and asked him to write the title, "Sexual Health Plan", and then to make three columns with the headings "Boundaries", "Ambivalence", and "Health". .

In the Boundaries column, Dan decided to write "No use of internet sexual imagery" and "Sex only with Natalie". Initially, he toyed with the idea of defining internet sexual imagery narrowly to exclude only explicit pornographic images, but when I suggested that viewing "soft images" such as provocatively clad models could trigger him, he chose to define internet sexual imagery broadly by including soft images.

In the Ambivalence column, Dan put "Reduce use of pot by one-half and reevaluate after one month". Dan was ambivalent about changing his relationship with pot. Part of him realized it contributed to his sex addiction by triggering and heightening the pleasure he derived from pornography and sex workers; part of him was anxious about letting go of it because it mellowed him out after a stressful day at work. He agreed to the suggestion of harm reduction; namely reducing his use by one-half and reevaluating in one month.

In the Health Column I explained that I would provide tools that would help him to change his behavior, thoughts, and feelings. Because tools for changing behaviors are straightforward and can have an immediate impact, we started with this.

Tools for Changing Behaviors

First, I suggested a tool called Stimulus Control. I explained that if access to sexual imagery on-line (the stimulus) is only a click away, over time our willpower, which is finite, is slowly worn down by resisting urges and eventually we give in. Similar to an alcoholic who practices stimulus control by not having alcohol in the house, stimulus control in relation to sexual imagery on-line involves implementing a blocking and/or monitoring service. Dan decided to install both on his lap top and to lock his Smart Phone at night in a drawer to which his wife had the key.

Next, I suggested Dan join Sex Addicts Anonymous (SSA), a 12-Step group for sex addiction. Dan balked at this suggestion initially, saying that he was shy and that listening to men talk about their sexual problems would merely fuel his addiction. When I pointed out that it was okay to go and listen until he felt ready to talk and that attending such a group could provide a program of recovery as an adjunct to therapy, he agreed reluctantly to check it out. Given that SAA meetings differ depending on the individuals present, I encouraged him to "shop around" in order to find a group that he felt comfortable with, and to attend a minimum of six meetings before making a decision about its helpfulness.

Next, we discussed healthy masturbation defined as using his internal images and fantasies in response to a natural desire to be sexual as opposed to a desire to escape uncomfortable feelings as an adjunct to making love to Natalie if she wasn't ready or available for sex. Dan seemed relieved to know that learning how to masturbate in a healthy way was an option because he had been apprehensive about stopping masturbation all together.

Other tools for changing behavior Dan agreed to were: 1) becoming transparent re his spending behavior by making all his financial transactions available to Natalie, 2) asking "What Else?" he could refocus on whenever he experienced urges to "act out" in order to engage in alternative, healthy activities such as exercise, hobbies, and reading (urges subside generally in about 15 minutes with refocusing), 3) bringing the addiction "into the light" (addiction thrives on secrecy) by confiding in family, close friends, and SAA members for accountability and support, and 4) learning mindfulness meditation, a breath focused approach to meditation, to relax his body and calm his mind.

Tools for Changing Thoughts

Dan listened to a negative thought process that mediated his sexual behavior. He rationalized his visiting massage parlours by telling himself, "I deserve sexual satisfaction. What Natalia doesn't know won't hurt her. Besides, I'm not involved emotionally with the women I have sex with. It's only sex". Also, he rationalized his use of pornography: "I've had a hard day. I deserve some pleasure. Besides, internet pornography is harmless. Every guy does it". The negative voice not only rationalized his sexual behavior, but also created guilt after the behavior. Dan berated himself, "I have no self-control. I'm weak and selfish". As he listened to these attacks against himself, he became sullen and withdrawn, setting himself up for "acting out" again to try to feel better.

With respect to tools for changing these thoughts, I introduced Dan to "Externalizing the Voice". Although similar to "Externalizing the Resistance", the technique that had helped Dan increase his motivation for change, I explained that with Externalizing the Voice, Dan would play both the role of dramatizing the negative inner voice and the role of countering it.

Following Dr. Robert Firestone, the "voice" refers to a well-integrated pattern of hostile thoughts and attitudes about self and others. The voice is construed as a destructive overlay on the healthy self, an alien point of view about the self and others. Because it is internalized at a young age, people experience it as compelling, highly convincing, even comfortable. Because the voice is only partially in awareness, people are often unaware of it or its adverse impact such as contributing to people avoiding their feelings by talking themselves into addictive behavior.

Confronting the voice requires separating this destructive thought process out from one's healthy point of view about self and others. What is required is a shift from listening uncritically to the voice and falling under its influence to separating it out and countering forcefully from one's own healthy point of view. Robert Firestone has developed a procedure for doing this. He suggests "saying the voice" in the 2nd person, "**You**", as if someone else is talking to the person. He also suggests saying the voice in the 2nd person with the affect or emotional tone that it has in one's head. By following this procedure, people have an experience of the voice as a hostile, alien point of view about themselves, an enemy within, which is not in their best interest to listen to. Once people separate out or externalize the voice, they are encouraged to counter the voice forcefully from their healthy point of view in the 1st person singular, "I". The steps in this procedure, then, are: 1) awareness of the negative voice, 2) externalizing the voice by saying it in the 2nd person "**You**", and 3) countering forcefully from one's own healthy point of view in the 1st person, "I".

Dan learned to externalize the voices that rationalize his addictive sexual behavior in the 2nd person. For example, rather than telling himself in the 1st person, "I've had a hard day, internet pornography is harmless, every guy does it, and I deserve some pleasure", Dan learned to say this as if someone else was addressing him: "**You've** had a hard day, internet pornography is harmless, every guy does it, and **you** deserve some pleasure." He identified the tone of the voice in his head as matter of fact and permission giving.

I encouraged Dan to talk back to the voice forcefully, reminding him that unless we view the voice as a destructive thought process that is hostile toward us, and talk back to it accordingly, it is easy to fall under its influence. Dan learned to say, "I know who you are. I know that you are like a wolf in sheep skin. I know that you want to devour me. I won't let you ruin my relationship! I want real gratification making love to Natalie." I also encouraged him to externalize the voice by writing out this internal dialogue in a journal in order to have even more control over the voice.

Dan also learned to externalize the voices that followed his "slips" in the 2nd person. Rather than telling himself, "I have no self-control. I'm weak and selfish", Dan learned to say, “**You** have no self-control. **You’re** weak and selfish!” He identified the tone of the voice as attacking and self-hating.

I encouraged Dan to counter these attacks against himself from a compassionate point of view toward himself in the 1st person, informing him that it is best to learn from our slips but never to attack ourselves (we have enough self-hatred without compounding it). He countered, “I know that acting out sexually is not in my best interest. I will learn from this mistake. I don’t deserve to attack myself when I slip. Beating myself up only makes me feel worse about myself, setting me up to “act out” again.

Tools for Changing Feelings

I explained that changing feelings was the most challenging and time consuming aspect of overcoming addiction, and that before introducing him to tools to change his distressing feelings, it was important to learn more about his past and to teach him about intrusive feelings, and how we avoid them at the expense of our happiness. When Dan said that he was up to the challenge, we started with an exploration of his childhood through early adulthood.

When I asked if it was okay to talk about what he knew about his parents’ circumstances when he was in his mother’s uterus, his birth, and the first year of his life, he seemed surprised but was cooperative when I explained that recent research shows that this early part of life has an enduring impact on our happiness and adjustment as adults. Dan indicated that his conception had been a surprise, occurring about six months after his parents had met. His mother had been ambivalent about having him because she was in the midst of studying to be a nurse and had wanted to work and travel. Because she was in love with his dad, they had decided to get married and to go through with the pregnancy.

In terms of his birth, his mom had been in labour for a long time when she was induced with Oxytocin. When signs of fetal distress were detected, he was born by Caesarian Section. He was in hospital for the first few weeks, taken from the nursery to have contact with his mom until she had recovered sufficiently to take him home. Once home, lacking the support of his dad who worked a lot and an extended family, his mom had become overwhelmed and fell into a severe post partum depression requiring a brief hospitalization. During this time he was cared for by a neighbour. When his mom came home she did not resume breastfeeding, and continued to struggle with depression. Apparently he was a fussy baby, difficult to feed and a poor sleeper. His mom said his sleep improved after they let him “cry it out”.

When asked what his parents were like through the eyes of himself as a small boy, he described his father as a “man’s man” and his mother as “loving”. Deeper probing indicated that his dad, a mid level manager, had been away a lot and when home was self-absorbed with outdoor activities, showing little interest in Dan. Deeper exploration indicated that his mother, a homemaker, had been depressed much of the time. He couldn’t recall his parents having shown much affection to him. He remembered how he felt frightened and blamed himself when his dad was angry and out of control. When he felt bad, afraid, or alone, he didn't recall either of his parents helping him with his feelings.

When asked to describe what his childhood was like, he stated he had had a "normal" childhood. Deeper probing indicated that he had had difficulty separating from home when he started kindergarten. Although his initial anxiety about going to school subsided gradually, he didn't like elementary school very much because he was teased a lot for being shy and a little overweight. He felt lonely at school and unlikable.

He also had difficulty adjusting to his parent's separation when he was eight. The event precipitating their separation was another of his father's affairs. He recalled how painful this had been, how he had blamed himself for the separation, and how no one had helped him with his feelings of shame, sadness, and fear.

When asked how he spent his time after the separation, he recalled spending a lot of time alone, distracting himself from painful feelings by watching TV and fantasizing about being a famous war hero while playing in his room with a miniature army set. While visiting at his dad's, he had discovered a stash of pornographic magazines. He found viewing pornography highly arousing and pleasurable. By the time he was twelve, he was masturbating to pornographic images on a daily basis. He found that doing so provided instant gratification and relieved uncomfortable feelings such as anxiety and loneliness.

While exploring his teen years, Dan reported that he lacked the confidence in high school to date. Instead, he preferred to fantasize about being a famous rock star while playing his guitar, to watch TV, and to masturbate to pornography. He discovered smoking pot at about age 14, and liked how it helped him feel as well as the acceptance he found from using it with peers.

It was at a bar that he had met his wife, Natalie. After meeting her, he had experienced excitement and euphoria in pursuing her and her wanting him; in addition, he had felt a certain comfort and "fit". Dating was intense, the sex was good, and for a time his urges to masturbate to pornography subsided before he resumed the behavior furtively.

Having explored Dan's childhood and later development, I proceeded to introduce him to Dr. Geoffrey Carr's theory of intrusive feelings in order to help him better understand his feelings.

Intrusive Feelings

Dan could recall distressing feelings growing up – such as the fear and shame he felt when his dad berated him, the anxiety he felt going to kindergarten, the pain he felt when teased at school, and the loneliness he felt when his mom was depressed and his dad was absent. He seemed surprised when I suggested that these distressing feelings reinforced earlier trauma feelings that he couldn't remember.

I explained how Dr. Geoffrey Carr's book, *Making Happiness*, presents research showing infants are much more sensitive and aware of their environments than previously thought, and that all infants to some extent experience intense trauma feelings. In addition, I indicated there is evidence that the fetus is affected by the mother's level of stress and anxiety, and that the birth experience can be highly traumatic if there are complications and unnecessary medical interventions.

According to Dr. Carr, in order to understand how an infant is traumatized, it is important to recognize that it is the infant's experience of the event rather than the event itself that is traumatizing. From an adult's point of view, if an infant is in a high level of distress crying alone in its crib, there is no danger. However, it is the infant's experience that matters. Infants don't understand why they are in distress, or when or if the distress will stop. The infant's experience of mild distress quickly escalates into overwhelming feelings of helplessness and pain if the infant isn't responded to in a timely and sensitive manner.

The only protection that an infant has against experiencing intense trauma feelings is a highly attuned caregiver who responds sensitively to the infants' needs before it becomes highly distressed and "freezes". The freezing response is a biologically in-wired physiological reaction that occurs in the animal kingdom whenever an animal can't fight or flee from a predator and is utterly helpless. This freezing response, in which the animal looks dead from the outside but is highly activated internally, is adaptive biologically because the animal has a greater likelihood of survival by appearing dead.

The freezing response in humans is called dissociation. When humans dissociate, they detach from their experience and feel numb. Dissociating provides relief from overwhelming, intense feelings of fear, shame, and pain. Unfortunately, when infants dissociate, the distressing feelings do not go away but are stored in implicit memory, ready to be triggered by way of a conditioned response whenever there is a reminder internally (thoughts, feelings, memories) or externally (the environment) of the trauma feelings.

All of our distressing feelings are best understood as intrusive feelings; that is, feelings that when triggered, intrude from the past into the present, colouring our experience of the world and causing us distress to to varying degrees. Although we are so accustomed to the trauma feelings that intrude at a low level chronically in the form of mild tension and dullness that we accept this as normal, it is when the trauma feelings are triggered and intrude at high levels of fear, shame, and pain that we feel most distressed.

Dan and I discussed the trauma feelings that he likely experienced while in his mother's uterus, during the birth experience, and the first year of his life. I suggested that likely he would have been affected by his mother's ambivalence about whether or not to terminate the pregnancy. I suggested that likely he would have experienced intense feelings during the long labour and during fetal distress after the administration of Oxytocin. I indicated that likely he would have missed the experience of being allowed to relax and let go of these intense feelings by lying on his mother's bare chest after being born because of the

Caesarian birth (one study show that infants who are able to lie on the mother's bare chest for two hours after birth are better adjusted on a number of variables than infants who miss this experience one year later). I stated that while in the nursery immediately after birth and again while his mother was hospitalized for post partum depression, likely he experienced the freezing response to avoid the intense feelings of anxiety and helplessness of being separated from her. In addition, I suggested that likely he would have experienced the freezing response when as an infant he was left to "cry it out" at night (once we experience the freezing response, we re-experience it subsequently at lower levels of distress).

Initially, Dan had a hard time believing that experiences that he could not remember would have traumatized him. However, when I told him that we learn a lot in the first year of life that we don't remember – such as how to walk, talk, and recognize our parents – he was more open to accepting that the source of the intense feelings that he avoids through his sex addiction is intrusive feelings. Knowing this also helped him to start feeling more compassion for himself.

We also discussed how the later painful events in his life that he could remember after about age three reinforced the early trauma feelings. Dan remembered how anxious he felt when his mother ignored him while depressed, how anxious he felt when he started kindergarten, how scared he felt when his dad raged, how ashamed he felt when he was teased at school, how anxious and ashamed he felt when his parents separated, and how lonely and isolated he felt as a teenager. Having introduced Dan to intrusive feelings, I then proceeded to help him understand how he had learned to avoid these feelings at the expense of his own happiness.

Avoidance of Intrusive Feelings

The freezing response that we experience as infants helps us to avoid being overwhelmed by intense feelings of helplessness, fear, and pain by partially numbing these feelings. As Dr. Carr explains in Making Happiness, as we grow up we learn other ways to avoid our feelings though a process called avoidance learning. With avoidance learning, whatever behaviors we perceive reduce our feelings of anxiety, shame, and pain are reinforced, whether or not the particular behaviors actually are effective or not. Unfortunately, how we avoid our trauma feelings leads to more suffering.

Some of the earliest behaviors that Dan learned in order to avoid his feelings were sucking his thumb, clinging to his stuffed animals, and rocking in his chair. When he was about six, he discovered that rubbing his genitals was pleasurable, a behavior he engaged in whenever he was upset. He also learned to use his imagination to avoid feelings, creating imaginary friends whom he played with when lonely. Another way that he learned to avoid feelings was watching a lot of TV.

In addition to avoiding feelings through these behaviors as a child, he learned to avoid feelings of anxiety and insecurity through a fantasy bond with his parents. As Dr. Robert Firestone writes, the fantasy bond is an imagined connection with one's parents in which the child imagines that the parents are more ideal and loving than they really are. The fantasy bond gives the child an illusion of security and safety, but at the expense of his own view of himself; that is, the only way a child can see his parents as more loving than they are in reality is by seeing himself as bad.

As a teenager, Dan continued to avoid feelings of anxiety, shame, and pain (loneliness) through fantasy (he imagined himself as a rock star), excessive TV, and masturbating daily to pornography on the internet.

As an adult, he avoided feelings in additional ways: distracting himself by working long hours, being constantly busy, and getting stoned on pot at night. Also, he extended the fantasy bond to his wife, Natalie. He imagined that he had a close, loving connection with her that gave him an illusion of security without the emotional risks of a real connection.

However, his main way of avoiding his feelings continued to be sex. What had started by rubbing his genitals as a child and continued by masturbating to pornography as a teen became a sexual addiction as an adult: surfing the internet for the perfect pornographic image to turn himself on, and visiting massage parlours for impersonal sex.

Avoiding his feelings of anxiety, shame, and emotional pain in these ways had resulted in an inward, addictive approach to sexuality in which he preferred to gratify himself in fantasy rather than experiencing a close, sexual connection with Natalie. He realized that when he engaged in addictive sexual behavior, he was using women as objects to gratify himself rather than experiencing a personal connection.

Identifying how he had learned to avoid trauma feelings helped Dan to increase his motivation for change. Whereas earlier the motivation for stopping his addictive behavior had been external (the fear of losing his marriage), now it was also internal; namely, the desire to feel rather than avoid his feelings and to be happier. With an understanding of his intrusive feelings, and how he had learned to avoid them in ways that increased his suffering, I turned to providing him with an approach to change these feelings.

Bringing Presence to Feelings

The basic approach for changing intrusive feelings is bringing our presence to feelings. This involves three steps: first, bringing attention to our feelings and observing or witnessing them; second, symbolizing our feelings in words, and third; relating to our feelings with wisdom and compassion. Although this procedure seems simple, as Dan discovered, it isn't and requires effort and practice.

I taught Dan the first step, bringing attention to feelings and observing them, by directing him to close his eyes, to imagine himself alone at night downstairs in his office in front of his computer after Natalie had gone to bed, and to focus his attention inside his body to his midsection, where we feel things. At first, Dan was able to identify feeling only a vague uneasiness or tension in his gut extending into his chest. He was unable to identify any fully formed intrusive feelings that he was avoiding by "acing out". I said I wasn't surprised, because often we learn as small children to disconnect from our bodies to protect ourselves. In addition, sexual urges eclipse intrusive feelings before they come into awareness. Also, I explained that often we experience intrusive feelings initially, not as fully formed feelings, but as vague sensations in the body. I encouraged him to begin practicing bringing attention to feelings by focusing on the sensations in his body at night.

The second step in changing intrusive feelings involves symbolizing feelings in words. The more we are able to identify in words what we are feeling, the more control and relief we feel. Finding the correct word to symbolize what we are feeling involves trial and error. As we witness or observe a sensation or vaguely formed feeling or fully formed feeling in the body, we try out different feeling words to see what word best matches our inner experience. When we find the right word, we have an internal experience akin to, “Ah! That’s what I’m feeling”, often accompanied by a sense of relief and control.

As Dan practiced bringing attention to the sensations in his midsection on nights he hadn’t smoked pot, he tried out feeling words like “uneasy”, “uptight”, “irritable”, and “on edge”. While these words identified aspects of his internal experience, the words that best resonated with him were “wound up” (an aspect of the intrusive feeling of anxiety) and “lonely” (an aspect of the intrusive feeling of emotional pain).

The third step in changing intrusive feelings involves relating to them with wisdom and compassion. Relating to intrusive feelings with wisdom involves reminding ourselves that although our distressing feelings are being triggered in the present (by way of a stimulus and a conditioned response), the intensity of the feelings is not about the present but is an echo from the past. Telling ourselves this won’t stop the distressing feelings, but reduces their intensity making it easier for us to contain them (not feel overwhelmed) and to soothe them.

Relating to intrusive feelings with compassion involves experiencing real feeling for ourselves when we have distressing feelings. Reminding ourselves that we didn’t deserve to experience overwhelming feelings of anxiety, pain, and shame when we were little, and we don’t deserve to have these feelings now, helps us to have compassion for ourselves. An attitude of compassion helps us also to contain and soothe intrusive feelings.

Dan learned to relate with wisdom and compassion to the intense anxiety and loneliness that were triggered when he was separated from Natalie and his child in hotel rooms on business trips using a tool I have developed called the “Heart Ritual”. This involves closing his eyes, imagining himself in the hotel room, and while feeling the intrusive feelings in his body, to repeat to himself a number of times, “These are old feelings. I don’t deserve to feel so anxious and alone. I am safe now”. Practicing this ritual helped him to contain and soothe the feelings rather than turning to pornography and masturbation or a sex trade worker to escape the feelings. He learned that if he could bring his attention to the feelings, symbolize them in words, and relate to them with wisdom and compassion, they would slowly shift, pass, and resolve.

As we bring our presence to intrusive feelings with wisdom and compassion, earlier memories of these feelings come to mind, allowing us to bring our presence to them in order to resolve them as well. For example, while focusing inside on the loneliness he felt sitting at his computer in the downstairs office at night, he recalled sitting in his bedroom alone as a teenager after he had been unable to go with his peers on an overseas school trip. I encouraged him to go with this memory, to bring his attention to the feelings in the moment. He said, "I feel so alone." As he allowed himself to feel the loneliness, he recalled an even earlier memory, by himself as a five year old looking out the window of the living room watching other children play. As he brought his attention to the feelings in the moment, he commented in a small, childlike voice, "I feel in so much pain. It was awful to feel all alone as a small boy". I then suggested that he soothe this feeling using the Heart Ritual.

I asked Dan to imagine what it would have been like for him as a helpless and dependent baby to have been separated from his mother because of her hospitalization for severe postpartum depression. Doing so helped Dan to have real feeling for himself as an infant, and more compassion for himself as an adult when intrusive feelings were triggered.

I also helped Dan become aware of intrusive feelings of shame. Shame is the feeling that one is bad, defective, not good enough and unworthy. Shame is linked inextricably to trauma feelings of anxiety and pain. I suggested that as a small child likely he felt bad about himself whenever he wanted nurture from his mother and she was unresponsive, or whenever his dad was angry or impatient with him. The only way he could have felt safe would have been to blame himself and to see his parents as god-like. To have viewed his parents as inadequate would have left him feeling utterly overwhelmed and helpless.

Dan's Sexual Health Plan

Boundaries	Health	Changing Thoughts
No use of internet sexual imagery Sex only with Natalie **Ambivalence** Reduce pot by one-half and reevaluate after one month	**Changing Behaviors** Stimulus Control Sex Addicts Anonymous (SAA) Healthy Masturbation Transparency re money Refocusing by asking, "What else?" Confiding Mindfulness Meditation	Externalizing the Voice **Changing Feelings** Bringing Attention to Feelings Symbolizing Feelings in Words Relating to Feelings with Wisdom and Compassion Heart Ritual

As Dan used the tools for changing behaviors, thoughts, and feelings in his Sexual Health Plan, he was successful in stepping away from frequenting massage parlours. He continued to have thoughts and urges about them, but these gradually decreased in frequency and intensity.

The accessibility, convenience, and ease of on-line pornography contributed to Dan having more difficulty separating from it than massage parlours. When he slipped by masturbating to pornography, I framed these experiences as part of the process of recovery to be learned from rather than as fodder for voice attacks against himself. Likening recovery from sex addiction to climbing a mountain, I suggested that, because he was tied into the mountain (his Sexual Health Plan and counselling), when he slipped his fall was limited. What was important was recovering quickly and beginning the ascent again. Telling Natalie about his slips and experiencing her support helped to rebuild trust. Over time, he had increasing periods of abstinence with pornography until it was no longer a problem.

Although I indicated that I liked his changes, given the tendency of people with addictive behavior to relapse, I stressed that it was important that he continue his journey of recovery after we finished working together by being mindful of everything he had learned.

Step III: Providing Help for the Partner

About a month after beginning to work with Dan, I invited his partner, Natalie, to attend a session with him in order to engage her in his recovery process. Natalie reported feeling like she was on an emotional roller coaster. In some moments she felt intense anger in relation to his addictive behavior and deceit; in other moments she felt intense pain and anxiety over the loss of the trust that she had assumed in the marriage. I indicated that typically spouses in her situation experience intense feelings that mimic the feelings of post traumatic stress disorder. I validated her feelings and reassured her that by feeling the feelings and talking about them they would diminish gradually.

Natalie stated that she wasn't sure if she could ever trust Dan again. I replied that the original trust in the marriage had been lost and could not be recovered. However, I told them that by each doing their own part, with time they could build a new trust. His part was to work on his recovery, to be transparent and honest, answering her questions as non-defensively and openly as possible, and to keep his agreements. Her part was to gradually soothe her anxiety and let go of her mistrust as he separated from his addictive behavior and dishonesty.

Natalie said that she wasn't sure if she wanted the marriage, but was prepared to wait and see. I validated her ambivalence and her deferring making a decision until she was clearer about what she wanted. I recommended that Natalie find an individual counsellor to help her work through her feelings. I also cautioned Dan about looking to her for emotional support early in recovery, suggesting that she was too overwhelmed to offer him support and encouraging him to move toward family, friends, and members of Sex Addicts Anonymous for support.

Over the early months of recovery as I worked with Dan, I held occasional sessions with Natalie and Dan together. I validated their progress as Dan experienced more abstinence and as Natalie experienced less anxiety and increased trust.

In one such session, Dan expressed frustration with Natalie's asking him constantly about his whereabouts as well as the details of his previous addictive behavior. What he felt even more exasperated about was her not being satisfied with his answers. Typically, she would question him, he would answer her, she would continue to question, he would become defensive and she would react with anger leading to an escalating fight until he shut down and withdrew to his office. Both found this recurring experience distressing, and were receptive to my explanation that they were caught in a negative cycle driven by anxiety. I suggested that Natalie's way of managing anxiety (questioning) was triggering his anxiety (he felt tense and on guard), and that his way of managing anxiety (defending himself and later withdrawing) was triggering her anxiety (feeling unheard and cut off).

In order to change this negative cycle, I encourage Dan to validate the anxiety driving Natalie's questioning, and for Natalie to validate the anxiety driving Dan's becoming defensive and shutting down. I

About three months into Dan's recovery, Natalie stated that she was feeling safe enough in the marriage to resume having sex. I indicated that because sex is best viewed as a "team sport", helping Dan shift from an addictive sexuality to a healthier sexuality would require both of them working together. As a first step, I encouraged greater emotional intimacy by helping them talk about their feelings about resuming their sex life. Natalie articulated not wanting the kind of sex that they had had, which she described as rushed and impersonal. She wanted to feel more pleasure and connection in sex. Dan admitted to feeling anxious about this, but was willing to try because he wanted real gratification with her rather than the gratification in fantasy which he knew didn't satisfy. Talking helped to diffuse these feelings and to increase their emotional connection.

As emotional intimacy increased, I encouraged them to show more affection and to experiment with a non hierarchical, pleasure approach to sex. I explained that in a non hierarchical approach, intercourse is not ranked above other aspects of sexual behavior (touch/kissing, oral pleasure, and manual pleasure), but is seen as equal to these other aspects of sexual behavior. Whereas in a hierarchical approach the goal is to reach climax during intercourse (often quickly), in a non hierarchical approach the goal is to give and receive pleasure. I suggested that they begin to experiment with this approach by taking intercourse off the table temporarily and playing together sexually. Dan found this approach awkward at first, particularly having intercourse off limits, but came to like how his arousal and pleasure increased as his anxiety diminished. Natalie liked the increased connection that she experienced as they played together sexually.

Playing together in this way also helped them to broaden their sexual script such that when they did resume intercourse they enjoyed a much richer, more playful and variegated script. Broadening their script also enabled them to enjoy different types of sex – such as slow, sensuous and warm sex – as well as more lustful, passionate sex.

Outcomes of Counselling

Dan reported tangible benefits from having separated from his addictive, sexual behavior: having more time, feeling better rested and more productive at work, feeling less anxious as the result of not having to plan and then cover up his sexual behavior, feeling more positive about himself, feeling more gratification from positive activities, and feeling more aware of his feelings. As emotional intimacy and sex improved, Dan also reported feeling more satisfaction from his marriage. I suggested that this increased marital satisfaction was the result of gradually relinquishing their fantasy bond characterized by an illusion of closeness and experiencing a more real, loving relationship.

Conclusion

Recovering from sexual addiction is a process of change. By developing a Sexual Health Plan that delineates tools for changing behaviors, thoughts, and feelings, investing the considerable effort, time, and resources required to implement these tools, and shifting from an addictive sexuality to a healthier sexuality with partners, men may experience the considerable benefits of living free of sexual addiction.