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‘Sexual Addiction’: an Investigation of a Contested Concept

A thesis submitted to the University of Dublin, Trinity College
in fulfillment of the requirements for the degree of
Doctor of Philosophy

March 2014

Benedict Gerard Hughes
Declaration

I, the undersigned, declare that this work has not previously been submitted to this or any other University, and that unless otherwise stated, it is entirely my own work. This thesis may be borrowed or copied upon request with the permission of the Librarian, University of Dublin, Trinity College.

Benedict Gerard Hughes

Dated: 21st March 2014
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Benedict Gerard Hughes
University of Dublin, Trinity College
March 2014
Abstract

The aim of this research is to gather detailed information on how two different sets of actors, those who self-identify as 'sexual addicts' and those involved in treating 'sexual addiction', conceptualise the phenomenon of 'sexual addiction' within an Irish context. The specific objectives are to investigate: 1) how they understand the aetiology of 'sexual addiction'; 2) what they perceive to be the main symptoms and lifestyle elements of this alleged condition; 3) how they view recovery and the role played by formal treatment or rehabilitation systems in the recovery process. From a theoretical perspective, this research is conducted against the background of two conflicting views of 'sexual addiction'. One such view, a positivistic view, is that the concept of 'sexual addiction' and its associated therapeutic practices reflect objective scientific progress in the understanding and management of problematic or out-of-control sexual behaviour. A more critical sociological view is that the concept of 'sexual addiction' is a social construct, which extends an already spurious addiction model from its base in the area of psychoactive drug use to an area of human behaviour marked by ongoing contention about what is normative and what is deviant; in instrumental terms, such critics are not persuaded that 'treatment' of 'sexual addiction' confers identifiable therapeutic benefits on its client group, and tend to see the creation of sex addiction services as another example of expansion within an already rampant addiction treatment 'industry'.

A qualitative methodology is adopted and data were gathered using focus groups, individual interviews and questionnaires which include 46 self-identified sexual addicts and 55 treatment providers involved in treating 'sexual addiction'. Interviews were recorded. Interpretative Phenomenological Analysis (IPA) and Thematic Analysis (TA) are used for data analysis. The data presents a specific but limited perspective of 'sexual addiction' which reflects a methodological shortcoming arising from the sample whose narratives have been shaped by their experience of the treatment philosophy.

The study objectives provide a thematic framework into which the data are organised into three key areas namely the origins and development of 'sexual addiction', the lived experience of 'sexual addiction' and the treatment of and recovery from 'sexual addiction'. The data reveal that a pattern of out-of-control sexual behaviour is experienced by some self-defined sexual addicts and is conceptualised as a 'sexual addiction'. The traits, consequences and prescribed treatment suggests that for 'sexual addiction' are very similar to that of substance addiction.

The findings regarding the origins and development of 'sexual addiction', suggest that an accumulation of disruptive formative experiences in childhood can produce negative core beliefs which are considered contributory factors to 'sexual addiction'. Data show that as the 'sexual addiction' develops, specific characteristics emerge which distinguishes it from 'normative' sexual behaviour. Out-of-control sexuality
is shown to be often associated with a variety of psychological and physiological conditions which reduces an individual's ability to control sexual impulses.

The data describing the lived experience of 'sexual addiction' depicts it in terms of explicit behaviours which serve a range of functions primarily associated with emotional management. 'Sexual addicts' are more explicit in describing the 'lived experience' of 'sexual addiction' observed particularly in terms of the origins and the expression of 'sexual addiction'. In contrast the treatment providers' experience, largely based on clinical evidence, appears more theoretical and deductive. All research subjects highlight further complexities involving associations between sexual addictive behaviour and factors such as dual addiction, sexual abuse and homosexuality. The negative consequences of 'sexual addiction' usually result in a crisis which commonly leads the 'sexual addict', voluntarily or reluctantly, to seek help after which a process of recovery begins.

The findings of the third key area, the treatment of and recovery from 'sexual addiction', suggest that the application of the concept of recovery to 'sexual addiction' is complex. A number of specific therapeutic supports are identified as beneficial. 'Sexual addicts' are generally more aware of the range of supports available, and are more knowledgeable particularly in terms of the sexual fellowships. They are also more articulate about what constitutes effective treatment and are more critical about the limitations of the services provided. Treatment providers appear more critical of the treatment industry which is perceived as designating behaviours as addictive in order to cultivate the addiction industry. However, treatment providers' overall knowledge of the concept appears compartmentalised, partly due to their specialised training and precise clinical experience which is often associated with the specificity of their professional expertise. The model of 'sexual addiction' is used by some seeking recovery from 'sexual addiction' particularly by self-identified sexual addicts. Overall, the use of the model of 'sexual addiction' is not unanimous and remains contentious. Some professionals, who may or may not believe in the concept as a valid scientific entity, view the model of 'sexual addiction' positively for its practical utility. Others in this study view the concept of 'sexual addiction' as a sociomedical construct attempting to pathologise non-normative sexual practices. Others claim that the concept is a moral construct striving to counteract sexual liberalism. 'Sexual addiction' is also viewed as an expression of the growing medicalisation of society and perceived as a cynical strategy by an expanding addiction and pharmaceutical industry.

In conclusion, the concept of 'sexual addiction' as a mental health disorder continues to be contentious. Arguments that it is a social construction, partially motivated by the seeming necessity to impose order on what is a culturally ambiguous area of human life, and partially by the self-interest of treatment providers, have obvious validity. On the other hand there is no doubt that in practical terms such a construction may be of value to those who seek help with compulsive sexual behaviours. Social scientists consistently argue that the more traditional conceptions of addiction or dependence involving psychoactive substances are also socially constructed; therefore whether constructions of 'sexual addiction' are more or less scientifically dubious is a moot point.
# Contents

Acknowledgements v

Abstract vii

List of Figures xv

List of Tables xvii

Chapter 1 Thesis Overview 1
  1.1 Introduction ................................................................. 1
  1.2 The Concept of Addiction ........................................... 3
    1.2.1 The Concept of ‘Sexual Addiction’ ................... 4
    1.2.2 Sexuality in Irish Society ............................... 5
  1.3 Study Aims and Objectives ........................................ 5
  1.4 Structure of the Thesis ............................................. 8
  1.5 Conclusion .............................................................. 9

Chapter 2 Literature Review 11
  2.1 Overview of Literature Review ................................... 11
  2.2 Sexuality ..................................................................... 12
    2.2.1 Sexuality in Ancient Cultures ............................ 13
    2.2.2 World Religions and Sexuality ......................... 14
    2.2.3 Cultural Perspectives on Sexuality: Middle Ages to the Sexual Counter-Revolution 16
  2.2.4 Sexuality in Ireland: The Socio-Religious Context .... 18
  2.2.5 Conclusion of Human Sexuality ......................... 20
  2.3 Addiction ................................................................. 21
    2.3.1 The Development of Addiction .......................... 22
    2.3.2 Prohibition ......................................................... 23
    2.3.3 The Birth of Alcoholism .................................... 24
    2.3.4 Critique of the Concept of Addiction ................. 26
## CONTENTS

2.3.5 Conclusion of the Development of Addiction .......................................................... 28

2.4 'Sexual Addiction' ..................................................................................................................... 28
  2.4.1 The Contemporary Model of 'Sexual Addiction' ................................................. 29
  2.4.2 The Socio-Historical Context of 'Sexual Addiction' ........................................... 31
  2.4.3 Predisposing Factors ..................................................................................................... 32
  2.4.4 The Development and Cycle of 'Sexual Addiction' ............................................ 35
  2.4.5 Behavioural Expressions of 'Sexual Addiction' ...................................................... 37
  2.4.6 Negative Consequences of 'Sexual Addiction' ...................................................... 38
  2.4.7 Treatment of 'Sexual Addiction' ............................................................................. 38
  2.4.8 Therapeutic Challenges .............................................................................................. 40
  2.4.9 Distinguishing 'Sexual Addiction' and Normal Sexuality .................................... 40
  2.4.10 Alternative Explanations for Out of Control Sexual Behaviour ..................... 43

2.5 Critique of the Concept of 'Sexual Addiction' ................................................................. 44
  2.5.1 The Social Construction of 'Sexual Addiction' ..................................................... 45
  2.5.2 'Sexual Addiction' and the Medicalisation of Society ......................................... 45
  2.5.3 'Sexual Addiction' or a Moral Construction ......................................................... 46

2.6 Conclusion .................................................................................................................................. 47

### Chapter 3 Methodology

3.1 Introduction .................................................................................................................................. 49

3.2 Rationale for the Qualitative Approach ............................................................................. 50

3.3 Sampling and Recruitment .................................................................................................... 51
  3.3.1 Recruitment of Research Subjects .......................................................................... 51
  3.3.2 Selection of Research Subjects ................................................................................ 52
  3.3.3 Research Subjects ........................................................................................................ 53

3.4 Data Collection Procedures .................................................................................................... 54
  3.4.1 Pilot Study ..................................................................................................................... 54
  3.4.2 Focus Groups .................................................................................................................. 56
  3.4.3 Semi-Structured Interview ........................................................................................ 57
  3.4.4 Questionnaires .............................................................................................................. 58
  3.4.5 Ethics ............................................................................................................................... 59

3.5 Data Analysis .............................................................................................................................. 59
  3.5.1 Interpretative Phenomenological Analysis (IPA) ............................................... 60
  3.5.2 Thematic Analysis (TA) ............................................................................................. 60
  3.5.3 The Analytical Process ............................................................................................. 61
  3.5.4 Study Limitations ....................................................................................................... 64

3.6 Conclusion ................................................................................................................................. 67
# Chapter 4 Origins and Development of 'Sexual Addiction'

4.1 Introduction to Findings Section ............................................. 69  
4.2 The 'Sexual Addict' ................................................................. 70  
4.2.1 Socio-Demographic Profile of the 'Sexual Addict' ................... 70  
4.2.2 'Sexual Addict': Core Beliefs ............................................. 72  
4.3 'Sexual Addiction': The Pre-Disposing Influences ..................... 74  
4.3.1 Physiological Influences ..................................................... 74  
4.3.2 Mental Health and 'Sexual Addiction' .................................. 75  
4.3.3 Neurology and 'Sexual Addiction' ....................................... 77  
4.3.4 Psychosocial Influences and 'Sexual Addiction' .................... 78  
4.3.5 Family of Origin and 'Sexual Addiction' ............................... 78  
4.3.6 Parental Attachment and 'Sexual Addiction' ......................... 81  
4.3.7 Childhood Sexualisation and 'Sexual Addiction' ................... 83  
4.3.8 Homosexuality and 'Sexual Addiction' .............................. 86  
4.3.9 Sexual Education and 'Sexual Addiction' ............................. 87  
4.3.10 Religion and 'Sexual Addiction' ........................................ 89  
4.3.11 Miscellaneous Events and 'Sexual Addiction' ...................... 90  
4.4 Realisation of 'Sexual Addiction' ........................................... 91  
4.5 The Development of 'Sexual Addiction' .................................. 93  
4.6 Characteristics of 'Sexual Addiction' ...................................... 95  
4.6.1 Out-of-Control Sexual Behaviour ....................................... 95  
4.6.2 Secrecy .............................................................................. 96  
4.6.3 Shame .............................................................................. 97  
4.6.4 Compulsion ...................................................................... 98  
4.6.5 High-Risk ........................................................................ 98  
4.6.6 The Cycle of 'Sexual Addiction' ........................................ 99  
4.7 Conclusion .......................................................................... 101

# Chapter 5 The Lived Experience of 'Sexual Addiction'

5.1 Introduction .......................................................................... 103  
5.2 Expression of 'Sexual Addiction' .......................................... 104  
5.3 Function of 'Sexual Addiction' ............................................. 114  
5.4 'Sexual Addiction' and Other Addictions .............................. 118  
5.5 'Sexual Addiction' and Homosexuality ................................. 122  
5.6 Consequences of 'Sexual Addiction' ..................................... 128  
5.7 Turning Points ..................................................................... 131  
5.8 Conclusion .......................................................................... 133
# Chapter 6  Treatment and Recovery from 'Sexual Addiction'

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Introduction</td>
<td>135</td>
</tr>
<tr>
<td>6.2 ‘Sexual Addiction’: A Lack of Clarity</td>
<td>136</td>
</tr>
<tr>
<td>6.3 Beginning Recovery</td>
<td>137</td>
</tr>
<tr>
<td>6.4 Psychotherapy, ‘Sexual Addiction’ and Recovery</td>
<td>139</td>
</tr>
<tr>
<td>6.4.1 Group Psychotherapy</td>
<td>141</td>
</tr>
<tr>
<td>6.4.2 The Psychotherapist</td>
<td>143</td>
</tr>
<tr>
<td>6.5 Critique of Psychotherapy</td>
<td>144</td>
</tr>
<tr>
<td>6.6 Residential Treatment and Recovery</td>
<td>146</td>
</tr>
<tr>
<td>6.6.1 Critique of the Residential Treatment of ‘Sexual Addiction’</td>
<td>148</td>
</tr>
<tr>
<td>6.7 12-Step Sexual Fellowship and Recovery</td>
<td>150</td>
</tr>
<tr>
<td>6.7.1 Critique of the 12-Step Sexual Fellowships</td>
<td>152</td>
</tr>
<tr>
<td>6.8 Medical Support</td>
<td>155</td>
</tr>
<tr>
<td>6.9 Psycho-Educational Support</td>
<td>157</td>
</tr>
<tr>
<td>6.10 Family Support</td>
<td>159</td>
</tr>
<tr>
<td>6.11 Recovery Progress</td>
<td>161</td>
</tr>
<tr>
<td>6.12 Critique of the Concept of ‘Sexual Addiction’</td>
<td>162</td>
</tr>
<tr>
<td>6.12.1 ‘Sexual Addiction’ or Social Construction</td>
<td>163</td>
</tr>
<tr>
<td>6.12.2 ‘Sexual Addiction’ or Moral Construction</td>
<td>164</td>
</tr>
<tr>
<td>6.12.3 ‘Sexual Addiction’ and the Medicalisation of Society</td>
<td>166</td>
</tr>
<tr>
<td>6.12.4 Inconsistencies Regarding Terminology, Criteria and Concept</td>
<td>167</td>
</tr>
<tr>
<td>6.13 Conclusion</td>
<td>169</td>
</tr>
</tbody>
</table>

# Chapter 7  Discussion and Conclusion

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Introduction</td>
<td>171</td>
</tr>
<tr>
<td>7.2 Conflicting Perspectives</td>
<td>171</td>
</tr>
<tr>
<td>7.3 The Origins and Development of Sexual Addiction</td>
<td>176</td>
</tr>
<tr>
<td>7.4 The Lived Experience of Sexual Addiction</td>
<td>179</td>
</tr>
<tr>
<td>7.5 Treatment and Recovery from Sexual Addiction</td>
<td>182</td>
</tr>
<tr>
<td>7.6 Conclusion</td>
<td>184</td>
</tr>
</tbody>
</table>

# Appendix A  Glossary of Terms & Abbreviations

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1 Terminology Describing ‘Sexual Addiction’</td>
<td>189</td>
</tr>
<tr>
<td>A.2 Research Subjects</td>
<td>189</td>
</tr>
</tbody>
</table>

# Appendix B  Information Leaflet for Treatment Providers

# Appendix C  Information Leaflet for Sexual Addicts
List of Figures

2.1 The Addiction System Carnes (1983:26) ........................................ 36
List of Tables

3.1 Data Collection Process ................................................................. 55
3.2 Data Analysis Procedures of Individual Interview Transcripts .......... 65
A.1 Abbreviations used in this research ............................................. 191
D.1 Profile of Research Subjects - Treatment providers (TPs) .......... 197
D.2 Profile of Research Subjects - Treatment Providers (TPs) continued 198
D.3 Profile of Research Subjects - Sexual Addicts (SA) ...................... 199
Chapter 1

Thesis Overview

1.1 Introduction

The aim of this research was to gather detailed information on how two different sets of actors, those who self-identify as sexual addicts and those involved in treating sexual addiction, conceptualise the phenomenon of sexual addiction in an Irish context.

From a theoretical perspective, this research was conducted against the background of two conflicting views of sexual addiction. One such view, a positivistic view, is that the concept of sexual addiction and its associated therapeutic practices reflects objective scientific progress in the understanding and management of problematic or out-of-control sexual behaviour. A more critical sociological view is that the concept of sexual addiction is a social construct, which extends an already spurious addiction model from its base in the area of psychoactive drug use to an area of human behaviour marked by ongoing contention about what is normative and what is deviant; in instrumental terms, such critics are not persuaded that 'treatment' of sexual addiction confers identifiable therapeutic benefits on its client group, and tend to see the creation of sex addiction services as another example of expansion within an already rampant addiction treatment 'industry'.

Out-of-control and excessive sexual appetites have been documented and discussed from the beginning of time. Historically, it was understood in terms of morality while at later periods it was viewed as a medical condition and discussed in terms of a disease (Finlayson, Sealy & Martin 2001). Recently out-of-control sexuality has been described in terms of addiction, thus the development of the popular term 'sexual addiction', a concept which is highly contested (Hook et al. 2010). This concept has been widely popularised in the media particularly by the number of high profile celebrities who are allegedly addicted to sex. This growing pattern of popularity is observed in a recent radio advertisement offering treatment for sexual addiction in a residential addiction centre in Ireland. In such instances the concept was presented in similar terms to substance use which perceives the individual as having lost control over their sexual behaviour but who continues to
engage in the behaviour despite the recurrence of significant negative consequences. While the label of addiction is suggested by some as a classification for out-of-control sexual behaviour, the concept of 'sexual addiction' remains a highly controversial issue. In the literature the two major conflicting views on this concept are generally represented by authors such as Carnes (1983) a prominent advocate of sexual addiction, and Levine & Troiden (1988) among others, who dismiss the concept as a pseudo-scientific construction with no scientific validity.

The data in this thesis contains the experience and attitude of a very specific population, namely the self-identified sexual addict and the treatment provider, on a controversial topic regarding a sensitive aspect of human sexuality. While these data contain interesting insights from the research subjects’ perspective, the data also contain significant limitations particularly in terms of the sample in this study. Many of the self-defined sexual addicts have undergone some type of treatment experience, mainly psychotherapy or a 12-step fellowship, in order to help them manage their addictive sexual behaviour or another addiction. As a result, their opinions are influenced by the treatment philosophy which many of them positively subscribe to. Moreover, the majority of the treatment providers in this study were involved in the provision and promotion of therapeutic support which is heavily influenced by the treatment ideology. As a result their opinions and experiences generally contain a bias towards the treatment philosophy.

Furthermore, the data collection in this study is based on self-report questionnaires and interviews which document the research subjects’ recollection of experiences and attitudes. Reliability associated with self-report techniques is limited in all research and particularly in terms of addiction research (Del Boca & Noll 2000). The process of explaining human problems, in this instance sexual addiction, with reference to past experiences, a process referred to by some as ‘effort after meaning’ (Garro 2007), is a common human occurrence. Individuals often engage in this process in order to understand and explain past events retrospectively, but explanations are not necessarily accurate. This study is further limited by the fact that no control group has been used in this study. Therefore, it is not possible to make comparisons with the experiences of those who participated. The value of a control group is particularly observed in instances where sexual addicts in this study claim that certain historical factors, such as childhood trauma or abuse, led to the development of sexual addiction. Despite the sincerity of the research subjects’ claim, it is not possible to argue that such problems invariably lead to the development of sexual addiction in later life as not all individuals who have ever encountered such experiences develop a sexual addiction. Therefore, in this instance, it remains difficult to accurately identify risk factors for the development of sexual addiction. As a result of such limitations these data must be interpreted within the specific context in which they have emerged and must be cautiously used in terms of other populations.

Moreover, the distinction between normal and abnormal sexuality emerged as an issue, explicitly and implicitly in this study. The concept of sexual addictive behaviour is often considered an expression of abnormal behaviour which can be resolved with the assistance of some type of
1.2 The Concept of Addiction

Historically, the concept of addiction to psychoactive drugs particularly to alcohol can be traced back to the religious writings of the seventeenth century (Porter 1985). The notion of addiction as a disease is initially associated with pioneers like Benjamin Rush (1746-1813). By the 1950s the disease concept of alcoholism 'was presented unambiguously to the world as a discrete disease which could be medically diagnosed' and treated (Butler 2002, p21). The increased acceptability of alcoholism as a disease provided the opportunity for the creation of an entire infrastructure of 'treatment' to assist those affected by this 'disease'. The contemporary concept of addiction is commonly understood in terms of substance use, usually alcohol or illicit drugs which in medical terms is viewed as a disease, characterised by increased use, loss of control and continuation of the addiction despite the negative consequences.

The concept of addiction does not enjoy unanimous agreement and has been continuously refuted. 'Despite this long history of conceptual acrobatics' the presence of the disease of addiction...
has not been discovered and the concept remains highly controversial (Reinarman 2005, p312). The concept of addiction as a disease is generally viewed by social scientists as a social construct which emerged during the temperance movements in America in the nineteenth century and which has been influenced by significant historical and cultural events within a specific socio-political context since then (Room 2003)). Further controversy has arisen with the proposal that the traditional understanding of addiction, which is confined to substance use, is overly restrictive and that the time has come to widen the definition to include other, out-of-control or excessive behaviours, commonly referred to as a behavioural addiction (Juhnke & Hagedorn 2006). Behavioural addictions usually include out-of-control or excessive gambling, eating, Internet use and sexual activity. It is within this suggested reconstruction of addiction that out-of-control sexual behaviour is being considered as a new category namely ‘sexual addiction’.

1.2.1 The Concept of ‘Sexual Addiction’

The concept of ‘out-of-control’ sexual behaviour has been popularly referred to as ‘sexual addiction’ since the 1970s. The concept rapidly grew within the historical period of the 1980s and its growth is attributed to a combination of social, religious, cultural and clinical factors (Hall 2011). Orford (1978) suggested that out-of-control sexuality exhibits similar patterns to substance addiction in terms of an attachment to an activity that produces pleasure but of which the individual loses control and results in negative consequences. While Orford (1978) was one of the first to propose the inclusion of out-of-control sexuality in terms of ‘addiction’, popular recognition of the term ‘sexual addiction’ is more commonly associated with Carnes’s descriptive publication on the concept (Carnes 1983). His proposal ignited a debate about the validity of whether or not out-of-control sexuality should be viewed as an ‘addiction’. As the debate continues, the popular growth of this concept is often attributed to a combination of socio-cultural dynamics coalescing since the 1960s (Levine & Troiden 1988).

The 1960s was characterised by the sexual revolution marking a radical shift regarding sexual attitudes and behaviours. However, between the 1960s and the 1980s there was a marked increase in sex-related diseases culminating in the AIDS epidemic in the 1980s. This resulted in a sex-negative period where excessive and out-of-control sexual behaviour became associated with disease and death (Malhotra 2008). Some have argued that this created a climate where the concept of sexual addiction became an acceptable explanation for the sexual upheaval of that period, resulting in the view that out-of-control sexual behaviour will benefit from the diagnostic label of sexual addiction and associated treatment (Reay, Attwood & Gooder 2013). The development of the concept was further helped by the process whereby society became increasingly medicalised (Tiefer 2007). As a result of this process the concept of sexual addiction was gradually introduced and became more acceptable as a treatable condition particularly visible with the development of specific treatment programmes for sexual addiction within the expanding addiction industry.
Furthermore, the concept of sexual addiction was also facilitated by the growth of a number of right wing religious movements and the emergence of a new political conservatism during the 1980s which filled the vacuum created by the decline in religious institutions (Irvine 1995). These movements expressed a desire to protect society from a liberal sexual agenda and accepted the concept of sexual addiction as a framework to understand and treat such out-of-control sexual behaviour. Another significant factor contributing to the popular growth of this concept was the influence of the media particularly observed by the number of celebrities who explain their sexual behaviour in terms of sexual addiction. This combination of factors facilitated the development and acceptability of the concept of sexual addiction. Despite the growing popularity of this concept it remains a contentious issue among social scientists and philosophers who argue that the concept has been socially constructed and lacks sufficient evidence to validate it as a scientific condition (Levine & Troiden 1988).

1.2.2 Sexuality in Irish Society

This study investigated the concept of sexual addiction within an Irish context and therefore it is beneficial to examine the social-cultural background in which the sexual addict has been socialised. Sexuality in Ireland is predominantly understood in terms of the Judeo-Christian tradition, and attitudes to sexuality can be viewed in terms of a few major historical influences namely the theology of St Augustine and the influence of early Irish monasticism. The Judeo-Christian belief on sexuality is that sexuality is essentially for the purpose of procreation and consequently all other expressions of sexuality are perceived as sinful (DeLamater 1981). The culmination of these religious influences has created a prolonged negative repression of Irish sexuality by the ‘pervasive power of the Church’ (Salazar 2008). While the Church’s monopoly of control may have ended, a residue of Church moral influence continues to linger. This complex mixture of Christian morality, sexual suppression, and negativity towards sexuality forms the social context which significantly influences the attitudes, behaviours, and sexual mores of the research subject. It is against this socio-religious background that the concept of sexual addiction was investigated.

1.3 Study Aims and Objectives

The aim of this research is to gather detailed information on how two different sets of actors (those who self-identify as sexual addicts and those involved in treating sexual addiction) conceptualise the phenomenon of sexual addiction. The specific objectives are to investigate: 1) how they understand the aetiology of sexual addiction; 2) what they perceive the main symptoms and lifestyle elements of this alleged condition to be; 3) how they view recovery and the role played by formal treatment or rehabilitation systems in the recovery process. The three objectives of the study provide a thematic framework for this thesis. Corresponding with the objectives above, the data
are organised into three findings chapters namely the origins and development of sexual addiction, secondly, the lived experience of sexual addiction, and thirdly, the treatment of and recovery from sexual addiction. The first findings chapter explores the origins and development of sexual addiction. It begins with an examination of sexual addicts and their core beliefs. The pre-disposing influences on sexual addiction are discussed and the development and characteristics of sexual addiction are explored. In the second findings chapter, the lived experience of sexual addiction is examined and it focuses on the expression, function and consequences of sexual addiction. Sexual addiction is examined with reference to other addictions and to homosexuality before significant turning points are discussed. In the third findings chapter, attention is focused on treatment and recovery from sexual addiction. It investigates the therapeutic supports used to manage sexual addiction and a range of interventions are identified and critiqued. The findings chapters describe the concept of sexual addiction in terms of a progressive pathway. Each chapter focuses on a specific dimension of sexual addiction which cumulatively represents a broad overview of the concept of sexual addiction from the research subjects’ perspective. The findings chapters are intentionally presented as representing a common trajectory, which according to the research subjects, is frequently experienced by the sexual addict.

Since Carnes’s (1983) publication ‘Out of the Shadows: Understanding Sexual Addiction’ a debate about whether or not out-of-control sexuality should be viewed as an addiction has continued. Consequently a range of terms have been proposed to describe out-of-control or excessive sexual behaviour. Coleman (1992) describes it as Compulsive Sexual Behaviour (CSB) and Finlayson, Sealy & Martin (2001) presents it as Problematic Hypersexuality. Kafka (2010) uses the term Hypersexual Disorder and Carnes (1983) describes it as sexual addiction. The terms ‘sexual addiction’ or ‘compulsive sexual behaviour’ (Carnes 1983, Coleman 1986) (Coleman 1986) are frequently used simultaneously and the choice of term used often indicates the individual’s philosophical beliefs or professional background. The issue of description and classification do not enjoy consensus.

For the purposes of this thesis the term ‘sexual addiction’ and ‘sexual addict’ is generally used. The terminology is used in the full knowledge of its controversial and contested status, but is it used because it is the terminology used by many who define their personal problems in this way, and by many who purport to ‘treat’ these problems. Furthermore, ‘sexual addiction’ and ‘sexual addict’ are the most frequently used terminology in the literature. It is understood that such terminology can be viewed as pejorative, but no such meaning is ascribed to it in this research. The use of the terms ‘sexual addiction’ or ‘sexual addicts’ does not indicate that the researcher subscribes in a positivistic way to the idea that this is a value-free, scientifically valid and reliable classification of particular types of human sexual behaviour.

References to the term ‘sexual addiction’ and ‘sexual addict’ as they appear in the title page, the abstract, the summary, the table of contents, the chapter headings and sub-headings throughout the thesis will be placed in inverted commas to demonstrate that there are complex issues associated
1.3. STUDY AIMS AND OBJECTIVES

with the use of these terms. In all other instances throughout the body of the thesis where the term 'sexual addict' or 'sexual addiction' appears it is implied that the use of these terms are contentious and do not enjoy consensus or scientific validity and the reader is invited to view them in such a manner.

Similar difficulties exist in relation to the creation of nosological systems for psychoactive drug problems. Social scientists see this is as an essentially contested arena. Room (2011) commenting on the debates and controversies about how DSM deals with substance use disorders describes it as 'a conceptual and terminological muddle'. The prospect of achieving a scientific consensus in the clinical area, free of cultural bias or value judgement, seems unattainable.

This study, like all others, was vulnerable to researcher bias where the researcher would consciously or unconsciously influence the study in such a way as to control the outcome. This kind of qualitative study has been often referred to as 'an assembly of anecdotal and personal impressions strongly subject to researcher bias' (Mays & Pope 1995, p.110). In order to lessen the possibility of personal bias it was necessary to create a framework to minimise it from happening. In the first instance I have and maintained a high degree of awareness of my cultural, social and educational background and how any of these factors could influence my study. As an Irish male originating from a traditional Irish family of origin who was ordained a Roman Catholic priest I approach this study as an independent scientific researcher.

I also bring a potential bias to this study as a trained teacher and psychotherapist. However, my training in these areas has socialised me into a clinical culture of being accepting of and non-judgemental towards people who seek help, so that in approaching the topic of sexual addiction from the perspective of an academic researcher I am already familiar with doing so from a non-moralistic stance.

In order to lessen any personal bias I undertook a detailed literature review on the topic of human sexuality. This reminded me explicitly of the cultural relativism associated with the aspect of human behaviour. This process reaffirmed that there are widely diverging views on what is normative and these views vary from place to place and time to time, with no absolute consensus on what constitutes 'normal' or culturally acceptable sexual behaviour. In general, it is obvious to me that from the study's inception that it would be virtually impossible to conduct such a study were I to embark on it in a judgemental frame of mind. It became clear as the work progressed that Roman Catholic teaching on human sexuality was accepting of two of DeLamater’s ‘scripts’ (1981) - the procreational and the relational while generally remaining rejecting of the recreational script.

Additionally I analyse and present in a transparent manner, the broad issues that underpin the study namely addiction and sexuality. I also present the historical context in which the concept of sexual addiction has emerged. The cultural and social context in Ireland in which the concept of sexual addiction is being researched, is presented and discussed.
CHAPTER 1. THESIS OVERVIEW

The methodological approach used in this study is another instrument which is purposefully used to lessen personal bias. The interpretative phenomenological approach (IPA) concedes that all collected data is contaminated and that the collected data will always be tainted by the researcher's own perceptions (Smith 2004). Given that information, every effort is made, since the outset of the project, to lessen personal bias and to increase objectivity by meticulously following the IPA procedures which is fully described in chapter three. Personal bias is further limited by creating an ethical framework for the study which was independently reviewed by the ethics committee within College. Attention to personal bias is further addressed in the process of data analysis when an additional method of analysis namely thematic analysis (TA) is used in order to strengthen reliability.

Throughout the research process I presented my work at conferences and submitted it for publication which opened the research to peer-review and which drew attention to any hidden bias; see Appendix S. Academic supervision helped facilitate an in-depth critique of the entire process which resulted in rigorous and reflective research.

1.4 Structure of the Thesis

Chapter one presents an overview of the research context drawing attention to the historical concept of excessive sexuality and briefly examining how it has developed. The contemporary concept of sexual addiction is introduced and discussed in terms of traditional addiction. The study is further contextualised by an examination of sexuality in Ireland and the aims and objectives are outlined.

Chapter two is an examination of the literature which provides an insight into the wider discourse regarding addiction, documenting its development and noting the recent emergence of the concept of behavioural addictions. The historical understanding of out-of-control sexuality is explored and the contemporary concept of sexual addiction is discussed in depth. Attention is paid to the proposed characteristics, development, behavioural expression and consequences associated with this phenomenon.

Chapter three outlines the methodology by which the research project was undertaken. The theoretical context and the methodology used are explained. The predominantly qualitative phenomenological perspective is outlined. The procedures for data collection are explained, giving consideration to the sample selection, recruitment, ethical framework and related challenges when dealing with the sensitive issue of sexuality. The choice of Interpretive Phenomenological Analysis and Thematic Analysis is explained and data analysis procedures are outlined.

Chapter four is the first of the three chapters containing the findings this study. This chapter investigates the origins and development of sexual addiction. It begins by presenting a generic profile of sexual addicts and their core beliefs. The alleged pre-disposing influences of sexual addiction are discussed and suggestions are made regarding the identification of sexual addiction.
1.5 CONCLUSION

An overview of how sexual addiction develops is presented and the final section of this chapter identifies and examines the main characteristics associated with sexual addiction.

Chapter five, the second findings chapter, outlines the major expressions and associated patterns of sexual addiction. The function of sexual addiction was investigated and the data reveal that sexual addiction is used for a variety of psychological and emotional reasons which are discussed. The lived experience of sexual addiction is further complicated by the fact that dual addiction is identified as a significant issue among many of the sexual addicts. The complex inter-relationship between sexual addiction and other addictions is examined. Additionally, the relationship between sexual addiction and homosexuality emerges as a considerable issue and the interplay between these two concepts is investigated. The consequences of sexual addiction are presented and discussed before outlining the major turning points that become catalysts for behavioural change which usually initiates a process of recovery from sexual addiction.

Chapter six, the third findings chapter, examines the treatment and recovery of sexual addiction which emerged as a unique dimension of the sexual addict’s experience. The process of seeking help for sexual addiction is examined. A number of specific therapeutic supports are identified and critiqued such as psychotherapy, 12-step fellowships and medical help among others. This chapter also presents a critique of the concept of sexual addiction and examines the alternative perspectives which might explain out-of-control sexual behaviour.

Chapter seven concludes this thesis with a discussion of the main themes in light of the current literature. The chapter concludes by setting out some recommendations and identifies areas of future research.

1.5 Conclusion

Out-of-control or excessive sexuality is a human phenomenon that has been experienced, discussed and categorised in a variety of different ways throughout history. Traditionally it has been described in terms of morality, psychiatry and deviance among others. In recent times, as the concept of addiction is expanding, it has been suggested that such behaviour may be best understood as a behavioural addiction. The concept of sexual addiction is increasingly presented as a clinical entity and has gained acceptance among some. Nonetheless it remains an issue of contention among many who view it as a social construct reflecting a variety of social, moral and cultural influences. This thesis aims to gain an understanding of sexual addiction within an Irish context where no previous research of this kind has been completed. In order to gain a comprehensive understanding of this complex concept, an initial literature review is undertaken which provides an overview of the existent material upon which the next chapter has its foundation.
Chapter 2

Literature Review

2.1 Overview of Literature Review

Human sexuality has been viewed from a multiplicity of perspectives throughout history. This review focuses specifically on issues pertaining to the contested phenomenon of sexual addiction, an alleged expression of behavioural addiction which describes the experience of out-of-control sexual behaviour. In the literature the two major conflicting views on this concept are generally represented by authors such as Carnes (1983, 1991, 1994) an advocate of sexual addiction, and Levine & Troiden (1988) among others, who dismiss the concept as a pseudo-scientific construction with no scientific validity. This concept of sexual addiction is reviewed within the context of the broader areas of this study, namely sexuality and addiction. The literature review is presented in three main sections: sexuality, addiction and sexual addiction.

Section one of this chapter begins with an examination of the concept of human sexuality and reviews the prominent perspectives associated with it. The historic understanding of sexuality is investigated by focusing on sexuality in ancient culture and among non-Western religions. Consideration is given to the contrasting dynamics of how sexuality is associated with pleasure and spiritual fulfilment in antiquity as opposed to procreation and repression within the Western cultures. The development of sexuality is further investigated with specific reference to the role and impact of religion especially Christianity. Attention is focused on how sexuality is understood in modern times, especially over the last two centuries during which significant developments have occurred which have impacted sexuality. Influential factors, such as Victorianism and the development of science and psychology, associated with sexuality are examined. The contemporary understanding of sexuality is reviewed in terms of the political and cultural shifts occurring mostly from the 1950s onwards. Due to the fact that this research is conducted within an Irish context, the development of sexuality in Ireland is addressed. This section of the review concludes by considering sexuality in terms of a social construct which suggests that sexuality is continually shaped
by the ever changing socio-cultural factors to which it may be exposed.

In section two of the literature review the concept of addiction is reviewed on the basis that the phenomenon of sexual addiction is presented as a behavioural expression of addiction. An examination of the historical origins of addiction is undertaken before investigating the development of the concept in terms of influential factors such as the American temperance movements and prohibition in the United States of America (USA). The post-prohibition concept of alcoholism is then examined and considered in relation to events such as the founding of Alcoholics Anonymous (AA), the establishment of the Yale Centre of Alcohol Studies and the inclusion and exclusion of the term alcoholism in the Diagnostic and Statistical Manual. The contemporary understanding of addiction and behavioural addiction is discussed before concluding with a critique of the concept.

The third and final section of the literature review examines the concept of sexual addiction. At the outset the historical understanding of excessive sexuality is explored. Before examining the contemporary notion of sexual addiction, the socio-historic context from which the concept has arisen is discussed. The theoretical framework of sexual addiction is outlined paying attention to characteristics, pre-disposing factors, development and behavioural expressions. The therapeutic support, related challenges and consequences are explored. Alternative explanations for dysregulated sexuality are also considered. Finally, the concept is critiqued from a number of perspectives discussing in particular the impact of social construction, medicalisation, and moral and social conservatism on this concept.

2.2 Sexuality

The concept of human sexuality has always been a topic of interest albeit a complex one. Throughout history sexuality has been lived in a variety of different ways and understood from different perspectives such as anthropology, medicine and social science among others. Gagnon (1990) argues that every society develops a set of norms to govern sexuality. These norms are currently referred to as 'sexual scripts' and they indicate the type of sexual behaviour that is acceptable or unacceptable during a particular period of time. DeLamater (1981) states that three distinct sexual scripts have emerged in Western society, namely, the procreational, the relational, and the recreational. The procreation script emphasises the reproductive aspect of sexuality while the relational is person-focused and the recreational highlights the aspect of physical pleasure. The sexual scripts change over time and the dominant sexual script usually influences how sexuality is understood in that society. The shifting of sexual scripts became obvious during the liberated period of the 1960s. During that period the recreational script replaced the procreational and relational scripts. This shifting of the sexual scripts was observed among the psychosexual categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM) which removed masturbation and homosexuality as psychosexual disorders (Levine & Troiden 1988). Another major shift in sexual
scripts was observed as a result of the fear associated with the AIDS epidemic in the 1980s; the recreational script was abandoned and the relational script was reinstated. Given that the dominant sexual script determines what is sexually acceptable and what is considered 'out of control' sexuality, Levine & Troiden (1988) argue that the concept of sexual addiction is a social construct driven by the prevailing sex-negative script during the 1980s. They reject the claim that it is an independent scientific entity.

This section begins with an examination of sexuality in ancient cultures such as Rome and Greece and among some non-Western religions. Sexuality is then considered in terms of major world religions focusing on Christianity and the Roman Catholic perspective in particular. Further developmental landmarks from the Middle Ages to the Victorian era, including the medical perspective, are discussed. The prominent changes regarding sexuality in the twentieth century are analysed with particular reference to the sexual revolution of the 1960s and the counter-revolution of the 1980s. This section concludes with an examination of the major issues regarding sexuality in Ireland.

Sexuality as we now understand it, in the modern world, has resulted from the influence of many significant issues over a long period of time. A review of the historical development of sexuality is particularly significant in terms of this research which investigates the concept of sexual addiction, the term used for the contested concept of out-of-control sexual behaviour, popularised in the 1980s. This concept begs the question about what constitutes 'normal' and 'abnormal' sexuality and asks how normal sexuality is determined and who determines it. A historical review of sexuality and its influences will help to clarify what determines individual sexual preferences as opposed to pathological sexuality.

2.2.1 Sexuality in Ancient Cultures

Sexuality has been lived and understood by different societies in a variety of ways over different periods of history. In some ancient cultures sexuality was generally viewed as something that was pleasurable and healthy. In particular, the attitudes and behaviours among Greek, Oriental, and Hindu communities were often positive. Sex was often viewed as a source of enjoyment and even presented as a path to spiritual fulfilment (Bullough 1980). In ancient Greece marriage was popular and while monogamy was expected, Greek males enjoyed sexual freedom outside of marriage (King 2002). Despite the popular idea that the Greeks lived in a world of leisurely uninhibited sexuality, there were ethical obligations associated with sexuality which were based on the individual's ability to demonstrate self-control and acquire mastery. Control was undertaken through understanding and reason rather than externally imposed, as was frequently the case in later periods (Hawkes 2004). Ancient Greeks recognised that sexuality could bring healing, predisposing the soul to tranquillity, and it could also create negativity (Foucault 1988). The Greek ideal was to enjoy and manage pleasure and thus achieve balance, self-control, freedom, health and
inner harmony. The combination of pleasure and self-management, not without challenge, in classical Greek life (Hawkes 2004) is beneficial particularly in terms of a modern society which sometimes considers sexuality as an addiction. The Greek achievement of celebrating sexuality within a context of personal harmony and social order is noteworthy.

Similar attitudes of positivity are associated with sexuality in ancient China, where some of the oldest sex manuals in the world containing erotic literature originated. Sexuality was understood in terms of the yin-yang philosophy which resulted in the complementary togetherness of male and female being valued while also valuing homosexuality (Wu 2003). This positive attitude was also found in Taoism but in later centuries especially during the late Middle Ages, the open attitudes of previous eras were replaced by a repression of sexuality influenced by the morality of neo-Confucianism (Ruan & Matsumura 1991). The negative suppression of sexuality continued and became strictly enforced by the Communist governments from the 1950s onwards. In contemporary China, a high degree of suppression exists and is politicised in terms of population control. Sexual education is tolerated to deal with the management of sexual disease and the reduction of teenage pregnancy (Liu, Wu & Chou 1997).

Sexuality in ancient India was viewed in highly positive terms reflected in literature such as the Kama Sutra, an ancient script which emphasised the value of sexual pleasure and harmonious relationships. Love making was a behaviour that was to be learned and practised (Devi 2008). Within the Indian culture sexuality was sometimes associated with spirituality where sex was considered a sacred duty (White 2001). Over time the concept of sexuality changed and the positive attitudes associated with sexuality in ancient times were reduced. This was often due to factors such as colonisation and the influence of Western values which were frequently associated with religions and especially Christianity. From the outset the Christian tradition has strongly emphasised the procreative aspect of sexuality and this viewpoint has significantly influenced the cultural understanding of sexuality. There has been some acceptance of the relational aspect of sexuality among some Christian traditions and a strong rejection of its recreational dimension.

2.2.2 World Religions and Sexuality

Religion has played a very significant role in the development of sexuality. Underpinning all the major religions are ethical beliefs which form the basis for their perception of sexuality. These beliefs range from seeing sexuality positively, in terms of a spiritual dimension of life, or seeing it as something which detracts from the spiritual and therefore is viewed as dangerous and evil. Before examining the relationship between sexuality and Christianity, a brief review of how sexuality is perceived in the other major world religions is undertaken.

Islam in ancient times enjoyed a positive attitude towards sexuality from its founder the Prophet Muhammad. Marriage has been associated with power, politics and sensual pleasure. Islamic views on sexuality have changed over time and currently there is an emergence of Islamic fundamentalism
which is repressive of sexuality (Hyde & DeLamater 2010). In Hinduism a variety of approaches to sexuality are found, ranging from advocacy of complete indulgence in sexual pleasures to those who advocate ascetic avoidance for the purpose of acquiring peace and spirituality (Parrinder 1996). Buddhism is primarily associated with a balanced spirituality popularly referred to as ‘the middle path’ which seeks to avoid the extremes of sexual hedonism and sexual repression (Hyde & DeLamater 2010). Celibacy among the Buddhist monks is a spiritual choice whereas sexuality is also viewed as a means of developing union with the Divine often referred to as sexual mysticism (Parrinder 1996). In Judaism sexuality is generally viewed in positive terms, as depicted in the Hebrew Scriptures, particularly in the Book of Genesis where it is said that God created man and woman and sees them both as good. The sexual purpose of man and woman was to be fruitful and multiply thus affirming the procreative role of sexuality. A further Judaic affirmation of human sexuality is observed in the book of Genesis where it refers to Adam and Eve who were naked but felt no shame (Hyde & DeLamater 2010).

Christianity and Sexuality

Christianity has always had a strong influence on how sexuality is presented and perceived. Francoeur (1992) argues that a negative philosophy against sexuality developed shortly after Jesus died. This was associated with the dualistic philosophies of Plato which viewed the soul as being superior to the body. This dualism led to the development of sexual asceticism and is connected to the anti-sex religious philosophies observed in Stoicism, Gnosticism and Manichaeism (Bullough & Bullough 1995). A later but equally strong influence on sexuality is the theology of St. Augustine (354-430). Augustine’s negative views on sexuality have created an indelible association between sexuality and sin (Ranke-Heinemann 1990). This sinful view was later compounded by the theology of St. Thomas Aquinas (1225-1274) who in his best known work, ‘Summa Theologica’, stated that sex is limited to marriage and intended for procreation and all other forms of sex outside of marriage were condemned as being unnatural. Another significant turning point regarding sexuality and Christianity emerged from the Protestant Reformation in 1517. Luther and Calvin both criticised the imposition of celibacy. The reformers approved divorce and remarriage and finally priestly marriage was sanctioned (Masters, Johnson & Kolodny 1995). Despite more positive attitudes towards sexuality notable groups such as the Puritans and Jansenists, associated with the repression of sexuality, emerged in the early 1600s. Inglis (1998, p.248) states that ‘there is little doubt that a Roman Catholic brand of Jansenist practices was imported under the umbrella of rigorism’ into Ireland. The negative influence of Jansenism is believed to have survived longer in Ireland where repression of sexuality is perceived to be high in comparison with other parts of the world (Gregersen 1983).

In the modern world, the official teaching and attitude of the Christian church leaders regarding sexuality have not changed significantly. These teachings are acceptable to some but are frequently
CHAPTER 2. LITERATURE REVIEW

criticised and rejected by others. The main issues that provoke controversy are abortion, homosexuality, contraception and reproductive technology. Members of the Roman Catholic Church who had sought a more liberal attitude towards sexuality had hoped that the Vatican II council, which had created an expectation of change, would provide increased latitude. The expectation of change from the Vatican Council was quickly dashed when the Vatican encyclical, Humanae Vitae (Pope Paul VI 1968), condemned the use of artificial contraception, a ban that has been generally ignored. Renehan (2006) argues that the teaching on sexuality remained strictly conservative under Pope John Paul II. In 1986 the Church reaffirmed its teaching on homosexuality and described it as 'an objective disorder' which leads towards 'an intrinsic moral evil' (Sacred Congregation for the Doctrine of the Faith 1986). During Pope Benedict’s XVI leadership, sexual controversy continued and attention focused on the use of condoms to prevent the spread of AIDS and also on clerical child sexual abuse. As a result of the Church’s attitude, Christianity is often held responsible for creating psychological damage as a result of its negative teaching on sexuality (Bullough 1987). The discussion of sexual issues such as women priests, married clergy and homosexuality led to Vatican disapproval of its own clergy, notably the Vatican’s current disapproval of six Irish priests because of their opinions on similar matters concerning sexuality. The current pontiff, Pope Francis, suggests that the Church is overly obsessed with issues such as abortion, gay marriage and contraception and that there is a need to find a new balance. Despite all the secular changes the Roman Catholic Church continues to emphasise strongly that the primary purpose of sexuality is for procreation. The relational aspect of sexuality is acknowledged but is given less attention and the recreational dimension of sexuality is generally understood to be sinful.

2.2.3 Cultural Perspectives on Sexuality: Middle Ages to the Sexual Counter-Revolution

In addition to the religious influences sexuality has been strongly shaped by a variety of social and political factors. During the Middle Ages sexuality was moulded by the European Christian Crusaders who were influenced by a range of Arab practices such as the custom of Arabic bath houses which led to the development of brothels (Hill 2007). During the Renaissance period, (14th-17th century), the importance of marriage and the family were emphasised for the success of society (Ruggiero 1993). In spite of the ideals aspired to by Renaissance philosophers, premarital sex, prostitution, adultery and homosexuality are recorded as being problematic social concerns. The Protestant Reformation of the sixteenth century, as discussed previously, was a significant turning point regarding sexuality. This facilitated an alternative worldview to the sole domination of the Church perspective. The eighteenth century was one of the first periods since antiquity where the possibility of viewing sexuality as enjoyable re-emerged (Hawkes 2004). Sexuality during this period was not necessarily linked to commitments, emotion or social order. Prostitution and erotic literature were available and pornography emerged in England, as opposed to importing material
from Europe (Hawkes 2004). During nineteenth century Victorian England, a major moral shift towards sexual repression took place. Women were represented as being virtuous and devoid of sexuality (White 1993). In contrast to the Victorian ideals, the syphilis epidemic of this time gave the medical fraternity, moral and medical, authority to assume control of sexuality which provided the opportunity to begin the study of sexuality (Hawkes 2004). In contrast to popular opinion, Foucault (1990, p.11) argues against the ‘repressive hypothesis’ associated with the Victorian era and believes that the last three centuries have distinguished themselves in creating ways to speak extensively about sexuality. During the post-Victorian era the study of sexuality began. The task of sexual reform was greatly advanced during the sexological period from the middle 1800s until the 1980s by many sexologists such as Freud, Ellis, Hirschfeld, Kinsey, Reich, Masters and Johnson and others (Robinson 1976). The puritanical values of the Victorian era were replaced by the presentation of sexuality as pleasurable, healthy and integral to human satisfaction (White 1993).

The 1960s was an era of great sexual change, ‘upending America’s traditional values’, and reflected in the rise of movements such as women’s liberation and gay and lesbian groups (Nieli 2011, p.74). The liberation movements became associated with the politicisation of sexuality as they sought social recognition and reform (Hyde & DeLamater 2010). Bayer (1987) states that the political influence of the liberation movement became more obvious after the APA agreed to remove homosexuality as a diagnostic category in 1973 from the DSM-II. This resulted from a majority vote by committee members of the American Psychiatric Association (APA), an incident which is frequently used as evidence to highlight the lack of scientific validity in the entire DSM classification system (Kutchins & Kirk 1997), among others. The liberal ethos of the 1960s permitted the development of the recreational sexual script which emphasised sensual pleasure as the primary purpose of sexuality as opposed to the procreative script which had been generally perceived as the sole purpose of sexuality (Levine & Troiden 1988). Another significant landmark associated with this period was the research undertaken by Masters and Johnson on sexuality during the 1960s. Sexuality was presented as a positive and significant dimension of the individual’s identity in a world where men and women were equal (Taylor 2007). On the other hand, dissatisfaction with sexual liberalisation, among some, expressed itself in strong opposition, initiated by religious groups who rejected homosexuality and particularly abortion (Marty 1997). Opposition increased and resulted in a highly political counter-revolution. The radical change of sexual behaviour during the 1960s was always challenging especially for those who were content with the traditional sexual values of previous decades. It became even more difficult for them as sexual disease and teenage pregnancies continued to climb rapidly. The AIDS epidemic heightened the debate between the social conservatives and liberals which resulted in the counter-revolution of the 1980s marked by a period of sex-negativity. It is argued that the sexual counter-revolution was a well structured ideological campaign which was socially divisive and politically influential (Cohen 2012). It is within this political and social context that the contemporary concept of sexual addiction emerged.
This concept is viewed particularly by social scientists as an expression of the sex negative culture of the 1980s demonstrated by the sexual counter-revolution (Reay, Attwood & Gooder 2013).

2.2.4 Sexuality in Ireland: The Socio-Religious Context

Sexuality in Ireland has been formed by the major influences previously discussed, especially Christianity. The sex repressive theology of St Augustine (354 -430) was reflected in the religious writing of the Irish monks during the sixth century. This was particularly noticeable in the monks’ compilation of a moral code for sexuality which became known as the Irish penitentials (Payer 1984). The monastic perception of sexuality was generally negative and extensive periods of sexual abstinence were demanded (Brundage 2009). The Roman Catholic Church in Ireland grew in dominance and became a very significant institution with influence in every aspect of Irish life. The rise of the Church is linked to the failed attempts by the British government to colonise Ireland which led to the gradual acceptance of the Church’s legitimacy (Corish 1981). Its growth is also associated with the political campaign led by Daniel O’Connell for civil and religious rights which became linked to the moral practice of the church. Additional factors associated with the growth of the Church were the loss of the national language and national identity (Larkin 1972), the fear of being Anglicised and the loss of the Celtic practices which were replaced by the rituals of the church (Miller 1975). Furthermore, the Roman Catholic Church became part of the greater European civilising process and introduced a new class structure and a respectable society which facilitated the acceptability of the Church’s moral discipline (Goudsblom 2003).

Moral control was further established by the organisational power, hierarchical structure and bureaucratic system associated with the Church. This was added to by the economic resources available to the church which were directed at the establishment of educational, health and social welfare systems. This resulted in the Roman Catholic Church becoming responsible for the moralisation and discipline of Irish society (Inglis 1998). The Church’s influence also grew in terms of politics, economics, and social life. The dominance of the ‘simple faith’ meant that ‘many Irish Catholics did not develop an intellectual interest in, or critical attitude towards, their religion’ (Inglis 1998, p.2). The lack of challenge facilitated the uncritical development of the institution including its negative attitude towards sexuality which has remained constant through the centuries and has been reinforced by the suspected arrival of Jansenist-led doctrines in the seventeenth and eighteenth centuries. As mentioned previously a religious rigour developed and resulted in the denial of emotional expression, the ridicule of affection, a segregation of the sexes and a society where cold awkward marital relationships were common. In Irish society ‘there was little or no possibility of any open, honest communication about sex’ (Inglis 1998, p.249).

The impact of the Church’s teaching on sexuality was captured in an ethnographic study by anthropologist John Messenger from 1958 to 1966 in a rural area of Ireland called Inis Beag. The study described the extensive level of moral control issued by the Church. Messenger (1971)
explained how sexual expression was discouraged from childhood. The display of affection after infancy ended and nudity was detested. The study highlighted how sexual morality was outwardly observed due to the techniques of social control which are exercised by the Church and which are based on an overwhelming fear of damnation (Messenger 1971). In recent history, the Church’s influence was observed in the ‘formal and informal enforcement of Catholic social teaching particularly in the area of sexuality’. During the establishment of the Free State this was especially noticeable after De Valera assumed power in 1927 (Howes 2002, p.924). The Constitution of the Irish State created in 1937, is a document which reflects the close alliance between the Church and the State. It acknowledges the Roman Catholic Church as having a ‘special position’ in the Irish State and endorses Roman Catholic values such as prohibiting divorce and contraception reflecting the influence of the Roman Catholic Church in political affairs (Kissane 2007). Smyth (1998), citing O’Brien, says that while Church power and influence may have declined, a culture of deference to religious authority continues to stifle public and political discussions about sexuality. The culmination of centuries of sexually repressive theologies supported by an infrastructure of political and social control has created a distinctively prolonged negative repression of Irish sexuality facilitated by the ‘all pervasive power of the Church’ (Salazar 2008, p.137). Inglis (1998) argues that this resulted in the creation of shame which silenced people regarding sexuality, a silence which is now broken.

The decline of the Roman Catholic Church in Ireland is associated with a number of factors such as secularisation, decrease in vocations and the loss of control in areas like education, health and social provision. Additionally, the disintegration of the deferential Church-political relationship, epitomised by leaders like Dé Valéra, is indicative of an institution that no longer enjoys the political and social privilege of times past. The ongoing sexual scandals are undermining the last vestige of moral control associated with the once powerful Roman Catholic Church in Ireland (Canavan 2012). The new Roman Catholic Church contains members who identify themselves as Christian, are questioning of their faith and the Church’s teaching, and have a liberal sexual agenda (Ryan 1983).

Ireland has transformed itself from being a traditional society on the edge of Europe to becoming a modern European nation within a secularised Western society, a transition which has not been easy (Inglis 2005). The impact of becoming a modern secular society is often reflected in the nation’s sexual behaviour. The Irish Study of Sexual Health and Relationships (ISSHR) (Layte et al. 2006) report, documents the change in sexual attitudes and behaviours over the past thirty years. A majority of individuals consider sex before marriage, homosexuality and casual sex as acceptable which contrasts sharply with the socio-religious beliefs of a traditional Roman Catholic nation. The separation of sexual behaviour from the context of marriage and the decline of morality has contributed to the increase in sexual partners among Irish men and women (Layte et al. 2006).

This complex mixture of Christian morality, sexual suppression, secularisation, negativity and
crisis towards sexuality forms the social context which significantly influences the attitudes, behaviours, and sexual mores of the research subjects who took part in this research. The impact of prolonged sexual repression as experienced in Ireland requires further research while the relationship between such a history and the concept of sexual addiction requires further investigation.

**Sexuality and Sexual Health Policy in Ireland**

There is currently no national sexual health strategy in Ireland which is best understood within the historical context of independent Ireland, post-1922. The Roman Catholic Church held a monopoly on the provision of health care, education and social welfare services (Inglis 1998). Subsequently the Church had a powerful influence in all areas of social policy, particularly in relation to sexuality and family life where the Jansenist-type of influence remained dominant until recently. Whyte (1980, p.21) argues that since Irish Independence there has been a reluctance in the State ‘to touch on the entrenched positions of the Church’ in terms of social policy. Their reluctance was particularly observed during the controversial debate regarding the import and sale of contraceptives which was illegal in Ireland until the 1970s. Despite many calls for a change in the law regarding contraception the Government was reluctant to change the ban, out of deference to the hierarchy’s opinion. In 1977 the contraception debate resurfaced under the Minister of Health, Mr Charles Haughey. He consulted widely on the issue and he included the Irish hierarchy in the consultative process. The Heath bill, permitting the import and sale of contraceptives came into law in 1979. Haughey, mindful of the bishops concerns, gave assurances that contraceptives were only available on prescription to ‘bona fide’ couples seeking contraception ‘for family planning purposes or for adequate medical reasons’ (Whyte 1980, p.415). The influence of the Roman Catholic Church in terms of social policy was further observed in the controversy surrounding the Health Education Bureau (HEB). In the 1970s the HEB organised a life skills programme in response to the growing public concern regarding drugs in Ireland. Some Roman Catholic bishops and lay groups criticised the life skills education. The programme was perceived as being, ‘secular, humanist and fundamentally antithetical to traditional Christian methods of religious and moral education’ (Butler 2002, p.179). These criticisms were not helpful to the HEB which was closed down in 1987. Inglis (1998) argues that despite the changing status of the Roman Catholic Church in Ireland, the influence of the Church on social policy and especially sexuality has been enormous. The implementation of a National Sexual Health Strategy as recommended to the Departments of Health (Layte et al. 2006) remains outstanding.

### 2.2.5 Conclusion of Human Sexuality

Human sexuality has been understood and explained in a variety of ways since time began and influenced by many factors such as culture, religion, and medicine. Cultural and religious attitudes to sexuality have ranged enormously where sexuality has been viewed in terms of pleasure by some
but also as sinful by others. This has often been expressed by tensions between institutional regulation of sexuality and personal freedom and the challenge between sexual-pleasure and self-discipline. DeLamater (1981) states that over time, three distinct sexual scripts or perspectives have emerged in Western society, namely, the procreational, the relational, and the recreational. The procreation script emphasises the reproductive aspect of sexuality while the relational is person focused and the recreational highlights the aspect of physical pleasure. The Christian church has a long tradition of viewing sexuality in terms of procreation and has understood any other forms of sexuality as immoral, a philosophy that has been adapted to greater or lesser extents by many Western societies. Exceptions to these sex-negative attitudes have emerged periodically. Despite intermittent efforts to break away from the tradition of negativity, the anti-sexual attitudes of the early Christian thinkers continually reemerge recently expressed by some who viewed the AIDS epidemic of the 1980s as God's retribution for sexual immorality. During this period of the 1980s excessive sexual behaviour was labelled a sexual addiction and perceived as a psychiatric condition by some.

Sexuality in Ireland, largely shaped by the Roman Catholic Church, is generally viewed in terms of negativity and repression and policy has been generally influenced by Roman Catholic morality. The reluctance to develop a liberal sexual health policy is associated with the residual influence of the procreative sexual script which was dominant in Ireland for such a long period. The recent recommendations to develop a national sexual health strategy may provide a framework to respond more effectively to the contemporary needs of sexuality among a diverse Irish population.

Throughout history a cyclical pattern has emerged regarding sexuality marked by agreement as to what constitutes acceptable sexual behaviour. After a certain period of stability some dimension of life changes and creates a need for reform resulting in the creation of a new perspective on sexuality or the restoration of a previous model. This cycle of continuous change and reform has operated from the beginning of time and at present is expressed by some who seek to designate excessive sexual behaviour as a medically based disorder. Since this concept is being understood within the framework of addiction the next section reviews the concept of addiction and particularly behavioural addiction which considers out-of-control sexuality as potentially addictive.

2.3 Addiction

In this section the concept of addiction is reviewed. The rationale for this is that the phenomenon of sexual addiction is presented as a behavioural expression of addiction and therefore an understanding of the concept of addiction will prove helpful. An examination of the historical origins of addiction is undertaken before investigating the development of the concept in terms of influential factors such as the American temperance movements and prohibition in the United States of America (USA). The post-prohibition concept of alcoholism is then examined and considered
in relation to events such as the founding of Alcoholics Anonymous (AA), the establishment of the Yale Centre of Alcohol Studies and the inclusion and exclusion of the term addiction in the DSM (Clark 2011). The contemporary understanding of addiction and behavioural addiction is discussed before concluding with a critique of the concept.

2.3.1 The Development of Addiction

The contested concept of addiction which has developed over the past one hundred and fifty years enjoys popular acceptance in the Western world. It is typically associated with the consumption of psychoactive drugs and medically understood in terms of

- Compulsivity
- Loss of control
- Negative consequences

The treatment and management of addiction is generally assigned to the medical profession, and it is usually managed within the speciality of psychiatry, often reflected by the inclusion of addiction as part of the psychiatric diagnostic systems. Recently the concept of addiction has expanded beyond the traditional confines of psychoactive drugs to include the concept of behavioural addictions which consider certain behaviours as potentially addictive (Juhnke & Hagedorn 2006). Despite the popular use of the concept of addiction and the growth of an entire infrastructure of addiction treatment, the concept remains hugely controversial.

Reinarman (2005), a sociologist, argues that the concept of addiction is not founded on scientific data. Instead, he believes that it is the cumulative result of a number of social and cultural factors that coalesced over a historical period which facilitated that development of the concept. Room (2003), who also views the concept of addiction in terms of a social construct, claims that the long standing drinking traditions, which existed from antiquity, came under scrutiny during the height of ascetic Protestantism and early capitalism. Alcohol and pleasure were rejected to create space for the growth of productivity and purity which were associated with the Western notion of individuality, a key requirement for a developing society (Reinarman 2005). Levine (1978) claims that from the late 1780s onwards the attitude towards alcohol shifted considerably and social acceptance of alcohol as a normal aspect of life was replaced by the perception of alcohol as dangerous and evil (White, Boyle & Loveland 2002).

The rise of the concept of addiction is closely associated with the writings of Benjamin Rush (1745-1813) (Levine 1978). In his 1784 publication, An Inquiry into the Effects of Ardent Spirits on the Mind and Body, Rush stated that 'distilled liquors were physically toxic, morally destructive and addictive' (Levine 1984, p.110). Rush also claimed that 'chronic drunkenness' was a disease (Porter 1985, p.390) and that alcohol causes the individual to lose control. Described as a disease
of the will, Rush claims that it is morally harmful, causes additional diseases and is socially destructive behaviour (Valverde 1998). In order to manage its addictive nature ‘total abstinence’ is recommended (Levine 1984, p.110). Rush believed that the drunkard was a victim of the socially accepted culture of alcohol and was in need of care which marked the end of the corrective approach and promoted the philosophy that drunks could recover and resume a normal life if they received help (Levine 1984). This led to the establishment of inebriate homes for the treatment of drunkards which was the beginning of the medicalisation ‘of drunkards into alcoholics’ (Porter 1985, p.393). Groups dedicated to the cure of alcoholism developed, all of whom laid the foundations for the contemporary groups such as Alcoholics Anonymous (AA) (Levine 1978).

The concept of addiction developed in tandem with the temperance movements which adopted Rush’s philosophical opposition to alcohol (Ferentzy 2001). The early development of the temperance movement is attributed to the support it received from physicians, clergy, and middle-class businessmen who associated the growing economic and political problems with the misuse of alcohol. The successful establishment of the temperance movement led to the deepening awareness of the negative consequences of alcohol. Essentially alcohol was regarded as inherently addictive and it was believed that all those who persisted in consuming it would inevitably become addicted. This belief provided the platform to call for the prohibition of alcohol. It is argued that the call for prohibition was strengthened by the increased value which was placed on the concept of the ‘autonomous individual’ (Cohen 2000, p.592). This notion of personal control was deemed highly valuable in an emerging capitalist and industrialised society. In this new industrialised society the individual is socialised to recognise their loss of control and they respond by seeking assistance from the ‘addiction doctor’ (Cohen 2000, p.596). The concept of being out-of-control, a cultural construct, further affirmed the concept of alcohol as inevitably habit-forming and facilitated the construction of addiction. The growing attitude of negativity towards alcohol ensured that by the 1850s prohibition laws were passed in some American states. In 1869 the political Prohibition Party was established which marked a significant socio-historic milestone in terms of the historical development of addiction (Levine 1984).

2.3.2 Prohibition

Levine (1984) describes how a gradual but powerful movement began to agitate for prohibition expressed by groups such as the Prohibition Party and the Anti-Saloon League (ASL). The call for national prohibition was based on the traditional values of the temperance movement such as social and moral reform and personal health. The cultural climate of the early twentieth century, with its new social needs, had become conducive to prohibition. There was a need for a new industrial and efficient society which required a population of sober workers. It is this type of socio-political framework among other factors which Reinarman (2005) claims led to the construction of the concept of addiction. Reinarman (1988) also argues that prohibition was, in
fact, a moral mask for developing big business while the advocates of prohibition argued that the benefits held positive consequences for all sectors of society. Prohibition was also perceived as a symbolic crusade associated with the decline of the status of the American Protestant in relation to the emergence of new immigrant populations. The dominance of the established group was asserted by imposing their values, particularly regarding alcohol, in order to maintain and develop their status. In America, after a long but effective moral and political movement, prohibition began in 1920 and lasted until 1933 (Levine 1984). Gusfield (1986, p.119) argues that prohibition supported the ‘abstaining dry proclivities of the Protestant middle classes’. The impact of prohibition has been vigorously debated and advocates and opponents have both claimed victory. Despite the initial enthusiasm for prohibition, arguments against it developed and were primarily framed in terms of economics and social issues. These were collectively voiced by The Association Against Prohibition Amendment (AAPA) which was comprised mainly of businessmen (Levine 1984). The worsening economic recession culminating with the arrival of the Great Depression was a significant economic factor promoting the argument in favour of repeal. The campaign for repeal claimed that the revival of the alcohol industry would generate revenue, provide employment and stimulate economic growth, similar arguments that had previously been used to secure prohibition. The prohibition against alcohol was successfully repealed in 1933. The political, social and economic controversy once surrounding the issues of alcohol soon dissipated after repeal became established. The control of alcohol was framed in terms of The Rockefeller Plan which suggested that the law should be involved in the lawful distribution of alcohol. It also suggested that the temperance issues of alcohol which related to personal or social problems Rockefeller should be managed by medical, educational and religious organisations (Pennock & Kerr 2005).

2.3.3 The Birth of Alcoholism

The perception of alcohol in the post-prohibition era changed (Levine 1984). A subtle but significant shift of emphasis occurred. The problem of drunkenness was no longer associated with the substance of alcohol but instead the vulnerability to get drunk resided with the individual who took the drink. In other words, most individuals could drink alcohol successfully but a minority of the population was deemed susceptible to drunkenness which renders them unable to control alcohol. This new understanding of alcohol facilitated the emergence of the concept of alcoholism which is viewed as a ‘discrete entity’ affecting only a minority group of those who consume alcohol (Butler 2002, p.20). Alcoholism is now considered as a disease which is specific to the individual, associated with compulsive drinking, results in the loss of control and could be remedied through abstinence. The development and popular acceptance of the concept of alcoholism, according to Levine (1984), is associated with other factors such as the beginning of Alcoholics Anonymous (AA), the Yale Medical Centre and the National Council for Alcoholism (NCA).
Butler (2002) explains that the disease model of addiction was expanded further when the World Health Organisation (WHO) chose to adopt the American model of disease. The adoption of the disease concept of alcoholism is associated with the influential contributions of Jellinek, particularly his 1952 publication on the Phases of Alcohol Addiction, which was significant in the development of the WHO policy on alcohol. Mainly attributed to Jellinek the disease concept of alcoholism ‘was presented unambiguously to the world as a discrete disease which could be medically diagnosed’ and which could and should be treated with a similar method to all other diseases (Butler 2002, p.21). Since the 1950s the WHO has defined alcoholism as a disease which has provided the opportunity for the creation of an entire infrastructure of treatment to assist those affected by this addiction. Reinarman (2005, p.311), critical of the disease concept of addiction, argues that the WHO have frequently changed their description from ‘drug addiction’ to ‘behaviours that entail no use of psychoactive substances’. The medicalisation of addiction was also observed in the inclusion of the term ‘addiction’ in the International Classification of Diseases (ICD) even though the terminology has changed over time (Room 1998). This pattern has been repeated in the Diagnostic and Statistical Manual (DSM) (Reinarman 2005). Furthermore, the criterion for addiction have been continuously recreated, redefined and presented by organisations such as the American Psychiatric Association (APA), (Surratt 1999). The criteria, such as withdrawal, tolerance and compulsion, have been challenged and the cross-cultural applicability of these has proven difficult (Room 2003).

O’Brien (2011) remarks that the pattern of changing descriptions is further observed in the current recommendation that the term addiction be replaced in the new edition of the DSM in 2013 after it was previously removed on the grounds that it was deemed pejorative and may alienate some individuals who sought help. The forthcoming edition of the DSM is considering the inclusion of non-substance behaviours which are considered potentially addictive behaviours but which do not involve the intake of any psychoactive substance (O’Brien 2011). These typically include behaviours such as gambling, eating and sex and are popularly labelled as behavioural addictions. The concept of sexual addiction was included in the DSM-III-R (American Psychiatric Association 1987) for the first time and enjoyed initial recognition as a behavioural addiction. However, it was removed in a later edition due to the lack of empirical data and the ongoing lack of agreement regarding the validity of the concept (Garcia & Thibaut 2010). The most recent attempt to have sexual addiction included in the 2013 edition of the DSM, under the category of Hypersexual Disorder, was rejected (Samenow 2013). This seems to suggest that there is no consensus regarding a definition particularly in terms of what constitutes an agreed level of sexual behaviour that is excessive, or out of control.
2.3.4 Critique of the Concept of Addiction

Despite the fact that research has continued, in scientific terms, to create clear diagnostic criteria, social scientists argue that addiction is not a scientific discovery but a social construction which fitted into the post-prohibition world and justified the repeal of prohibition. The concept of addiction is also understood as a manufactured concept which has been created and promoted by the addiction treatment industry, a concept which underpins a multimillion dollar industry (Peele 1989). Consequently, the concept of alcoholism was gradually displaced from the mid-1970s onwards and replaced by the public health perspective. The public health perspective has reverted to the common sense notion of alcohol as ‘no ordinary commodity’. Under this approach it is believed that if alcohol is promoted and made more accessible without strict control, then more problems will occur. In Ireland the development of the public health perspective was restricted given the strong association with the disease model and observed in the conflicting views among members in agencies such as the Irish National Council of Alcoholism (INCA). The development of the public health perspective was further restricted by the introduction of the Minnesota Model, an American based treatment model, into Ireland. The establishment of treatment centres, such as the Rutland centre, which used the Minnesota Model, led to the ‘popularisation of the disease concept’, which distracted the focus from the health promotion perspective (Butler 2002, p.58). The transition from the disease model to the health promotion model was slow, observed in the protracted process involved in developing a national alcohol policy in Ireland, a policy which failed to incorporate the health promotion dimension fully. Butler (2002, p.104) argues that the shift from the concept of the disease model of alcoholism to the public health perspective on alcohol was ‘an incremental drift towards an alcohol policy where the disease concept was dominant’.

In spite of the lack of scientific evidence to support the concept of addiction, the concept remains popular because it serves to explain unacceptable behaviour, legitimises treatment and absolves blame (Davies 1992). Reinarman (2005) claims that the concept of addiction has become an acceptable dimension of our contemporary therapeutic culture. An individual who experiences out-of-control behaviour often assimilates the culture of disease and recovery promoted by the addiction industry. The concept of addiction did help to create a positive shift in the attitude and understanding of substance use in terms of public health and treatment. Addiction in contemporary society is understood more humanely as an issue in need of medical care and support (Reinarman 2005). On the other hand, the addiction construct is often thought to serve as a defence mechanism, used to ignore the major social issues that underpin it (Hammersley & Reid 2002).

Controversy continues regarding the concept of addiction, recently observed in the debate as to how the substance use disorders should be described in the DSM-V (O’Brien 2011). Social scientists generally agree that the concept of addiction is not based on the discovery of an independent scientific entity but is based on a social and cultural attitude towards alcohol as a social construction (Room 2011). Clinicians remained in favour of calling the disorder ‘addiction’ and
demonstrated a pragmatic concern with helping people who in common sense terms have experienced problems with alcohol and drug use (O’Brien 2011). It may be difficult, if not impossible, to disentangle cultural and moral views from objective scientific views, but they are trying.

Similar shifts are observed in terms of ‘treating’ substance use. A growing intolerance towards drunkenness led to the development of alcoholism as a disease and as an addictive disorder (Porter 1985). Consequently the need to control the use of alcohol was promoted and expressed in a number of ways escalating in the prohibition movement (Levine 1984). Over time it has been generally accepted that the most effective treatment for the ‘disease’ of alcoholism is abstinence (Levine 1984). The concept of ‘treating’ substance has been contentious and has changed over time. Recent calls have been made to move away from the ‘acute treatment model to a sustained recovery management model’ (White, Boyle & Loveland 2002, p.107). This type of model encourages a long-term perspective of ‘recovery’ from substance use which includes multiple harm reduction strategies to be used over a period of time. It is envisaged that such measures are supported by ‘a multi-faceted public-health approach’ to combat the perceived negative consequences associated with excessive drinking (Orford 2001, p.27).

Without doubt, the most radical changes which occurred in relation to the treatment and rehabilitation of addicts and problem drug users from the mid-1980s onwards were those which are commonly discussed under the rubric of harm reduction. This refers to the implementation of practices within health and social service systems which accept that many drug-using clients either cannot or will not become and remain abstinent, despite being medically detoxified (perhaps on multiple occasions) and counselled to remain abstinent. From a policy perspective, it had until the advent of HIV/AIDS been the norm in most developed countries that the healthcare sector was ideologically at one with the criminal justice sector in that it insisted that drug use was an illicit and deviant activity; and on this basis both sectors collaborated in working towards the goal of abstinence for individual drug users and, in a more general way, the attainment of a ‘drug-free’ society. Such intersectoral consensus was shattered, however, in the era of HIV/AIDS and by the dawning realisation by public health authorities that abstinence models of addiction treatment were technically ineffective, and that a moralistic insistence by health authorities that drug users should become abstinent were of little practical value and were likely to lead to increased rates of HIV infection amongst drug users and - through sexual contact between drug users and non-users - in the general population. This then led to a situation where health authorities internationally introduced a range of pragmatic practices (for example, needle and syringe exchange for injecting drug users, safer injecting facilities and long-term opiate substitution treatment in the form of methadone maintenance). From a moral perspective, these practices were controversial since they deviated so obviously from previous beliefs and practices which were enshrined in the drug conventions of the United Nations. Rhodes & Hedrich (2010) have provided a detailed analysis of how harm reduction practices in the drugs sphere were introduced across the European Union, and Butler &
Mayock (2005) have argued that the harm reduction policy process in Ireland was largely shrouded in ambiguity so as to avoid contentious debate. In the general context, of this thesis what harm reduction in the drugs field reflected was a pragmatic acceptance by policy authorities that citizens could not be stopped from using psychoactive drugs for pleasure and recreation, and that health authorities might have to satisfy themselves with merely reducing drug-related harm as opposed to delivering the ideal of a drug-free world.

2.3.5 Conclusion of the Development of Addiction

The concept of addiction remains controversial. For some it merely indicates a shift in attitudes towards alcohol from a pre-industrial era where alcohol was enjoyed and drunkenness was tolerated. The dawn of a new era emphasised the importance of self-control as being essential for productivity and progression. This provided a motivation for individuals such as Rush and groups like the temperance movement to preach the dangers of alcohol and to advocate the advantages of abstinence. This idea was further valued by a growing middle class industrial society who politically agitated for the prohibition of alcohol for the good of society. The cost of enforcing prohibition and the loss of revenue from the alcohol industry led to the repeal of prohibition which eventually lost credibility as a worthwhile goal. After repeal alcohol was no longer viewed as an addictive substance and the concept of addiction was re-established with a new assertion that the addiction was related not to the substance but specifically associated with a minority of individuals who were susceptible to developing an addiction. Building on this assertion further research on alcohol led to the widely accepted belief that alcoholism was a disease that could be cured by treatment. A variety of diagnostic classifications have been created for addiction by the medical community and a multitude of treatments have been created by an expanding treatment industry. The concept of addiction has been reconstructed by different actors in an ever changing society. Currently a new wave of social anxiety has emerged regarding excessive behaviours such as food, gambling and sexuality and the concept of addiction has been re-formulated by the medical community to classify these non-substance addictions. Despite the benefits that have been attributed to the concept, addiction is generally viewed by social scientists as a social construction that has been born within a specific socio-historic period and which has been continuously reconstructed by a variety of influential forces since then. The most recent expression of this reconstruction is the concept of sexual addiction which is the focus of review in the next section.

2.4 ‘Sexual Addiction’

The third and final section of the literature review examines the contested concept of sexual addiction. At the outset the historical understanding of excessive sexuality is explored before examining the contemporary notion of sexual addiction, specifically examining the socio-historic context from
2.4. ‘SEXUAL ADDICTION’

which the concept has arisen. The theoretical framework of sexual addiction is outlined paying attention to characteristics, pre-disposing factors, development and behavioural expressions. The therapeutic support, related challenges and consequences are explored. Alternative explanations for dysregulated sexuality are also considered. Finally, the concept is critiqued from a number of perspectives discussing in particular the impact of social construction, medicalisation, and moral and social conservatism on this concept.

Out-of-control and excessive sexual appetites have been documented and discussed from the beginning of time (Finlayson, Sealy & Martin 2001). Historically a number of labels are used to describe this behaviour, including nymphomania, satyriasis, and Don Juanism some of which are no longer in popular use (Garcia & Thibaut 2010). In times past excessive sexuality was understood in terms of religion and morality, while at later periods especially during the nineteenth century it was deemed as an issue best viewed as a medical condition and assigned to psychiatry (Hart & Wellings 2002). It has also been discussed in terms of pathology and labelled as a disease, with associated medical consequences (Finlayson, Sealy & Martin 2001). A growing interest in excessive sexuality has been documented in recent times and much attention has been focused on the proposal that the disciplines of psychology and addiction may be appropriately equipped to capture the full essence of out-of-control sexuality, an argument which remains highly contested (Hook et al. 2010). The quest to understand, define and classify this phenomenon of out-of-control sexuality and the debate regarding terminology continues today and numerous contemporary descriptions have been forwarded to describe it (Giugliano 2009). Descriptions such as Impulsive sexuality, Sexual Behaviour Disorder and Hypersexuality continue to emerge (Manley & Koehler 2001, Kafka 2010). The description chosen is sometimes indicative of the individual’s philosophical beliefs or professional background. Excessive sexual behaviour is now commonly presented as sexual addiction (Carnes 1983). While the label of addiction is advocated by some as an appropriate classification for out-of-control sexual behaviour the concept of sexual addiction remains a highly disputed issue and has been examined from a variety of perspectives (Kingston & Firestone 2008). A brief overview of the contemporary concept of sexual addiction will provide an introductory context for the study being undertaken.

2.4.1 The Contemporary Model of ‘Sexual Addiction’

The concept of out-of-control sexual behaviour has been popularly referred to as sexual addiction since the 1970s. The concept rapidly grew within the historical period of the 1980s. While Orford (1978), despite the lack of scientific evidence, was one of the first to propose the inclusion of out-of-control sexuality in terms of addiction, popular recognition of the term sexual addiction is more commonly associated with Patrick Carnes’s descriptive publication on the concept (Carnes 1983).

The concept of sexual addiction proposed by Carnes (1983) is typically conceptualised in terms of individuals who have lost control over their sexual behaviour and who continue to engage in
the behaviour despite the recurrence of significant negative consequences. The justification for linking excessive sexual behaviour to the concept of addiction is that it allegedly contains some of the characteristics typically associated with traditional addiction such as the continuation of out-of-control behaviour despite the negative consequences, among others (Goodman 1998). Carnes defined sexual addiction in terms of a ‘pathological relationship with a mood altering experience’ (1983:4). Carnes & Wilson (2002, p.5) state that ‘when sexual behaviour is compulsive and yet continues despite adverse consequences, it is called sex addiction. Goodman (1998) argues that the presence of a sexual addiction is better viewed in terms of the person’s disposition, their motivation, the impact of the behaviour on their lives and their inability to stop and is not based on the type or frequency of the behaviour. Additionally, Finlayson et al. (2001) says that the concept is neither specific to sexual orientation nor related to moral or social values. This is vehemently denied by critiques of the concept who believe that the concept is an attempt to use medical classifications to label morally unapproved behaviours (Levine & Troiden 1988).

Carnes (1991) identified the following characteristics as indicators of sexual addiction:

1. A pattern of out-of-control sexual behaviour despite adverse consequences.
2. Persistent pursuit of self-destructive or high-risk behaviour.
3. Ongoing desire to limit sexual behaviour.
4. Sexual obsessions become a primary coping mechanism.
5. Increasing amounts of sexual experience required.
6. Severe mood changes around sexual activity.
7. Neglectful of other aspects of life.

These characteristics are frequently used in clinical practice and in popular literature. They are deemed useful, in the absence of clearly defined scientific criteria which is viewed as a hindrance, towards the recognition, diagnosis and treatment of this behaviour (Finlayson, Sealy & Martin 2001). Carnes (1983) suggests that the characteristics may indicate the presence of a sexual addiction. Coleman (1986) claims that the global traits used such as out-of-control, high-risk, preoccupation, among some, are subjective and value laden and are insufficient for assessment. Gold & Heffner (1998) are critical of Carnes’s work and argue that the study on which the concept is based, is unreliable and that the criteria used is subjective and culturally defined.

The pattern of addictive sexual behaviour is typically characterised as comprising of a number of distinctive features. Despite the negative consequences, individuals who experience this are compulsively driven to satisfy their sexual needs, and become unable to control their sexual thoughts, fantasies or behaviours (Woody 2011). Gradually the individual becomes tolerant and an increased amount of sexual activity is required often resulting in self-destructive activities to
maintain satisfaction (Bancroft et al. 2003). It is argued that sexual addictive behaviour is not typically sought for sexual pleasure but used to regulate emotions (Reid et al. 2010). The individual learns to numb negative feelings through sexuality (Gold & Heffner 1998). Increased anxiety leads to the need for increased sexuality and a cycle of emotional coping develops which initially brings relief and later becomes addictive. The initial relief is allegedly associated with the release of chemical endorphins which generate significant mood alterations. A pattern of addiction develops as positive moods are continually sought through sex (Carnes 1983). The impact of this addiction is typified in the neglect of other areas of the individual's life and the creation of a host of related negative consequences (Marshall & Briken 2010).

2.4.2 The Socio-Historical Context of ‘Sexual Addiction’

Carnes's proposal ignited a debate about the validity of whether or not out-of-control sexuality should be viewed as an addiction. As the debate continues, the popular growth of this contested concept is attributed to a combination of social, cultural, religious and medical dynamics coalescing between the 1960s and the 1980s (Levine & Troiden 1988). The concept has reignited controversial debate as Kafka (2010) proposal to designate hypersexuality as a psychiatric disorder was proposed and rejected for inclusion in the 2013 publication of the DSM.

The contemporary concept of sexual addiction has its origin in the post sexual revolution period of the 1960s, a period noted for the significant transformation of human sexuality (Irvine 1995). Despite all who embraced the sexual freedom of the 1960s, opposition to it also emerged particularly by those who perceived that their moral and social values were being undermined by a liberal sexual agenda. This led to a conflict between the social conservatives and liberals which intensified as the rate of sexual diseases increased and which was exasperated by the arrival of the AIDS epidemic in the 1980s. Those opposed to the sexualisation of society attributed all the social ills to the newly gained sexual freedom. The conflict culminated in the socio-political sexual counter-revolution of the 1980s which marked the beginning of a sex-negative period. The sexual counter-revolution, a well-structured ideological campaign (Cohen 2012) resulted in the association of non-traditional and excessive sexuality with disease and death (Malhotra 2008). Sexuality became polarised between social conservatism and sexual ‘commodification’ within a complex sexual culture (Greig 2006, p.88). This created a climate where the concept of sexual addiction became an acceptable explanation for the sexual upheaval and resulted in the proposal that out-of-control sexual behaviour could be diagnostically labelled as a sexual addiction (Schwartz & Bradsted 1985). The development of the concept was further helped by the increasing medicalisation of sexuality, particularly the growth of addiction medicine (Tiefer 2007). Gradually, the concept of sexual addiction developed and over time became more acceptable as a treatable condition. This was observed particularly in the emergence of specific treatment programs for sexual addiction within the expanding addiction industry. Furthermore, the concept was also facilitated by the growth of a
number of right-wing religious movements and the emergence of a new political conservatism during
the 1980s which filled the vacuum created by the decline in religious institutions (Irvine 1995).
These movements expressed a desire to protect society from a liberal sexual agenda and they
welcomed the concept of sexual addiction as a framework to treat ‘the disease’ of sexual promiscuity.
Another significant factor, contributing to the popular growth of this concept is the influence of
the media, added to by the celebrity status associated with sexual addiction (Reay, Attwood &
Gooder 2013). In addition, it has been argued that the traditional understanding of addiction
which includes only substance addiction is overly restrictive and that the time has come to widen
the definition to include other out-of-control behaviours (Griffin-Shelley, Sandler & Lees 1992)
commonly referred to as behavioural or process addiction (Juhnke & Hagedorn 2006). The rationale
for including behavioural addictions as a legitimate category is that they allegedly display similar
characteristics to substance use addictions. Reay, Attwood & Gooder (2013), among others, argue
that behavioural addictions, such as sexual addiction, are social constructions which facilitate the
creation of diagnostic categories in order to pathologise expressions of non-normative behaviour.
They frequently mask factors such as social conservatism or moral disapproval. Additionally, the
proliferation of addictions may lessen the validity of substance use addiction. It was through
this combination of factors and within this political and social context that the concept of sexual
addiction developed over the past thirty years.

Despite the growing popularity of this concept it remains a contentious issue particularly among
social scientists and philosophers, among others, who claim that the concept has been socially
constructed and lacks sufficient evidence to validate it as a scientific condition (Levine & Troiden
1988). The concept is viewed as a historical invention which reflects the cultural anxieties and the
socio-political reaction to the sexualisation of society in the late twentieth century. The concept is
perceived as a contemporary expression of social conservatism and a disapproval of non-traditional
sexuality associated with the sexual revolution (Reay, Attwood & Gooder 2013).

2.4.3 Predisposing Factors

The purported cause of sexual addiction remains unclear and according to Bancroft (2009) insuf­
ficient time has been dedicated to this area while there has been an overemphasis on the issue
of definition. Many conjectures have been proposed and the major factors associated with sex­
ual addiction are often linked to early formative experiences. Sexual addiction is often perceived
as being a result of dysfunctional family-of-origin environments where the individual’s ability to
develop and maintain satisfactory relationships have been fractured (Schneider 2000). Additional
influences associated with the development of sexual addictive behaviour are factors such as loss,
abandonment, intimacy and emotional development (Schwartz 2008, Davis 2009).

It is claimed, by some, that the experience of of childhood trauma and particularly child sexual
abuse (CSA) is closely associated with sexual addiction and particularly child sexual abuse (CSA),
2.4. 'SEXUAL ADDICTION'

(Schwartz 1992, Lew 2004, Kafka & Prentky 1994, Carnes 1991, Hunter 1990). Spiegel (2003) claims that adult males with histories of CSA are more likely than non-abused males to have problems around hyper-sexuality. Briere (1992) specifically identifies factors such as, an impaired ability to trust, fear regarding attachment, and sabotaging close relationships as traits that result from childhood trauma. These characteristics will increase the adult survivor's vulnerability to engage in sexually addictive behaviour which requires little trust and which may indicate abuse. Furthermore, in the aftermath of sexual abuse, the individual inherits a confused connection between nurturing love, sex and abuse. In such situations the abused individual may believe that sexual behaviour of any kind will secure intimacy. In pursuit of intimacy they frequently engage in sex which results in a cycle of sexual addiction (Herman & Hirschman 2000). Others like McCarthy (1994) suggest that sex is understood in terms of a power dynamic for some individuals who have been abused. Continuous sexual behaviour may indicate the individual's effort to retrieve control or power over what they previously lost. The repetitive nature of sexual addictive behaviour is sometimes explained as a behavioural re-enactment of their original abuse in order to gain meaning and resolve (Schwartz 1992). Freud believed that repetition would achieve mastery while others argued that it would only serve to further aggravate the problem (van der Kolk & Fisler 1994). Sexual activity often becomes a coping mechanism for those who experienced abuse which later develops into a compulsive pattern (Laaser 2004).

Research on the association of CSA and sexual addiction remains inconclusive. Gold & Heffner (1998) argue that such an association be treated with caution. In contrast with the belief that sexual addiction is an inevitable result of sexual abuse, Weiss (2005) notes that abuse does not cause addiction but claims that addiction may be a maladaptive response to the abuse while Goodman (1998) believes that it is simply a combination of the addictive process plus sexualisation. Lew (2004) also says that many individuals who experience child sexual abuse have the capacity to recover and live healthy sexual lives. The over-identification of child sexual abuse and sexual addiction may lead to the mistaken conclusion that these two concepts are essentially linked, creating a situation where vulnerable individuals may be influenced by suggestibility (Gold & Heffner 1998). Gold & Heffner (1998) suggest that it will be necessary to examine self-identified sexual addicts who have no history of child sexual abuse in order to clarify the exact nature of the relationship.

Another influential factor which predisposes an individual towards sexual addiction according to Schaef (1990) is sexual education. She claims that the school and the church, as primary sources of education, have operated a dualistic model of obsession and repression regarding sexuality. This often results in a similar expression of repressive and addictive sexual behaviour. Earle & Earle (1995) claim that the individual's vulnerability to sexual addiction is rooted in formative learning experiences where sexuality is presented negatively. The Church is identified as one teaching agency that has contributed to the development of sexual addiction through its association of sexuality
CHAPTER 2. LITERATURE REVIEW

with sin, secrecy and rigidity (Edger 2012).

The concept of shame is repeatedly mentioned as a cause and a consequence of sexual addiction (Reid 2010). Shame is often a by-product of situations where continuous disapproving judgments are made regarding sexuality. This often creates a shame cycle where the individual exhibits intense rigid control over their shame based sexual behaviour (Laaser 2004). Over time the unresolved shame demands release and is expressed in the form of sexual addictive behaviour (Fossum & Mason 1986). Gilliland et al. (2011) discusses shame as both a consequence of sexual addiction but also as a factor which maintains the behaviour. He claims that those who only feel shame lack the motivation to change while those who feel coexisting guilt are more likely to seek help and change.

Weiss (2005) claims that the level of shame may be heightened for the sexual addict who is homosexual because homosexual children are often forced to hide and reject their sexuality. They are vulnerable to negative labelling which reduces their opportunity for social interaction and intimacy (Hanson & Hartmann 1996). Homosexuality is also associated with internalized homophobia and secrecy dynamics which are associated with sexual addiction (Dew & Chaney 2005). Rendina et al. (2012) argue that the experience of shame is particularly relevant to the subpopulation of gay, bisexual and HIV positive men who may experience societal and internalized stigma due to their HIV status and their sexual orientation. Men with high levels of HIV stigma sometimes use sexual behaviour as a way of coping which may be associated with symptoms of sexual addiction (Parsons et al. 2008). While Giles (2006) criticises the concept of sexual addiction and views it as a means of pathologising non-normative sexual behaviour, Dodge et al. (2008) claim the concept of sexual addiction is beneficial in terms of reducing sexual risk among HIV positive men and in terms of sexual health. A higher prevalence of sexual addiction is suggested among gay and bisexual men (Grov, Parsons & Bimbi 2010). A combination of socio-historical and cultural factors associated with members of the lesbian, gay, bisexual and transgendered (LGBT) population render the concept of sexual addiction a sensitive, complex and controversial topic (Pincu 1989).

The use of the Internet for sexuality is increasingly common. Griffiths (2012) argues that the Internet has become a significant contributory factor facilitating sexual addiction. The Internet is used to complement offline sexuality or as a primary source of sexual behaviour including cybersex, pornography and making sexual contacts. Specific factors are attributed to facilitating sexual addiction such as access, affordability, anonymity, convenience and escape (Cooper 1998, Young et al. 1999). These factors increase the probability that Internet sexuality will become addictive for those who already have an off-line sexual addiction or those who use cybersex for psychological management (Stein et al. 2001). Clinicians report an increase of clients presenting with Internet sexual addiction (Cooper, Delmonico & Burg 2000) and who are dealing with complex issues including downloading and distributing illegal sexual material, and cyberstalking. The widespread commercialisation of pornographic sexual material on the Internet has led to a normalisation of such material. The unrestricted availability is generally understood in terms of consumer sovereignty.
and any attempt for the State to restrict it may be interpreted as paternalistic.

Additional perspectives regarding physiological or psychological disorders such as anxiety or depression are discussed in a later section called, alternative explanations for sexual addiction. An ever increasing number of causal factors are proposed by advocates of the concept while opponents dismiss such propositions as pseudo-scientific constructs (Levine & Troiden 1988) and the lack of consensus continues.

2.4.4 The Development and Cycle of ‘Sexual Addiction’

Carnes’s (1983) theory of sexual addiction is based on the principle that the individual formulates a faulty core belief system which becomes a primary influence on an adult’s thoughts. The core beliefs are summarised as following:

1. I am basically a bad, unworthy person
2. No one would love me as I am
3. My needs are never going to be met if I have to depend upon others
4. Sex is my most important need

These faulty core beliefs become significant factors in the development and maintenance of sexual addiction. The negative core beliefs emanate from formative experiences where experiences of humiliation were often seen as deserved, resulting in the first core belief which states, ‘I am basically a bad, unworthy person’. As a consequence, those affected will automatically believe that they are unlovable which is associated with the second core belief which states, ‘No one would love me as I am’. In turn they feel incapable of loving or being loved rendering relationships and intimacy as untrustworthy resulting in the third core belief which states, ‘My needs are never going to be met if I have to depend upon others’. This is often expressed in the creation of a persona which rejects help or intimacy. Isolation and secrecy begin and sexual addiction becomes the source of survival resulting in the fourth core belief which states, ‘Sex is my most important need’. These faulty core beliefs form the basis for impaired thinking which allows the negative consequences of the addiction to be minimised. The combination of faulty core beliefs and impaired thinking gives rise to the development of the cycle of sexual addiction. See Figure 2.1.

The cycle has four major components namely, preoccupation, ritualisation, compulsive behaviour and despair. Preoccupation is a mental trance where the obsessive search for sexual stimulation begins. This is followed by ritualisation which is a pre-sexual behavioural routine that intensifies arousal and excitement. Black (2009, p.71) says that the ‘pre-sexual rituals intensify the powerful and neurochemical high’. The third component is the compulsive sexual behaviour, consisting of the chosen behaviour. The final part of the cycle is the experience of despair in the face of being powerless and ashamed as a result of the behaviour. Ironically the sexual addict
CHAPTER 2. LITERATURE REVIEW

The Addictive System

Belief system

Unmanageability  Impaired Thinking

Addiction Cycle

Preoccupation

Despair  Ritualization

Sexual Compulsivity

Figure 2.1: The Addiction System  Carnes (1983:26)
seeks relief from the despair through seeking additional sex which begins the entire process again and the cycle continues (Carnes 1983). Carnes's model is based on the individual's negative self-perception which leads to sexual addiction. In contrast, Reid et al. (2008) challenge the sexual addiction concept and argue that the basis for negative self-perception has multiple causes which if accurately identified and managed will not necessarily result in sexual addiction. Furthermore, Coleman (2003) argues that some of the negative perceptions and sexual difficulties may be related to the individual's sexual development which will be resolved through the process of sexual maturation and which do not necessarily indicate the presence of a sexual addiction.

2.4.5 Behavioural Expressions of 'Sexual Addiction'

Addictive sexual behaviours are commonly categorised into internal and external manifestations. The most common internal addictive activity is sexual fantasy. This involves thinking about and mentally obsessing about sex. Some treatment providers claim that sexual fantasy in a clinical situation is very difficult to detect since the addict can use this mode to easily escape unnoticed into their addiction. The other types of sexually addictive behaviours are more obvious and are externally expressed. Citing Carnes (1991) and Schneider (1994), Griffiths (2001) has identified eleven typical categories of behavioural expressions of 'sexual addiction'. They are:

1. Fantasy Sex: continuously thinking and obsessing about sex.
2. Seductive Role Sex: being flirtatious and seductive to gain sexual power over others.
3. Anonymous Sex: actively seeking out and sexually engaging with anonymous partners.
4. Paying for Sex: such as prostitution, phone sex, saunas, swinging clubs and the Internet.
5. Trading Sex: hiring for or pimping others for sex in exchange for money or drugs.
6. Voyeuristic Sex: gaining sexual pleasure from secretly watching others.
8. Intrusive Sex: making uninvited and exploitive sexual advances.
9. Pain Exchange: inflicting or accepting pain in order to intensify sexual pleasure.
10. Object Sex: such as sex toys, sexual fetishes, rituals and animals, and
11. Sex with Children: sexual engaging with children for the adult's pleasure.

Carnes (1983) has further categorised the sexually addictive behaviours into three separate levels. Within level one there are behaviours that are regarded as normal like masturbation or pornography. In level two there are behaviours such as exhibitionism, voyeurism and intrusive phone sex. These are viewed as an unacceptable nuisance and if perpetrators are caught they are
prosecuted. Level three behaviours include child sexual abuse, incest and rape. These behaviours have grave legal and emotional consequences for the victim and the addict. Goodman (1998) argues that sexual addiction cannot be distinguished in terms of the behaviours alone as many of the behaviours that are associated with sexual addiction are also behaviours that other people use to enjoy healthy pleasurable sexual lives. Goodman (1998) argues that the behaviours in themselves are not addictive and that sexual addiction is not measured by the type or amount of sexual involvement. His argument reflects the beliefs about alcohol during the post-prohibition period when it was claimed that addiction was not in the substance but that it was a discrete entity that affected a minority of vulnerable individuals. Goodman (1998) claims that the presence of a sexual addiction is better viewed in terms of the individual’s disposition, their motivation, the impact of the behaviour on their lives and their inability to stop.

Levine (2010), critical of Carnes’s model, argues that the label of sexual addiction is often used inaccurately by self-identified sexual addicts and professionals. Some individuals may identify with the term sexual addiction in situations where they experience a conflict of personal values regarding their sexual behaviour such as homosexual attractions or alternative sexual practices (Coleman 2003). In order to ensure accuracy, careful attention is required particularly noting the individual’s circumstances, their personal and interpersonal issues before any labels are applied. Inaccurate labelling may result in masking the primary issue and delay the appropriate response which an underlying issue requires. Winters (2010) argues that Carnes’s model lacks scientific validity. Klein (2006) contends that the concept of sexual addiction does not acknowledge the influence of alternative factors on sexuality and consequently creates models of sexual normality and pathologises behaviours of eroticism that do not conform to the cultural norm.

2.4.6 Negative Consequences of ‘Sexual Addiction’

Carnes (1983) claims that the external consequences are seen in terms of the sexual addict’s relationships, health, finance and employment. Those involved in sexual addiction leave themselves vulnerable to physical attack and disease which has health implications for their partners and families (Levin 1999). The less visible consequences are commonly experienced emotionally and psychologically. Issues such as diminished quality of life, physical, mental and emotional pain are associated consequences in terms of sexual addiction. Benotsch, Kalichman & Pinkerton (2001) claim that the consequences are also experienced by the individual’s family, friends and employers who experience increasing implications due to absenteeism, loss of productivity, job-related injury, and litigation arising from sexual addiction.

2.4.7 Treatment of ‘Sexual Addiction’

A range of therapeutic supports are used by individuals to help them manage their addictive sexual behaviour and include psychological, medical and psycho-educational approaches (Kaplan &
Krueger 2010). Psychotherapy is one of the major psychological supports and may use a number of theoretical approaches such as cognitive behavioural therapy or psychoanalysis among others. Psychotherapy aims to identify the problematic issues and to develop skills to resolve and manage them. There is increasing emphases on the value of an educational component and the offer of additional resources such as medical or sexual health (Giugliano 2008). Within psychotherapy co-morbid issues often emerge in need of attention which require additional or specialist care such as issues like sexual abuse or substance use (Schneider 2005). Dedicated treatment centres for sexual addictions are popular in the USA but in England and Ireland treatment centres with a primary focus on substance use offer an additional facility to deal with sexual addiction within the range of services available. It has been noted, particularly in treatment centres, that sexual addiction is often discovered when an individual seeks help for substance use, and unresolved sexual issues can be injurious to substance use recovery (Siegel 2011). Group and family psychotherapy for sexual addiction, not commonly available, is usually offered by, but not limited to, residential treatment centres. It provides learning about interpersonal relationships, particularly helpful for the sexual addict who struggles with intimacy and relationships (Swisher 1995) and needs competent facilitation. Understanding sexual addiction in clinical practice is challenging (Nathan 1995). A deficit of specifically qualified personnel exists in this area and a low level of knowledge and skill among other professionals regarding sexually addictive behaviour is reported (Hagedorn 2009).

Schneider (2005) says that another major component of support is the 12-step sexual fellowships. These are group meetings, based on the model used by Alcoholics Anonymous (AA). A number of sexual fellowships exist, of which two are available in Ireland namely, Sex and Love Addicts Anonymous (SLAA) and Sexaholics Anonymous. Coleman (2003) acknowledges their usefulness but is critical particularly of the fellowships who promote the abstinence model which does not easily replicate from alcohol to sexuality. The fellowships have a spiritual dimension but are not affiliated with any specific religious organisation. Reinarman (2005) claims that the 12-step movement is another dimension of the social infrastructure supporting the myth of addiction. He claims that individuals who attend the 12-step groups learn the addiction model through interaction with other members and subsequently they repeat the accepted group parlance which serves to confirm the existence of addiction.

Medication is increasingly considered as an additional support for those seeking help with out-of-control sexual behaviour. The aim of medication in terms of sexual addictive behaviour is to reduce the sexually compulsivity and improve control. A number of medications such as antiandrogenic, naltrexone as well as anti-anxiety drugs have been effective (Raymond, Grant & Coleman 2010, Fong, De La Garza & Newton 2005). Medical support is also sought from the sexual health clinic by those with sexual disease such as STIs and HIV, which are allegedly a common consequence of sexually addictive behaviour. Goldmeier & Petrak (2011) say that while anecdotal evidence exists about an increase of clinical presentations, it remains controversial especially when
sexual behaviours that are considered normal are being medicalised.

Additional supports such as literature, the Internet, legal and vocational supports can be used Giugliano (2009). Supplementary support is discussed in terms of partner or family therapy. Attention regarding the needs of specific populations such as women or homosexuals may be required within clinical settings. The supports are frequently perceived as being complementary and used simultaneously. The concept has been considered beneficial by some (Pincu 1989) while others such as Peele (1989) claim that the concept of sexual addiction is perpetuated by a self-serving addiction industry and conveniently supported by the psychotherapeutic profession.

2.4.8 Therapeutic Challenges

Despite the fact that the concept of sexual addiction is viewed as a social construction by many there are specific therapeutic challenges identified particularly observed within a clinical context. These include issues such as professional competence, the therapeutic relationship, transference and counter transference and legal dilemmas. The client-professional relationship is particularly difficult for those who are managing problematic sexual behaviours and dealing with issues such as boundaries and appropriate behaviour (Griffin-Shelley 2009). Herring (2001) notes that for many professionals this is a relatively new area and one that needs attention in terms of personal comfort, sexual values, cultural bias and professional skill. He suggests the use of continuing professional education and supervision. Additional legal challenges such as child sexual abuse, the transmission of HIV among others will emerge in this work. The acquisition of sufficient knowledge in order to deal with complex areas such as child pornography among others and to offer supportive care and to avoid the distribution of inaccurate information is necessary (Samenow 2012).

The concept of sexual addiction contains specific challenges for members of different populations who encounter this issue, such as those who identify as being gay or bisexual. Weiss (2002) argues that it is beneficial for treatment providers to possess an understanding of issues such as socio-cultural factors, homophobia and HIV status. Other specific populations such as females, substance users, or professionals who deal with sexually addictive behaviours may also require specific attention. Despite the legitimate concerns associated with clinical practice the concept of sexual addiction remains a contested issue perceived by many as a ‘pseudo-scientific’ notion sustained by the self-interest of the therapeutic industry (Levine & Troiden 1988).

2.4.9 Distinguishing ‘Sexual Addiction’ and Normal Sexuality

Consensus is extremely difficult to reach regarding the concept of normal and abnormal sexuality. Over the years ‘abnormal’ sexuality has been described as deviant, perverse, atypical and more recently addictive. The difficulty in reaching a universal consensus regarding normal sexuality is associated with the fact that sexuality is significantly influenced by personal preference, cultural, historical, religious, and medical values, among others which have shaped attitudes, behaviours
and expectations regarding sexuality (Hyde & DeLamater 2010). Bullough (1980)’s expansive description of sexual norms and behaviour across different cultures, religions and historical periods serves to highlight the difficulty and futility of defining any sexual behaviour as normal or abnormal. Sexual normality is relative and it changes over time as it is influenced by a range of factors such as religious, medical, legal, social and cultural among others. In some cultures atypical sexual behaviour is perceived as a personal quirk which is usually tolerated. In other instances atypical sexual behaviour is designated as sinful, sick or illegal by institutions such as the religious, medical and legal professions respectively. The acceptability of sexual behaviour often depends on the level of rigidity or permissiveness operating within a society at any given time. Homosexuality was once labelled in the DSM-II as a psychiatric illness (Mayes & Horwitz 2005), deemed an immoral act and listed as a crime in Ireland until 1993 (Inglis 2005). The understanding of homosexuality has changed considerably in recent years and this example of change is often cited as an illustration of the transitory nature of the concept of sexual normality (Haeberle 1983).

In Western civilisations, the norm regarding sexual behaviour was predominantly defined by the Christian Churches who maintained a moral monopoly on sexuality for centuries. Normal sexual behaviour according to writers such as St. Augustine and St. Aquinas consisted solely of penile-vaginal intercourse between husband and wife for the purpose of procreation (Bullough & Bullough 1995). In modern history, the influence of the Church regarding sexuality has lessened and the understanding of sexuality is influenced by disciplines such as psychology, anthropology and biology among others. As a result sexual behaviour is more commonly understood in terms of a psycho-medical perspective and noticeable by the fact that sexual behaviour that was once considered sinful is now labelled as pathological or sick (McAnulty & Burnette 2003). The medical labelling of sexual behaviours is most observable in manuals such as the DSM which in the 1950s began to categorise sexual behaviour in terms of sexual deviations, an issue that remains a source of controversy (Lev 2006). More recently the medical approach describes abnormal sexual behaviour as psychosexual disorders and classifies them as paraphilias as outlined in the current DSM-IV-TR (American Psychiatric Association 2000). In addition to the medical perspective, Hyde & DeLamater (2010) identify a number of other approaches used to distinguish normal and abnormal sexual behaviour. The statistical approach suggests that any sexual behaviour that is rare and not commonly practised is abnormal. The sociological approach determines sexual behaviour as normal based on the dominant societal norm which offers a culture specific definition of normality. Abnormality has also been viewed in terms of Buss (1966)’s psychological criteria of discomfort, bizarreness and inefficiency. Historical and cross-cultural studies demonstrate the negative repercussions of designating atypical sexual behaviours as abnormal (Haeberle 1983). Nonetheless, it is noted that a general agreement exists which views non-consenting as abnormal and illegal (McAnulty & Burnette 2003). Caution is required when determining normal or abnormal sexual behaviour. Unusual or atypical sexual behaviour is determined by a multitude of
influences which do not determine that the behaviour is abnormal.

The question of what constitutes normal and abnormal behaviour emerges explicitly and implicitly with the concept of sexual addiction. The concept of sexual addiction is frequently described in terms such as pathological, out-of-control, excessive, maladaptive, and socially deviant among others (Carnes 1983, Kafka 2010, Woody 2011). This description indicates the presence of an underlying social construct designating certain sexual behaviours as normal and others as abnormal. The concept of abnormality is further associated with sexual addiction by the commonly held belief, particularly among treatment professionals, that sexually addictive behaviours can be normalised by engaging in some type of therapeutic assistance (Briken et al. 2007). The proponents of the concept of sexual addiction are accused of promoting a sexuality that is defined by the dominant socio-cultural norms. In many instances sexual behaviours that deviate from the culturally accepted standards are perceived as 'abnormal' and are inaccurately labelled as sexually addictive (Levine & Troiden 1988). The concept of sexual addiction is perceived as being aligned with the values of religious and social conservatism. This results in an attitude which perceives heterosexual relationships in a monogamous, and preferably long-term committed relationship, as being most desirable and normal (Rubin 1999) and by implication all other expressions of sexuality are abnormal. The concept of sexual addiction is identified as a stigmatising label created to describe atypical behaviour that incorrectly designates it as abnormal and deviant (Levine & Troiden 1988). Proponents of the concept of sexual addiction defend such accusations by claiming that sexual addiction is not defined by the type or frequency of the behaviour but rather by the individual’s motivation and the consequences of the behaviour on the individual’s life (Goodman 2001). Advocates of the concept argue further that sexual addiction does not refer to specific sexual orientations or to particular religious or social values (Finlayson, Sealy & Martin 2001). It is counter-argued that the lack of agreed criteria and a definition can result in the misinterpretation of an individual’s behaviour and the inaccurate promotion of the concept by interest groups. The inaccurate labelling of this concept attaches negative connotations to those who engage in non-conforming sexual behaviours (Coleman 1986) and results in deeming them and their behaviour as abnormal.

Determining normal sexual behaviour is challenging especially for those who seek to understand out-of-control sexual behaviour. This is particularly obvious in situations where there is a clash of socio-cultural and religious values influencing the individual’s attitudes and behaviours (Levine 2010). Understanding problematic sexual behaviour involves learning how to accept and deal appropriately with one’s sexuality. It also entails investigating and dealing with underlying or related issues regarding sexuality (Finlayson, Sealy & Martin 2001). The conundrum continues in terms of what the self-defined sexual addict and the treatment provider should aspire to in order to create a healthy sexual life. It is commonly understood that distinguishing normal and abnormal sexual behaviour, except in a subjective way, is not possible (Orford 1978). Many professionals are guided by Kinsey’s 1948 suggestion that the terms normal and abnormal do not accurately
2.4. 'SEXUAL ADDICTION'

capture the complex nature of sexuality and that sexual behaviour is better understood in terms of a continuum (Hyde & DeLamater 2010).

The concept of sexual addiction particularly viewed from a treatment perspective is focused on the reduction of the risk typically associated with the negative consequences (Carnes 1991). In contrast to the traditional recommendation of abstinence associated with substance use (Ferentzy 2001) this is not the case with sexual addiction. Instead sexuality is understood to be an integral aspect of the human person and therefore the goal for those who experience out-of-control sexuality is to learn how to remove or reduce the symptoms so as to manage their behaviour. Additionally, it is expected that the long-term goal is to assist the individual to develop a new capacity in psychosexual functioning (Coleman 2003). Despite the lack of consensus regarding the validity of the concept it is increasingly observed, especially in clinical practice, that harm reduction strategies are being recommended to lessen the variety of personal and public health negative consequences associated with sexual addiction (Goldmeier & Petrak 2011, Grov, Parsons & Bimbi 2010). Currently the harm reduction philosophy and practice in relation to psychoactive drug use and 'safer sex' share a common approach. Advocates of both of these matters approach their topic from a respectful and non-directive standpoint, not attempting to dissuade clients from certain patterns of behaviour to which they seem devoted, but merely working with them pragmatically to try to ensure that risk of harm - to self and/or others - is reduced.

2.4.10 Alternative Explanations for Out of Control Sexual Behaviour

Excessive or out-of-control sexual behaviour may not necessarily indicate the existence of a sexual addiction despite the presence of similar characteristics which are typically associated with Carnes’s model of sex addiction. The out-of-control sexuality may be a manifestation of some underlying or co-morbid conditions which, when treated, eases the condition and regularises the sexual behaviour. Out-of-control sexual behaviour has been associated with a combination of factors such as physiological, psychological and social (Chughtai et al. 2010).

Conditions such as dementia, frontal lobe dysfunction and endocrine conditions are associated with dysregulated sexuality (Finlayson, Sealy & Martin 2001). There is also a strong association between depression, shame, impulse-control and out-of-control sexuality (Kafka 2010, Kafka & Hennen 2002). In addition, sexually addictive behaviour is associated with head traumas and invasive surgery (Mendez & Shapira 2013, Samenow 2010, Chughtai et al. 2010). Hypersexuality is also associated with personality disorders, hypomania and developmental delay (Cantor et al. 2013). Finlayson et al. (2001) state that, given the range of possible causes for out-of-control sexual behaviour, it is necessary to undergo a comprehensive examination in order to determine accurately the exact nature of the behaviour being expressed.

Out-of-control sexual behaviour may indicate a mechanism to deal with a multiplicity of psychological needs such as emotional health, loneliness and low self-esteem (Torres & Gore-Felton 2007).
CHAPTER 2. LITERATURE REVIEW

It is also associated with poor attachment style in childhood which may result in the pursuit of sexual relationships without emotion or affection, or a craving for validation sought through multiple sexual partners (Bowlby 1973). Additionally, Cantor et al. (2013) argue that excessive sexuality is also associated with avoidant personality disorder, chronic adultery and sexual guilt.

Excessive sexual behaviour is also a feature associated with substance use (Washton & Boundy 1990). Sexual activity often declines during substance use and frequently returns when the substance use is ended. In these circumstances, excessive sexuality may merely indicate the challenge experienced by recovering substance users to negotiate their normal but unfamiliar sexual drive. Furthermore, excessive sexual behaviour may also represent compensatory behaviour for the loss of the individual’s substance. Coleman (1988) claims that sexuality is not frequently discussed in substance use recovery and says that the failure to deal with it among those recovering from substance use can be damaging to long-term recovery. Siegel (2011) suggests that sexuality can be addressed with individuals recovering from substance use in terms of sexual health and be presented as a factor which will enhance recovery and protect against relapse.

High risk sexual behaviour is also commonly associated with childhood sexual trauma, and is a common consequence of sexual abuse (Metzger & Plankey 2012) as previously discussed. As a consequence of sexual abuse, the individual may perceive sex as the only way to be loved and repeatedly pursue it without achieving intimacy fulfilment. Additionally, the sexual behaviour may be a way of re-enacting or resolving the childhood sexual trauma which over times develops into an addictive pattern (Parsons et al. 2008).

In some populations a pattern of non-relational sex, involving multiple partners without any commitment, often viewed as a sexual addiction and which, is a feature particularly among younger individuals, may be indicative of ongoing human and sexual development (Owen et al. 2010). Furthermore, the concept of sexual addiction is often used as an excuse for some individuals to explain or seek pardon for their unacceptable sexual behaviour (Ley 2012).

Out-of-control or excessive sexual behaviour may not necessarily represent what Carnes allegedly identifies as sexual addiction. Instead they may indicate a variance of unrelated phenomena in need of different interventions (Cantor et al. 2013).

2.5 Critique of the Concept of ‘Sexual Addiction’

The concept of sexual addiction has grown in popularity since the 1980s and the contested topic remains a subject of growing interest particularly within the social sciences, medical and therapeutic literature. The topic has also generated much criticism and is frequently viewed as a social construction, a result of the medicalisation of society and an expression of morality.
2.5. CRITIQUE OF THE CONCEPT OF 'SEXUAL ADDICTION'

2.5.1 The Social Construction of ‘Sexual Addiction’

The concept of sexual addiction, as previously discussed, is perceived, especially by social scientists as a social construct rather than a clinical entity. Foucault (1990, p.33) argues that the construction of the sexual universe is the product of 'a multiplicity of discourses produced by a whole series of mechanisms operating in different institutions'. Sexuality is continually influenced by factors such as history, politics, religion, psychiatry and other socio-cultural dynamics. In Western societies religion and the family are generally viewed as the primary sources of social control, providing a set of predefined expectations and behavioural norms which influence the individual's sexuality (DeLamater 1981). Once conformity becomes the measure of normality, it determines that those who depart from the socially agreed designated norm are automatically vulnerable to being labelled as deviant or diseased (Levine & Troiden 1988).

The concept of sexual addiction is understood in terms of 'a historical character constructed from the sexual ambivalences of a particular era' (Inglis 2005, p.429). The concept became a popular therapeutic diagnostic label facilitated by a number of influential socio-cultural factors, especially the sexual revolution and counter-revolution, resulting in the invention of a 'cultural narrative' popularly accepted as a behavioural addiction to sex (Irvine 1995, p.431).

The anti-sex culture of the 1980s created a conducive environment to 'repathologise forms of erotic behaviour that became acceptable in the 1960s and 1970s' (Levine & Troiden 1988, p.349). The designated behaviour in itself is not pathological but it is behaviour that is no longer viewed as acceptable in a culture that has abandoned the recreational script of sexuality and which has become hostile towards all forms of non-traditional sexuality. This reflects what Rubin (1999, p.151) describes as 'a hierarchical system of sexual value', where a caste system exists placing married heterosexuals with a procreational purpose on top of the erotic pyramid while the unacceptable sexual behaviours are designated as disorders. Consequently, value laden concepts like sexual addiction emerge. Such concepts are defined by the dominant cultural norm which, according to Gagnon (2004), becomes the source of determining whether sexual behaviours are perceived as normal or deviant. It is viewed as a social construction which threatens civil and sexual rights and denies the legitimacy of the unconventional sexuality.

2.5.2 ‘Sexual Addiction’ and the Medicalisation of Society

The development of the concept of sexual addiction was further helped by the increasing medicalisation of sexuality which marked a cultural shift away from the moral towards the medical perspective on sexuality (Tiefer 2007). Traditionally sexuality was controlled by religious institutions who prescribed acceptable and unacceptable behaviours in terms of morality and sin. Irvine (1995, p.430) believes that with the decline of the religious institutions the medical profession 'usurped' the moral authority of the church regarding sexuality. Rather than creating increased
sexual freedom, the medical community has created a multiplicity of diagnostic categories and psychosexual disorders, including the concept of sexual addiction. The result of the shift is that sexual behaviours that were once designated as immoral are now labelled a disease (Hart & Wellings 2002).

The medicalisation of sexuality is increasingly noticeable with issues such as erectile dysfunction or premature ejaculation (Tiefer 1996). Horwitz (2002) criticises the increasing list of psychosexual disorders in the DSM augmented by Kafka (2010)’s proposal to include ‘hypersexuality’ as a disorder in the forthcoming DSM-V. Tiefer (2000) complains that there is an excessive medicalisation of sexuality often motivated by the self-interest of the pharmaceutical industry which offers generous funding and professional opportunities in return for drug development and marketing. This has resulted in the development of a system of diagnostic classifications designating healthy and unhealthy sexuality and resulting in a reductionist perspective of sexuality. The medicalisation of sexuality is also observable within the field of addiction medicine, and noticeable in the popular acceptance of the concept of sexual addiction as a behavioural addiction. The medical dimension of sexuality was further affirmed as the concept of sexual addiction developed within the 12-step movement, based on the pre-existing model of AA, where claimants understand their behaviour in terms of the medical model of addiction (Irvine 1995). Furthermore, professional interest began to grow in the concept of sexual addiction which became a significant force in advancing the concept, clinically, ideologically and academically. Thus, the concept of sexual addiction has gradually developed and has become more acceptable, among some, as a treatable condition. In recent years, a successful sexual addiction industry has grown and currently provides a multifaceted treatment package for sexual addiction. The attachment of the addiction label to sexual behaviour is viewed as a cynical strategy created by an ever expanding addiction industry seeking to increase its own therapeutic self-interest (Reay, Attwood & Gooder 2013). Peele (1999) views those involved in the promotion of sexual addiction as ‘zealots’ of the recovery culture who are responsible for the diseasing of sexuality. The concept lacks scientific validity, negates personal responsibility, and promotes sex-negativity.

The concept of sexual addiction has facilitated the redefinition of sexual behaviours from a moral perspective to a medical one. Behaviours once considered morally deviant, are now viewed as a treatable disease (Irvine 1995). Zola (1972)) warns that while this new medical explanation is presented as being morally neutral, medical language frequently masks a combination of moral and social judgments which echo’s Szasz (1991)’s thoughts who stated that psychiatry in particular could stigmatise people with moral judgments and camouflage them as authentic diagnoses.

2.5.3 ‘Sexual Addiction’ or a Moral Construction

The concept of sexual addiction has been perceived as a moral label rather than an authentic scientific entity (Levine & Troiden 1988). During the 1980s when the concept of sexual addiction emerged, opposing moral perspectives were competing. The liberals sought to retain their sexual
freedom whereas the conservatives sought to reclaim traditional family values which they perceived were lost due to the immoral promiscuity of the sexual revolution. As a reaction, the morally objectionable behaviour of the 1960s was labelled as a sexual addiction. Furthermore, the emergence of the concept of sexual addiction happened during a period in which the traditional religious institutions declined resulting in a moral vacuum. In the absence of these religious institutions, which previously guarded sexual morality, a new structure emerged in the form of a number of right wing religious movements which rose in parallel with the emergence of a new political conservatism (Irvine 1995). These movements represented a growing population who challenged the ethos of sexual liberalism. The concept of sexual addiction mirrored the conservative philosophy of these movements and consequently, the concept was further recognised and as a result was culturally affirmed. The religious-based moral undertones are noticeable in some of the treatment programmes available for sexual addiction particularly among evangelical Christians, such as the one entitled, ‘Every Man’s Battle’, who view sexual addiction in terms of a battle against lust and who often perceive homosexuality as disordered (Edger 2012). Another moral endorsement of the concept of sexual addiction came through a feminist movement during the 1970s who advocated for social purity (Reay, Attwood & Goode 2013). They believed that sexuality is a primary source of women’s victimisation and view sex as dangerous and so it gave credence to the concept of sexual addiction with which it shared a moral ideology to promote the dangers of sex (Irvine 1995). Furthermore, Giles (2006) claims that the application of the pejorative label of sexual addiction to describe non-traditional sexual behaviour stigmatises sexuality which is deemed morally unacceptable. This is confirmed by the fact that the majority of the designated sexual behaviours viewed as potentially addictive, are behaviours not typically associated with procreation or relational commitment such as masturbation or anonymous sex. Therefore, the concept promotes the procreative morality of the Judaeo-Christian and as a result the recreational script of sexuality is rejected. Similar conflicts have been evident in Ireland, regarding sexuality and morality and are largely associated with the Roman Catholic Church and typified by sexual repression, sin and negativity (Inglis 2005).

2.6 Conclusion

The literature reviewed has clearly shown that across history and across cultures the subject of human sexuality has been a contentious one, with the dominant religious traditions presenting a consistent moral view of sex as primarily procreational with the main emphasis being put on monogamous heterosexual behaviours which are linked to procreation. Consequently the concept of recreational sex within the Christian context has generally been viewed as sinful. The medical community, while using different terminology, has adopted a similar and equally negative view of sexuality resulting in the description of out-of-control sexuality in terms of a disease rather than a sin.
More recently, new scholarship, in the context of constructionism presents the possibility of viewing sexuality within a historical and social context. The social analysis of sexuality recognises that societies establish social systems which control and regulate sexuality. Sexual hierarchies emerge and behaviours, desires and identities are classified as normal, healthy or moral. Other sexualities are stigmatised as abnormal, unhealthy and immoral. In Western societies the primacy of married reproductive heterosexuality is valued and all other forms of sexual behaviour are relegated. This hierarchal system was challenged by the sexual revolution of the 1960s which celebrated a multiplicity of non-traditional sexualities.

As a reaction to the sexual revolution which was associated with the alleged moral decline of society, a new coalition of moral and political radicals emerged and formed a sexual counter-revolution expressing their dissatisfaction with the liberal sexual agenda. The literature has shown that during this socio-historic climate in the 1980s a movement emerged to describe, what was perceived by some as, out-of-control sexual behaviour as an addiction. Whether the idea of sex addiction is more or less scientific than that of addiction to psychoactive drugs is a moot point, but it can be expected that the empirical findings of the present study will reflect these debates and controversies.
Chapter 3

Methodology

3.1 Introduction

The aim of this research was to gather detailed information on how two different sets of actors (those who self-identify as sexual addicts and those involved in treating sexual addiction) conceptualise the phenomenon of sexual addiction. The specific objectives were to investigate: 1) how they understood the aetiology of sexual addiction; 2) what they perceived the main symptoms and lifestyle elements of this alleged condition to be; 3) how they viewed recovery and the role played by formal treatment or rehabilitation systems in the recovery process. The three objectives of the study provided a thematic framework into which the data was organised and which became the finding chapters namely the origins and development of sexual addiction, secondly, the lived experience of sexual addiction, and thirdly, the treatment and recovery from sexual addiction.

This chapter outlines the process by which the research project was undertaken. The theoretical context and the methodology used are explained. The process of recruitment, data collection and data analysis are explained and provide the primary framework for investigating the concept of sexual addiction. Specific attention is given to issues such as ethics, research subjects and the limitations of this study.

When undertaking this study the two major paradigms, the quantitative and the qualitative approaches, each with their own distinctive advantages and limitations, were considered (Creswell 1994). Much research in the area of the social sciences has traditionally relied on the quantitative method (McLeod 2001) because of its reputation for having high scientific validity (McLeod 2001). In terms of this study, the quantitative method has limitations such as the element of reductionism which might result in a partial view of the concept of sexual addiction being revealed. The study might be further limited by the standardised measuring techniques associated with quantitative research. These might lack the flexibility for in-depth, holistic and explanatory research which is required in this instance. After consideration of the options, it was decided that a qualitative
method, which seeks to understand human behaviour and the meaning attached to it (Neale et al. 2013), was best suited to pursue the aims of this study.

3.2 Rationale for the Qualitative Approach

Denzin & Lincoln (1994)'s definition of qualitative research provides the context in which this study on sexual addiction was methodologically located.

‘Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret the phenomena in terms of the meanings people bring to them.’ (Denzin & Lincoln 1994, p.2)

The decision to choose a qualitative method of enquiry was based on a number of factors such as the nature of the research topic, the researcher's work experience and the philosophical nature of the qualitative approach. The topic, which largely originated in the USA and which remains contentious there and everywhere else, is under-researched in Ireland and will benefit from the use of a qualitative method, ensuring a comprehensive investigation. As the aims and objectives suggest, this project was investigative, descriptive and inductive which lends itself to a qualitative approach (Morse 1991). Given the sensitivities associated with sexuality in general and sexual addiction in particular, it was reasoned that the qualitative approach might be more beneficial for the research of individuals whose lived experiences were likely to be painful or embarrassing (Bunin et al. 1983). The qualitative approach provided the opportunity to gain new insights and provide in-depth information on a highly complex topic. Another motivation for choosing a predominantly qualitative methodology reflects my pastoral work and professional training as a psychotherapist. The dynamics of ministry and counselling are similar to qualitative methodologies and aim to understand the individual's world and environment. The qualitative approach was also chosen because it provides a forum to listen directly to the research subjects. This generates knowledge of the concept in a manner that is local and contextualised and concurs with the philosophy of qualitative research (McLeod 2003). This more grounded phenomenological approach will 'provide rich context bound information' (Creswell 1994, p.7), given the study's aim to acquire in-depth information about sexual addiction from a small group of people instead of drawing from a large representative sample of the entire population. Like all methodological approaches, a qualitative perspective has limitations. It is often perceived as soft data and has been referred to as 'an assembly of anecdotal and personal impressions strongly subject to researcher bias' (Mays & Pope 1995, p.110). Despite some of the justified criticisms, qualitative methods have become more acceptable within the social sciences over the years (Barker, Pistrang & Elliott 2002) and in this study produced a comprehensive data set on the concept of sexual addiction. Within the qualitative tradition further choices were required in terms of choosing a specific theoretical framework to guide
this study on sexual addiction such as grounded theory, ethnography and phenomenology among others. The phenomenological perspective was chosen as it is the systematic study of people's experiences, (Barker, Pistrang & Elliott 2002) and this study is about the experience of sexual addiction. As Husserl (1859-1938) developed this concept of phenomenology, he maintained that experience must be studied from the perspective of the first person and understood within the context of the individual's life, often referred to as their 'lifeworld'. In the phenomenological tradition the notion of ‘multiple perspectives’ are central (Barker, Pistrang & Elliott 2002). This means that sexual addiction will be experienced differently by every person and even differently by the same person in different circumstances. This study generated explanations of the individual’s purpose and meaning of sexual addiction which are key traits of the phenomenological approach (Giorgi & Giorgi 2008). In addition to the phenomenological approach the study was informed by two analytical perspectives. Initially Interpretative Phenomenology Analysis (IPA) was the primary methodology proposed for this study, even though IPA is associated with smaller samples (Smith 2004). When the number of research subjects reached over 50 in this study it was suggested that an additional methodological perspective might be valuable. As a result Thematic Analysis (TA) was employed to inform the study further. Both of the methods used will be discussed in detail in the section regarding data analysis later in this chapter.

3.3 Sampling and Recruitment

3.3.1 Recruitment of Research Subjects

The recruitment of research subjects happened in a number of specific ways. The primary source of recruitment resulted from contact with a range of professional organisations and individuals working in areas such as counselling, sexual health, addiction treatment and social work. These organisations were known to the researcher from his knowledge and experience of the counselling systems in Ireland. Initially information leaflets, designed separately for treatment providers (Appendix B) and self-identified sexual addicts (Appendix C), explaining the study, were sent to treatment providers as an initial call for research subjects. The preliminary response included treatment providers who agreed to participate as research subjects. Other individuals and organisations were prepared to identify potential research subjects, facilitate the recruitment of research subjects and act as 'gatekeepers'. Additionally, some individuals and organisations agreed to publicise the study among colleagues and acquaintances.

Another significant source of recruitment happened as a result of some of the organisations, who responded to the call for research subjects, requested a formal presentation of the study for their employees. This resulted in the researcher presenting the study at two medical conferences, two counselling agencies and one addiction centre, for the purpose of recruitment. These presentations included an overview of the study and focused on issues such as eligibility to participate, practical
requirements and ethics. The formal presentations led to direct interpersonal contact between the researcher and a range of treatment providers. It provided an occasion for potential research subjects and gatekeepers to clarify issues. The presentations provided an opportunity to discuss the ethical framework, particularly confidentiality, a key issue in terms of recruitment in this study, which is further discussed in the ethics section later in this chapter. The presentations led to the development of a networking forum which facilitated the direct recruitment of treatment providers and the indirect recruitment of sexual addicts.

The recruitment of sexual addicts was slower than the treatment providers but increased due to a number of specific factors. Firstly, after the formal presentations of the study, some organisations such as counselling agencies, sexual health clinics and addiction centres publicised the study among service users which resulted in the recruitment of sexual addicts. Furthermore, two organisations who received a presentation provided space in their premises for me to interview self-identified sexual addicts. These facilities were used over a four month period when necessary and added significantly to the recruitment process. Another factor that expanded the recruitment of sexual addicts was the use of peer recruitment especially among those who were known to each other through their shared interests in 12-step fellowship groups or therapeutic programmes. Peer recruitment involved a process of giving each research subject, at the end of their interview, information leaflets about the study to distribute (Appendix B and C). Furthermore, each sexual addict was asked to contact others who might be interested in participating, a practice used in previous studies (Johnston et al. 2010). Recruitment of sexual addicts was further increased through a small number of treatment providers and sexual addicts who emerged and acted as ‘gatekeepers’. They used their knowledge and experience to facilitate contact with sexual addicts and the researcher, a technique which has been used to access hidden populations in previous studies (Saunders 2012). As the study developed the entire recruitment process expanded significantly through snowball sampling as research subjects recommended the study to colleagues, agencies or acquaintances, as observed in other research (McElrath 2005). Recruitment has also happened as a result of the researcher presenting the study at various professional conferences. The recruitment resulted in the participation of 101 individuals in one-to-one interviews, consisting of 55 treatment providers and 46 sexual addicts. A profile of the research subjects is given in Appendix D.

3.3.2 Selection of Research Subjects

The process of selecting research subjects involved naming the target population, choosing the sampling procedures and determining the sample size. Given the nature of the topic being investigated a homogeneous sample, which was narrowly defined, was adopted in this study which is expected to produce a more focused study (Barker, Pistrang & Elliott 2002). As a result the target population was designated to include one group of self-identified sexual addicts and one group of treatment providers involved in treating sexual addiction. Recruitment criteria were formulated
and it was deemed essential that the treatment providers would be professionally accredited within their own profession. In terms of the sexual addicts it was required that all research subjects were adults, (18 years and older) and report dealing with sexually addictive behaviour. It was seen as beneficial that the sexual addicts had an interest in seeking help or be in recovery from sexual addictive behaviour. Having established the target population and the basic criteria, the sample was chosen. Purposive sampling was used which involved deliberately selecting research subjects on the basis of their relevance to the research project (Mason 2002). Additionally, convenience sampling was utilised and research subjects who met the essential criteria, and who were willing, available, voluntary, and accessible were chosen. In preparation for active recruitment an information pack, designed separately for treatment providers (Appendix E) and sexual addicts (Appendix F), was prepared including the study aims, the criteria for eligibility, the ethical guidelines and a consent form. After the initial research subjects were recruited snowball sampling and peer recruitment were used to increase participation. After agreeing to participate each individual was given the information pack. Questions and concerns were discussed and plans were made to meet formally for an interview.

3.3.3 Research Subjects

101 research subjects participated in individual interviews in this study. 46 (46%) were self-identified sexual addicts and 55 (54%) were treatment professionals. 36 (78%) of the sexual addicts were male and 10 (22%) were female. Half of the sexual addicts described themselves as heterosexual, 18 (39%) as homosexual and two (4%) as bisexual. Sexual addicts ranged between the ages of 21 and 60. 31 (67%) of the sexual addicts claimed to have experienced other types of addiction, typically alcohol, psychoactive drugs and gambling. Over half of the sexual addicts suffered from some type of mental health issue and 19 (41%) experienced child sexual abuse. Sexual addicts described themselves, almost evenly, as coming from middle and lower income families. 27 (59%) sexual addicts completed third level education and the majority was employed. 33 (72%) of the interviews with sexual addicts were based in Dublin and 13 (28%) were based elsewhere in Ireland. 40 (87%) of the sexual addicts were Irish citizens with the exception of six individuals, living in Ireland, but who are native to England, Spain, America and Canada. Additionally, some Irish sexual addicts discussed their experiences in countries outside of Ireland which accounts for references not related to Ireland in the study. 27 (59%) sexual addicts participated in recorded interviews and 19 (41%) chose to participate in non-recorded interviews.

The treatment providers were experienced in a variety of treatment environments, within the areas of sexuality, counselling and addiction. Their employment positions were categorised in terms of psychotherapists, psychosexual therapists, medical consultants, nurses, social workers, practice managers, policy advisers and project workers. Furthermore some of the professionals had considerable experience in medical research, legislation and policy regarding sexuality and
addiction. A fuller description of the treatment providers and their areas of professional expertise is in Appendix D. In addition to their work experience in Ireland, some had also worked in America and England which accounts for references in the study to situations outside of Ireland. The treatment providers are Irish with the exception of two who are native to Germany and America but who worked in Ireland. 26 (47%) of the treatment providers are male and 29 (53%) are female resulting in an overall gender ratio of 60:40 male to female. Treatment providers ranged between the ages of 35 to 62. 39 (71%) of the treatment providers interviewed were located in Dublin and 16 (29%) located throughout Ireland. 38 (69%) treatment providers participated in recorded interviews and 17 (31%) participated in non-recorded interviews.

3.4 Data Collection Procedures

The data collection techniques were purposefully chosen in relation to the aims of the research project and were compatible with the method of data analysis used in this project (Willig 2008). The aim of this research was to gather detailed information on how two different sets of actors, those who self-identify as sexual addicts and those involved in treating sexual addiction, conceptualise the phenomenon of sexual addiction within an Irish context. The specific objectives were to investigate: 1) how they understood the aetiology of sexual addiction; 2) what they perceived to be the main symptoms and lifestyle elements of this alleged condition; 3) how they viewed recovery and the role played by formal treatment or rehabilitation systems in the recovery process. In advance of the formal study a pilot study was undertaken. The data from the pilot study was used to inform the overall feasibility and structure of the study and not used in the findings chapters. The pilot study was followed by the primary data collection procedures which were focus groups, semi-structured interviews and questionnaires outlined in Table 1 below. The data from these provided the main source of data for the findings chapters.

3.4.1 Pilot Study

The pilot study consisted of four treatment providers and five self-identified sexual addicts. The treatment providers, known to the researcher from his knowledge and experience of the counselling systems in Ireland, were recruited from counselling and addiction organisations. The sexual addicts were recruited through the help of treatment providers who had access to sexual addicts. The pilot study was conducted to determine the intelligibility of the proposed project and the overall feasibility of the study. The research subjects were given the proposed aims of the study, and the interview questions, and asked to examine the study regarding the format, the content and the suitability of the interview questions. The pilot study provided objective feedback regarding the entire process including issues such as the length of time required in setting up, conducting and concluding interviews. The pilot study examined the proposed interview questions and drew
### Table 3.1: Data Collection Process

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Aim</th>
<th>Participants</th>
<th>Data Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Study: pre-data collection activity</td>
<td>To determine the feasibility of the study</td>
<td>4 Treatment providers</td>
<td>Data were used to inform the development of the study</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Sexual Addicts</td>
<td></td>
</tr>
<tr>
<td>Focus Groups</td>
<td>To identify key issues and prioritise topics for individual interviews and questionnaires</td>
<td>4 Focus Groups (a-d)</td>
<td>Data were used to guide the structure and used in the findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) 6 treatment providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) 4 female sexual addicts</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) 6 male sexual addicts</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) 2 male sexual addicts</td>
<td></td>
</tr>
<tr>
<td>Individual Interviews</td>
<td>To obtain a detailed understanding of the concept of sexual addiction</td>
<td>55 Treatment providers</td>
<td>Data were used as the primary source of the findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>46 Sexual addicts</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Total:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>101 individual interviews</td>
<td></td>
</tr>
<tr>
<td>Surveys</td>
<td>To collect demographic, medical, and social data and sensitive information</td>
<td>25 Treatment providers</td>
<td>Data were used as the primary source of the findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33 Sexual Addicts</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>58 individual interviews</td>
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</tr>
</tbody>
</table>
attention to ambiguity in some of the questions, identified language that was not easily understood and highlighted questions that were not relevant, a common research issue (Parahoo 1997). As a result of the pilot study the questionnaires and the interview structure were amended and refined. In addition, the pilot study evaluated the kind of information that was being gathered and ensured that it corresponded with the aims and objectives of the study. The recording of interviews was deemed a sensitive issue that needed clarification particularly regarding confidentiality. The importance of interviewing skills, such as listening and communicating, was highlighted given the sensitive nature of the research topic, as observed elsewhere (Denzin & Lincoln 1994). The pilot study also recommended the formation of two separate focus groups; one for self-identified sexual addicts and the other for treatment providers. Consideration was given to a combined group of research subjects but it was not pursued because some sexual addicts were not comfortable with that proposal. The pilot study also highlighted the potential difficulties regarding the recruitment of research subjects particularly the sexual addicts. The data from the pilot study was used to inform the overall feasibility and structure of the study and was not used in the findings chapters. After completion of the pilot study, preparations for the focus groups began.

3.4.2 Focus Groups

The initial recruitment of research subjects for focus groups was made by contacting a number of professional organisations such as counselling, sexual health and addiction treatment, organisations known to the researcher from his knowledge and experience of the counselling systems in the Dublin area. The call for focus group research subjects was accompanied by an information leaflet, designed separately for treatment providers (Appendix G) and sexual addicts (Appendix H), outlining the study and explaining the focus group. Recruitment resulted in the establishment of four separate focus groups which consisted of one group of treatment providers and three groups of self-identified sexual addicts. The focus group of treatment providers included six individuals working in the areas of counselling, sexuality and addiction. The focus group of female sexual addicts was convened by a female treatment provider who worked with this group of four women, and who acted as a gatekeeper in making contact between the group and the researcher. The male focus groups (consisting of six and two sexual addicts, respectively) were convened by treatment providers who established contact between the researcher and the sexual addicts. The reason why separate focus groups were established was due to the fact that a number of sexual addicts, in order to protect their anonymity, were not willing to participate with individuals that they did not previously know. Therefore, each focus group met separately. The primary purpose of the focus group was to identify key issues pertaining to the concept of sexual addiction and to prioritise areas of significance for individual interviews with research subjects. In advance of the focus group meeting the research subjects were given an information pack, designed separately for treatment providers (Appendix I) and sexual addicts (Appendix J), explaining the study and outlining the purpose and structure of
the focus group. The data collected informed the overall structure and content of the study and the data of the focus groups were used in the findings chapters.

The focus group meetings began with an overview of the study, and specifically focused on issues such as the purpose of the focus group, confidentiality and the signing of a consent form. Research subjects completed a questionnaire alone and participated in a group exercise and discussion. The purpose of the written questionnaire was twofold; firstly it provided a means of communicating information that was too sensitive to articulate publicly and secondly the written questionnaires were used as raw data which was retained by the researcher in the absence of the recordings as requested by some research subjects. The focus groups lasted two hours. Additional data was collected by means of notes taken by the researcher. The existence of a 'groupthink' mentality was observed in the focus groups. This was noted in terms of how some research subjects share attitudes and phraseology particularly among individuals who belong to the same profession or attend similar support groups. The groupthink dynamic, which can restrict the research conversation (Speziale & Carpenter 2011) highlighted the need for reflexivity on the part of the researcher. The resulting data from the focus groups identified key areas of research to be explored, and suggested the structure of the subsequent one-to-one interviews.

3.4.3 Semi-Structured Interview

One 101 research subjects completed one-to-one interviews. The one-to-one interview included a series of pre-formulated questions, designed separately for treatment providers (Appendix K) and sexual addicts, (Appendix L). The interview location was determined by professional and practical issues of availability, personal choice and ethics. The majority of the interviews were conducted in the researcher's office in Trinity College Dublin or in the research subjects' office. The motivation for using such locations was that they provided a semi-formal setting conducive to professional practice. 65 (64%) of the one-to-one interviews were recorded and later transcribed. Recording ensured that the individual experiences were reported as accurately as possible. As recommended by Pole & Lampard (2002) recording was carried out ethically with the full knowledge and permission of the interviewee. 36 (36%) research subjects were not recorded but completed a non-recorded spoken interview. Sexual addicts who chose not to be recorded were given a copy of the interview questions (Appendix M) in advance of the formal interview. They were asked to write out their responses and bring the written document to the interview which became the basis of their spoken interview with the researcher. The researcher's notes and the research subjects' written interviews were both retained as part of the data collection. Despite the benefits of semi-structured interviewing it is time consuming, practically difficult, expensive and emotionally tiring. During this study it was also observed that some research subjects are more articulate, comfortable and experienced with this type of interview and the topic than others. It is also noted that one-to-one interviewing is restricted by the fact that the information is filtered through the experience
of these individuals and their particular bias or value system. Incidentally, many research subjects reported that the research interview was a cathartic experience which was observed in previous studies (Edwards 1983, Lee 1993). The semi-structured interview achieved a detailed understanding of the concept of sexual addiction, a feature associated with the interview technique (McLeod 2003, Creswell 1994, Silverman 2005). The semi-structured interview provided an ideal opportunity for the researcher to listen to and hear individual research subjects speak about their lived experience. This kind of semi-structured interview facilitated the possibility of a more humane rapport and an empathic understanding between interviewer and interviewee. This was particularly useful when the topic being discussed included personal issues of a sensitive kind. The use of the semi-structured interview allowed the researcher the facility to monitor the relevance of the information being gathered as suggested previously (McLeod 2003). Furthermore, the semi-structured interview was compatible with the method of data analysis which was IPA and TA.

3.4.4 Questionnaires

In addition to the semi-structured interviews questionnaires were distributed to all of the 101 research subjects. 33 (72%) sexual addicts and 25 (45%) treatment providers completed questionnaires. The questionnaire was qualitative in style and contained a combination of open and closed style questions. It focused on issues such as the sexual addict’s family of origin, childhood, education, addictive behaviour, health, therapeutic support and spirituality. The questionnaire was given to all research subjects in advance of attending the one-to-one interview. They were asked to complete it before attending the individual interview and to bring it with them to the interview. The rationale for completing the questionnaire in advance of the interview was to give the research subjects an indication of the style and content of the one-to-one interview. It also ensured that the questionnaire was completed and returned efficiently. The questionnaire proved to be a practical method of collecting significant data especially from the sexual addicts in terms of demographic, medical, and family of origin information. The questionnaire was also a method of triangulation which added to the reliability of the research process. The questionnaire provided a proven method to communicate relevant information that was too sensitive to discuss during the one-to-one interview as suggested in previous works (Lee 1993). It was anticipated that the questionnaires would be more beneficial for the sexual addict and therefore they received an in-depth questionnaire (Appendix N) in comparison with the treatment professionals’ questionnaire (Appendix O). The questionnaires were analysed by using the software package Statistical Package for the Social Sciences (SPSS) which is a software package commonly used for statistical analysis in social science research.
3.5 Data Analysis

Data analysis primarily concentrated on the data arising from 101 individual interviews and 58 questionnaires. The data were analysed using a combination of manual techniques and computer
assisted programmes, namely Microsoft Excel and Statistical Package for the Social Sciences (SPSS) which are explained in later sections. The data arising from the focus groups were analysed immediately after the focus groups were completed as the primary aim of the focus groups was to inform the structure and focus of the study from the outset. Data analysis was largely influenced by two methods, namely Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin 2009) and Thematic Analysis (TA) (Braun & Clarke 2006). Both models are idiographic and remain true to the phenomenological nature of this study by exploring each research subjects' data in detail aiming to understand the specific experience of the individual before progressing to an understanding of the entire group. The aim of data analysis was to deepen the understanding of the concept of sexual addiction and to use the data to answer the original research questions (Pole & Lampard 2002).

3.5.1 Interpretative Phenomenological Analysis (IPA)
Interpretative Phenomenological Analysis (IPA) is a contemporary qualitative method founded by Jonathan Smith which shares the original aims of traditional phenomenological research in that it wishes to capture the quality and texture of individual experience (Willig 2008). Smith's model of IPA was chosen to ensure that the study went beyond the mere descriptive retelling of the research subjects' story. IPA facilitated an in-depth and analytical understanding of the concept of sexual addiction. IPA ensured that the collected data was comprehensively examined, a process that incorporated the descriptive, interpretative and analytical dimensions of phenomenology. Remaining true to the overall assumption in phenomenology, IPA in this study sought to understand the 'lifeworld' of the sexual addict and the treatment provider. This process began by applying the key IPA principals beginning with an interpretative engagement of the transcripts. The next phase involved the identification of themes, followed by the clustering of similar themes and the creation of a summary of the key themes. An immediate understanding of the concept of sexual addiction was gleaned by remaining connected to the original research question and close to the experiences of the research subjects in the data. A deeper understanding of the underlying issues was gained by developing an interpretative relationship with the data through the use of IPA (Smith, Flowers & Larkin 2009). The IPA approach concedes that all collected data is contaminated and that the collected data will always be tainted by the researcher's own perceptions (Smith 2004). Given that information, every effort was made to lessen bias and increase objectivity. The process of analysis was further helped by the use of Thematic Analysis (TA).

3.5.2 Thematic Analysis (TA)
Thematic Analysis (TA) is a method of examining, identifying, and recording themes in a data set (Braun & Clarke 2006). In this study TA was used to make sense of the research subjects' personal world and their experience of sexual addiction. Guided by the principles of TA the primary data set
for analysis was identified as data generated from individual interviews and questionnaires. It was noted that data from the focus groups, whose aim it was to inform the study at the outset were previously analysed. The use of TA facilitated an initial examination of individual transcripts in detail and subsequently a case by case analysis was undertaken. This idiographic approach (Braun & Clarke 2006) sought to understand the specific experience of the individual research subject before progressing to an understanding of the entire group. In this study TA was used both as a realist and constructionist method which allowed for the reporting of the individuals' experiences but also for analytical examination of how such experiences related to the wider issues operating in society. One significant feature associated with TA was the examination of the entire data set in order to identify common themes (Gibson & Brown 2009). In this study this resulted in a comprehensive process of cross-case analysis for both the sexual addicts and the treatment providers. The use of TA was also beneficial when analysing the commonalities across the two distinct populations regarding the concept of sexual addiction. TA was valuable in trying to understand and explore the concept of sexual addiction flexibly and in detail. The use of different methodological perspectives (Mason 2002), namely TA and IPA, highlighted different realities of the same concept and was a useful source of triangulation (Denzin & Giardina 2011).

3.5.3 The Analytical Process

The primary data set comprised of data generated from the interview transcripts and the questionnaires. The data were separated into two collections associated with the self-identified sexual addicts and the treatment providers. The interview transcripts were analysed first and after they had been completed the questionnaires were analysed. The data were analysed using a combination of manual techniques and computer assisted programmes, namely Microsoft Excel and Statistical Package for the Social Sciences (SPSS). The process of data analysis for the interview transcripts involved five distinct phases, described below. Throughout the first four phases the results were collated separately for the self-identified sexual addicts and the treatment providers. In the fifth and final phase of analysis the results for both groups were combined and resulted in the production of 25 Major Themes representing both groups. These 25 themes became the primary focus of discussion in this study (Appendix R).

The aim of phase one was to establish an initial coding system. This was achieved by a detailed reading and examination of each individual transcript. Each script was read systematically looking for significant comments, events and other noteworthy issues associated with the individual's experience. Notable words and phrases which meaningfully addressed the topic were highlighted in the transcript using fluorescent pens. In addition the researcher's thoughts or insights, emerging from reading the individual transcript, were written on the left hand side of the transcript. Quotable extracts were marked in the script by using the letter Q denoting quotation. After completing this initial process for the first transcript the researcher returned to the beginning of the same
transcript for further analysis. The written memos on the left hand side of the transcript and the words and phrases that were highlighted previously by fluorescent markers were refined and transferred to an Excel file which was created for each research subject. The 'data driven' extractions, pertaining to each research subject, were placed into the research subject's Excel file. The extractions were listed chronologically and numbered so that they could be easily traced back to their original location in case a full contextual understanding was later required (Braun & Clarke 2006).

This process resulted in the creation of Preliminary Themes specific to each transcript which typically numbered up to 100 themes per transcript. The next step involved a process of reducing the preliminary themes into thematic clusters. This happened by identifying patterns and relationships among the initial list of Preliminary Themes. Similar patterns were placed together on the basis of their shared meaning. After this process of reduction was completed a group of Clustered Themes emerged. Each Clustered Theme contained approximately eight themes and represented the contents of one interview transcript. Iterative analysis of this kind relies on the continual use of the researcher's interpretative skills while maintaining a vigilant adherence to what the research subject has said (Smith & Osborn 2008). This process resulted in a combination of interpretative and semantic content deemed meaningful by the researcher (Braun & Clarke 2006).

A second phase of analysis involved the process of cross-case analysis which was completed separately for the sexual addicts and the treatment providers. The value of cross-case analysis expanded the knowledge base and revealed significant patterns as observed by previous authors (Gomm, Hammersley & Foster 2000). The cross-case analysis entailed a totalling of the Clustered Themes, (described in phase one above), which were ascribed to each interview transcript. The cumulative result of Clustered Themes for the sexual addicts was 406 and 416 for the treatment providers. A further process of reduction was undertaken for both groups separately and resulted in a list of 22 themes for the sexual addicts and 19 themes for the treatment providers. These were called the Cumulative Themes.

The third phase of analysis examined the cumulative frequency distribution of the themes which was completed separately for the sexual addicts and the treatment providers. The process involved collating the total of the Clustered Themes (described in phase two above) which amounted to 406 for the sexual addicts and 416 for the treatment providers. Using Microsoft Excel these lists of themes were sorted alphabetically and the list was printed and analysed for frequency distribution. The process of clustering and collapsing results was employed. This resulted in two separate lists of the Most Frequently Used Themes which was 36 for the sexual addicts and 54 for the treatment providers. The themes were ranked from the most frequently used to the least. While numerical calculations did not definitely determine the themes for discussion, the list of most frequently used themes gives a clear indication of significant issues for both groups. The twin track approach which took account of both the cross-case cumulative summary of themes and a list of the Most Frequently Used Themes proved useful in that it prevented the themes being identified merely by frequency
3.5. DATA ANALYSIS

alone. It also allowed the researcher to comb analytically the data for infrequently mentioned but significant themes. The twin approach added a triangulation of methods and therefore increased the level of reliability to the analytical process.

The aim of the fourth phase of analysis was to create a separate set of Key Themes for each of the two groups, namely the sexual addicts and the treatment providers. This was the result of combining the Cumulative Themes and the Most Frequently Used Themes for each group separately. After a process of reduction was employed a list of 19 Key Themes emerges for the sexual addicts and 14 Key Themes for the treatment providers.

The fifth phase of data analysis aimed at creating one set of Major Themes for all the research subjects. It involved the combining of the Key Themes (described in phase four above) for the sexual addicts and the treatment providers. This was the first time that a process of combining the results of both groups happened in the analytical process. The 19 Key Themes for the sexual addicts and the 14 Key Themes for the treatment providers created a set of 33 themes which were analysed and reduced. This resulted in the final list of 25 Major Themes which became the thematic guide for the entire study and the primary focus of discussion within the findings chapters of this study.

After producing a final list of 25 Major Themes the individual transcripts are reread to retrieve the quotations which have been previously highlighted for their thematic content. These are copied and saved into a quotation archive, one created specifically for the sexual addicts and one for treatment providers. Each quotation extraction is labelled using the research subject’s reference number, the page number of the transcript from where the quotation came originally and a synopsis of the theme which it demonstrates. They are transcribed chronologically beginning with sexual addict number one and so on. This completed the major phase of data analysis for the interview transcripts summarised in Appendix Q. The analysis was ongoing throughout the entire study as the researcher returned continuously to reread, check and cross-reference material.

In addition to the data collated from the analysis of the one-to-one interview transcripts the questionnaires also proved a beneficial source of raw data. 33 (72%) sexual addicts and 25 (45%) treatment providers completed questionnaires but there were some unknown quantities which will slightly alter the statistics. The questionnaires were analysed using a software package named Statistical Package for the Social Sciences (SPSS). The initial step was to create codes for the entire set of questions so as to translate the raw data into meaningful categories. Formal analysis began with a complete reading of each questionnaire, beginning with questionnaire one. This was followed by the entering of the data for questionnaire one into the SPSS package and this process continued for each questionnaire. This process resulted in the generation of 198 variables in the data set. The analysis generated a significant collection of beneficial data which complemented the one-to-one interviews and missing data from the questionnaires was frequently sourced from the one-to-one interviews. The questionnaire was a means of triangulation which added to the
reliability of the study. However, the questionnaires generated a vast amount of data which was challenging to manage. Furthermore, given the mixed design of the questions, which included open ended and closed questions, this process of coding was complex and the entire process of questionnaire analysis was time consuming.

The major sources of data are the focus groups, the individual interviews and the questionnaires. The data from these different sources were gathered and analysed independently of one another. However the entire data were carefully woven together throughout the entire process and informed the overall findings. The data collected from the focus groups is the initial framework upon which the research structure for the individual interviews and the questionnaires is based. As the research process unfolded the data from the focus groups was frequently revisited in order to check for reliability and to compare the emerging issues from the others data sources.

The individual interviews and the questionnaires provide the largest quantity of data. Initially the data from these sources were analysed separately in order to capture the main issues. As the process of analysis developed the data from both sources were interwoven and collectively analysed. The primary manner in which this happened was by integrating the issues from the questionnaires (Appendix N) and O) with the 25 major themes emerging from the individual interviews (Appendix R).

Due to the vast amount of data collected as a result of 101 research subjects an effective process of data reduction was necessary throughout the study. This gave priority to the essential experiences articulated by research subjects. Careful attention was taken to ensure that no data was lost or neglected by continuously reviewing the transcripts, listening to the recordings and rereading the questionnaires. The 25 Major Themes that were deemed of particular significance were identified by a meticulous process of continuous examination and data reduction outlined in Table 2 below. The process of writing happened in conjunction with the analysis and both were ongoing throughout the study.

### 3.5.4 Study Limitations

This study is restricted by a number of methodological limitations. The sample was not chosen randomly but rather recruited by means of purposive sampling, snowball sampling and peer recruitment. The lack of random sampling leaves the recruitment process susceptible to researcher bias and restricts objectivity. The narrow homogenic sample generates a limited response from a very confined population, namely self-identified sexual addicts and treatment providers who work in the area of sexual addiction. Furthermore, this research population may be overly biased in favour of the concept of sexual addiction as a result of the initial criteria set down for eligibility to participate in this study. The criteria stated that individuals were self-identified sexual addicts, which would possibly lessen their critical perception of the concept. The criteria also suggested that the sexual addicts had an interest in seeking help or be in recovery from sexual addictive
### Table 3.2: Data Analysis Procedures of Individual Interview Transcripts

<table>
<thead>
<tr>
<th>Phase</th>
<th>Sexual Addicts</th>
<th>Treatment Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Initial Analysis of each transcript results in Preliminary Themes for each transcript reduced to Clustered Themes for each transcript</td>
<td>Initial Analysis of each transcript results in Preliminary Themes for each transcript reduced to Clustered Themes for each transcript</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Cross-case analysis results in Cumulative Themes 406 themes reduced to 22</td>
<td>Cross-case analysis results in Cumulative Themes 416 themes reduced to 19</td>
</tr>
<tr>
<td>Phase 3</td>
<td>Frequency Analysis results in Most Frequently used Themes Reduced to 36</td>
<td>Frequency Analysis results in Most Frequently used Themes Reduced to 54</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Aim: create Key Themes. Cumulative Themes &amp; Most Frequently Used Themes combined results in Key Themes Reduced to 19</td>
<td>Aim: create Key Themes. Cumulative Themes &amp; Most Frequently Used Themes combined results in Key Themes Reduced to 14</td>
</tr>
<tr>
<td>Phase 5</td>
<td>Aim: create one set of Major Themes for all research subjects</td>
<td>Key Themes of sexual addicts &amp; treatment providers combined &amp; reduced results in 25 MAJOR THEMES (Appendix R) representing all the research subjects</td>
</tr>
</tbody>
</table>
behaviour. This criterion led to a sample that was likely to have participated in some type of treatment experience, mainly psychotherapy or peer-support, to help them manage their sexual behaviour. As a result, they are predisposed to the treatment philosophy which many of them positively subscribe to. Moreover, the criteria deemed it essential that the treatment providers would have a working knowledge of the concept of sexual addiction, which does not necessarily mean that all treatment providers interviewed were unequivocally committed to this concept. As a result, it did lead to the recruitment of treatment providers who were primarily involved in the provision and promotion of therapeutic support which is significantly influenced by the treatment philosophy. This resulted in the participation of many treatment providers whose opinions and experiences contain a bias towards the treatment philosophy.

An additional limitation of this study is that, there was no control group used and consequently an objective comparison with the experiences of the research subjects is not possible. A control group is particularly beneficial in instances when the research subjects state that their sexual addiction is a direct result of childhood experiences such as sexual abuse or trauma. In spite of their genuine claim, it is not possible to argue that childhood trauma causes sexual addiction as not all individuals who experience such trauma develop sexual addiction. Therefore, it remains complicated to identify accurate risk factors for the development of sexual addiction. This study is further limited by the fact that the entire collection of data was generated through self-report questionnaires and interviews. These methods of self-report are frequently vulnerable to error (Schwarz 1999) and therefore perceived as being unreliable, often observed in addiction research (Del Boca & Noll 2000). Furthermore, many of the research subjects, especially the sexual addicts, explained sexual addiction in terms of experiences encountered in the individual's past life. This is a common occurrence where individuals try to understand and explain past events retrospectively referred to as 'effort after meaning' (Garro 2007), but explanations are not necessarily accurate. Specific limitations have also been observed with the interview questions and questionnaires which have weakened the analysis process. The design and content of the questions would have benefitted from increased clarity. The coding scheme for the questionnaires was inadequate for using SPSS. Consequently, the entering of data into the database was more laborious than necessary and it possibly increased the margin for error which has been noted in previous studies (Williams 2003). A more rigorous approach with the questionnaires would have resulted in a more focused design with less individual questions, and specifically designed for the SPSS database. As a result of study limitations these data must be interpreted within the specific context in which they have emerged and must be cautiously used in terms of other populations. Although the aim of this study was to gain an understanding of the phenomenon of sexual addiction from the research subjects' perspective, this understanding is transmitted through the researcher's interpretation of their account. Therefore, the entire study is liable to bias and may be deemed subjective, if not unreliable. In order to lessen the inevitable influence of the researcher (Smith, Flowers
3.6 Conclusion

This chapter has described the entire process that was undertaken in order to address the aims and objectives of the research question. The rational for choosing a qualitative approach was explained and the use of phenomenology was clarified. The process of data collection including the pilot study and focus groups were described. The primary instruments for investigating the concept of sexual addiction, namely one-to-one interviews and questionnaires were discussed. Specific attention was given to issues such as recruitment, ethics and the study limitations. The process of data analysis described how the raw data was transformed into meaningful themes with the guidance of a mixed methodology namely, IPA and TA. The analytical process resulted in the production of 25 Major Themes which are presented in the next three findings chapters. The findings describe the concept of sexual addiction in terms of a progressive pathway comprising of three major components; firstly the origin and development of a sexual addiction, secondly the lived experience of sexual addiction and thirdly the treatment and recovery from sexual addiction. Chapter four, the first findings chapter, which follows next, presents the origins and development of sexual addiction.
Chapter 4

Origins and Development of ‘Sexual Addiction’

4.1 Introduction to Findings Section

The findings section (comprising three chapters: 4, 5 and 6), presents the major themes which have emerged in this study. The aim of the study was to investigate the contested concept of sexual addiction, specifically examined from the perspective of the self-identified sexual addict and the treatment professional dealing with this issue in clinical practice within an Irish context. The specific objectives were to investigate: 1) how they understand the aetiology of sexual addiction; 2) what they perceive to be the main symptoms and lifestyle elements of this alleged condition; 3) how they view recovery and the role played by formal treatment or rehabilitation systems in the recovery process. The objectives of the study provided a thematic framework into which the data was organised into three findings chapters. Each of the findings chapters focuses on a specific dimension of sexual addiction which cumulatively represents a broad overview of the research subjects’ views on sexual addiction. The findings chapters are purposefully presented in a specific format which represent a common trajectory found in the data. The chapters describe the concept of sexual addiction in terms of a progressive pathway with three major components, firstly the origin or beginning of a sexual addiction, discussed in this chapter, secondly the lived experience of sexual addiction which is the focus of this chapter, and thirdly the treatment and recovery from sexual addiction which is explored in the last findings chapter.

The data in the findings chapters contain a range of insights into the concept of sexual addiction. However, the data are also limited due to the fact that they are based on the experiences of a very specific population of research subjects who, because of their personal or professional experiences, are influenced by the treatment philosophy which many of them positively subscribe to. A further limitation of this study is that, no control group has been used and as a result
it is not possible to make comparisons with the experiences of those who participated. As a result of such limitations, these data must be interpreted within the specific context in which they have emerged. The data in the next three chapters reveal that the question of what constitutes normal and abnormal sexual behaviour emerges among the research subjects. The question is observed as they seek to understand the concept of sexual addiction as a personal experience or an issue presented in clinical practice. Distinguishing normal from abnormal sexual behaviour is particularly challenging given that its meaning fluctuates depending on a variety of factors such as socio-cultural and religious values. Defining normal sexuality becomes even more complex when the expression of sexual addiction being considered as addictive is also a behaviour that is perceived as normative by other individuals. In some instances issues such as masturbation, pornography or multiple partners are perceived as normal (Levine, 2010) while for many research subjects these same behaviours are expressions of sexual addiction. The process of distinguishing normal sexual behaviour from addictive behaviour is complex and requires careful attention. A host of factors such as individual values, culture, developmental issues and sexual orientation among others need to be considered. The importance of recognising an extensive range of human sexual behaviours in terms of behaviour and frequency is recommended when considering the notion of what constitutes normal and abnormal sexuality (Coleman 1992).

This chapter, the first of three containing the research findings, focuses specifically on the origins, development and characteristics of sexual addiction. The chapter begins by presenting a demographic overview of the sexual addicts who participated which provides a contextual synopsis of the individuals involved. This is followed by a generic description of the sexual addict and a presentation of the core beliefs that are commonly associated with the sexual addict. The alleged predisposing influences regarding the instigation of sexual addiction are then identified and discussed providing an insight into the origins of sexual addiction. An overview of how sexual addiction develops is presented and the final section of this chapter identifies and examines the main characteristics associated with sexual addiction. Throughout the thesis, particularly in the findings' chapters, the statistics presented are based on the SPSS analysis of the data gathered from the individual interviews and questionnaires. Furthermore, a minority of the research subjects had previously lived or worked outside of Ireland which accounts for references to experiences and locations outside of Ireland in some of the data.

4.2 The 'Sexual Addict'

4.2.1 Socio-Demographic Profile of the ‘Sexual Addict’

46 self-identified sexual addicts took part in this research project. The majority of the sexual addicts are Irish citizens with the exception of five individuals, four of whom are American and one who is Spanish and who were living in Ireland at the time of interview. 36 (78%) of the sexual
addicts are male and 10 (22%) are female, and they ranged from age 21 to 63 years of age. 23 (50%) sexual addicts reported that they grew up in a major city, 7 (15%) in a provincial town and 11 (24%) in rural Ireland. 23 (50%) sexual addicts described themselves as heterosexual, 18 (39%) as homosexual and 2 (4%) as bisexual. Sexual addicts came from a range of socio-economic backgrounds. 19, (41%) of them described their family of origin as working class and 17 (37%) claimed that their family of origin was middle-class.

18 (39%) of the sexual addicts reported that they attended a single sex primary school and 10 (22%) attended a mixed gender primary school. In secondary school, sexual addicts stated that they attended single sex schools and mixed gender schools in almost equal numbers; 15 (33%) attended single sex schools and 14 (30%) attended mixed gender secondary schools. Sexual addicts reported a high level of education with over half 26 (56%) of them having completed third level education. 10 (22%) said that they completed secondary education only and 2 (4%) stated that they went to primary school only. 26 (56%) reported that they were in professional employment and 8 (17%) were in vocational related jobs.

A majority of the sexual addicts described the home environments of their childhood as being dysfunctional. The data suggest that many grew up in homes where communication was difficult and where emotions and sexuality were repressed. Many sexual addicts had insecure relationships with their parents as a result of issues such as fear and addiction. Many sexual addicts described the relationship with their mothers as being unreliable, overly close, clingy and dependent and not offering the support that a child could expect. The sexual addicts' relationship with their fathers was frequently described in terms of the father being absent, emotionally distant and where fear overshadowed the relationship.

22 (48%) of the sexual addicts reported that they experienced domestic violence in childhood. 19 (41%) sexual addicts reported that they were sexually abused as children. 27 (59%) of sexual addicts reported that they experienced a culture of addiction in their family of origin. Many sexual addicts reported the experience of a significant death in their early lives. The majority of sexual addicts claimed that they had low self-esteem and 25 (54%) of them reported that they have suffered from some kind of mental illness. 16 (35%) claimed that they have used medication for mental health issues, primarily in the form of anti-depressants and many other sexual addicts reported feeling depressed although they did not get a clinical diagnosis for it or take prescribed medication. 24 (52%) of sexual addicts also reported that their sexual addiction impacted on their mental health in a variety of complex ways. 30 (65%) sexual addicts claimed that they experienced emotional neglect particularly from their parents. 25 (54%) sexual addicts reported that their experience of emotional neglect is directly associated with their sexual addictive behaviour. 35 (76%) of sexual addicts experienced a variety of other addictions in their adult lives, predominantly but not exclusively to alcohol and drugs. Sexual addicts claimed that there is a complex inter-relationship between their sexual addiction and other addictions, particularly alcohol.
Regarding their relationship status, 6 (13%) sexual addicts were married and 6 (13%) were separated or divorced. 8 (17%) were living with their partner, in a relationship or both. 16 (35%) sexual addicts stated that they were in a committed relationship and 20 (43%) are single. 11 (24%) have children and 29 (63%) have no children. 4 (9%) of sexual addicts reported that they experienced legal implications because of their sexual behaviour while most sexual addicts did not have any legal consequences.

While each sexual addict had a unique story to tell, the cumulative data capture a generic profile of the sexual addict. The data focus attention on common traits, shared core beliefs and significant factors which affected the sexual addict’s sexual development and influenced the creation of sexually addictive behaviour.

4.2.2 ‘Sexual Addict’: Core Beliefs

Sexual addicts, like all individuals, develop a set of core beliefs from early childhood, about themselves, others and relationships. It is claimed that these core beliefs typically develop as a result of formative experiences in childhood (Goodman 1992) and strongly influence their sexual and emotional lives. In this study many sexual addicts experienced negative relationships in their family of origin, or experienced some form of abuse or neglect in childhood. As a consequence it is claimed that such traumatic experiences create negative beliefs regarding intimacy, trust and sexuality. As a result of being neglected, criticised or ignored many sexual addicts believe that they are unworthy of being loved. After being treated so badly by those whom they expected would love them, the sexual addict concludes that they must be faulty and unlovable. The result of neglect in those formative years creates core beliefs which include self-doubt, guilt, shame and a perception that they are undesirable. As a result of his dysfunctional childhood Oliver (SA), a fifty-six-year-old sexual addict who is in recovery from alcohol, believed that he was ‘intrinsically flawed’. Oliver (SA) believes that this core belief of being ‘flawed’ made him susceptible to develop sexual addictive behaviour which was expressed in:

An aversion to close personal relationships, aversion to allowing myself be seen as I am without the false front ... hiding behind a false self because I essentially feel the real self is flawed so I manufacture a false self ... It makes intimacy impossible; it creates pathological lying, dishonesty and in fact reinforces the sense of being flawed rather than alleviating it (SA 15, page 8).

Brid (TP), who offers cognitive behavioural therapy (CBT) and specialises in sexual addiction counselling, believes that the core belief underlying the concept of sexual addiction is poor self-esteem as she described:

Often at the core of this [sexual addiction] is a difficulty with intimacy ... a difficulty with their sense of themselves ... a sense of somehow ... I'm defective ... somehow there
Some sexual addicts believe that their low self-esteem can be improved by engaging in many sexual relationships. This is based on a belief system which mistakenly suggests that sexual relationships are required to gain personal validation. Ursula (SA), a twenty-two-year-old sexual addict, recovering from substance use, explains how her goal to strengthen her self-confidence by engaging in multiple relationships failed:

*I think with the men that I was with, I thought that by giving them kind of what they wanted, they would give me what I wanted ... and they would stay with me, and fill the need I was missing. It never happened. I thought it was great being with whoever, like I thought, building my self-confidence but it broke me* (SA 21, page 5).

Another core belief among sexual addicts was that relationships are unreliable and not to be trusted. This was typically associated with the sexual addict's childhood experience where trust was undermined in situations such as domestic violence, divorce, adoption or abuse. Arron (SA), a thirty-eight-year-old sexual addict who experienced sexual abuse and depression, associated his sexual addictive behaviour with the experience of his parents' dysfunctional relationship which he described as follows:

*I never saw anything like a healthy relationship at all; my mum and dad were completely messed up ... I never saw two equals. I saw people controlling people. I saw people playing games to trap people, and all this talk was open in front of the little boy, and so I assumed that all women were conniving constantly. Sex was talked about as a commodity, a trading thing ... do you know what I mean?* (SA 1, page 3-4).

As a consequence of unreliable relationships in early life the individual creates a core belief that relationships will result in being hurt or abandoned. This often leads to the creation of anonymous sexual relationships where the possibility of being abandoned will not happen and where a pattern of sexual addiction begins. Another reaction among those who experienced a lack of trust in formative relationships is that they become preoccupied with sexually pleasing their partner out of fear that their partner will abandon them as Gary (SA), a forty-two-year-old, gay, male sexual addict in recovery from substance use, explains:

*I would just be in a state of panic that they are going to leave me and, I would be like this fucking performing monkey in order to keep them hooked in ... and the worst part of it, the other side of it was, that I probably aren't even that interested in them* (SA 7, page 23).

Another core belief among some sexual addicts was that they believed that their emotional and psychological needs could be met through sexuality. In their search for happiness and intimacy
they sought any kind of sexual relationship believing that it was an indication of being loved as Ursula (SA), a twenty-two-year-old sexual addict who is recovering from substance use, explains:

*I thought that being with a bloke ... that he would make me happy you know but no. I think I just wanted somebody to be there, you know. Just to be with me, you know ... even to listen to me, or to put their arms around me, tell me everything will be all right, you know* (SA 21, page 5-6).

While each sexual addict is a unique individual, the data imply that sexual addicts share a common set of core beliefs which form the basis for developing and engaging in sexual addictive behaviour. These core beliefs are associated with issues such as dissatisfaction with their early childhood experiences in relation to self, sexuality, intimacy and parental attachment. Many sexual addicts feel inadequate, undeserving and incapable of intimate relationships. As a result of broken trust some sexual addicts believe that relationships are unreliable or potentially abusive. Other sexual addicts believe that sexual relationships will satisfy unmet childhood needs and provide psychological validation. As a result of these mistaken core beliefs the sexual addict is misguided regarding relationships and sexuality, and they become susceptible to developing sexual addictive behaviours.

### 4.3 ‘Sexual Addiction’: The Pre-Disposing Influences

The data infer that out-of-control or sexual addictive behaviour is associated with a wide range of physiological and psychosocial conditions. This corresponds with previous research regarding out-of-control sexual behaviour which states that when the underlying or co-morbid conditions are treated, it eases the condition and regularises the sexual behaviour (Finlayson, Sealy & Martin 2001, Chughtai et al. 2010, Samenow 2010).

#### 4.3.1 Physiological Influences

Out-of-control sexuality may be a manifestation of a variety of physiological and medical conditions such as depression, especially bipolar disorder and invasive surgery. These conditions affect sexuality and often increase the individual's sexual drive, reduce their ability to control impulses, and therefore cause a lack of sexual inhibition. Additional physiological effects of sexual addiction are described by Ultan (TP), a forensic psychologist specialising in addiction:

*There’s a gratification involved ... it’s a chemical gratification ... the euphoria associated with sexual climax and that type of a thing. So that has a kind of a neurological impact if you like so I think, what they get out of it is one, the physiological pleasure aspect of it ... there’s a pleasurable aspect with sexual climax and what I mean is that they’re almost like taking a drug. There’s a high associated with it ... there’s kind of*
4.3. ‘SEXUAL ADDICTION’: THE PRE-DISPOSING INFLUENCES

that distracting element to it so I think they’re also getting the problem solving aspect of it where it’s a temporary problem solver. It’s something that allows them to kind of switch off. And give them kind of freedom and space from concerns (TP 21, page 5).

Treatment providers, generally those with a medical training, were more aware of the physiological and neurobiological influences regarding sexual addictive behaviour. Some treatment providers admitted to a lack of knowledge while others demonstrated a lack of awareness of these influences. In contrast, some sexual addicts like Quintan (SA), a middle-aged gay man who is in recovery from substance use, was aware of the physiological influences associated with sexual addictive behaviour as he explains:

There’s a school of thought that says, during sex, you’re releasing various brain chemicals possibly serotonin and adrenaline and testosterone so basically part of it is that you get used to these chemicals (SA 17, page 20).

4.3.2 Mental Health and ‘Sexual Addiction’

The data suggest that there is a complex inter-relationship between sexual addictive behaviour and mental health especially depression. In some situations the sexual addicts state that their depression resulted from their sexual addiction and frequently caused suicidal ideation. In other instances the data indicate that the individual engages in sexual addictive behaviour in order to help alleviate the depression as discussed in previous studies (Reid 2010). Some individuals suffered depression from early childhood while others experienced it in adulthood. Statistically, 25 (54%) of the sexual addicts experienced some type of mental health difficulty throughout their lifetime, and many described their mental health condition as a form of depression even though it was not always clinically diagnosed. The level of depression varied from low-grade depression among some sexual addicts, which was manageable without medication, to depression which required a combination of out-patient or in-patient psychiatric care and psychotherapy. 16 (35%) sexual addicts reported that they have taken medication specifically for mental health conditions. Furthermore, sexual addictive behaviour impacts negatively on mental health and was described in terms of negative feelings, low self-esteem and fear in the aftermath of their sexual addictive behaviour. The intricate relationship between mental health and sexual behaviour is captured by Harry (SA), a sixty-three-year-old married sexual addict, who has bipolar disorder. Harry (SA) believed that his sexual addictive behaviour has ‘caused’ his bipolar depression:

When I was acting out heavily, looking back on it, I can say I was in a high mental state, immediately following that I could go into a low. I was diagnosed in 2004 as being manic-depressive / bipolar and I have been taking medication for that since then. I believe that the bipolar disorder directly relates to the sexual acting out. I do not think it’s necessarily physiologically part of me. I think it’s related to the acting out, and the
acting out has caused the bipolar almost rather than the other way around (SA 8, page 3).

In some instances the sexual addictive behaviour was perceived as a means of coping with mental anxiety as Gary (SA), a forty-two-year-old, gay male sexual addict in recovery from substance use, explained:

Well if I am feeling inferior, typically I would begin to withdraw into myself. I would feel anger and there would be, I suppose, slight depression that would come in there and I become overwhelmed. I think just a sense of uselessness ... there's no real purpose or value to who I am or what I am or what I'm doing ... and that can lead me into wanting to remove myself from those feelings ... so it's a case of well, let's kill that pain. And to kill it for me was to go act out and have sex ... I think I just felt so shit about myself a lot of the time that I needed that little bit more, and then I'd have sex with somebody and then I would have sex with somebody that I didn't want to have sex with ... so I might drink on that to get over that feeling of guilt or shame of having sex (SA 7, page 30-31).

One significant finding was that 24 (52%) sexual addicts explicitly said that their sexual addictive behaviour has negatively impacted their mental health. The negativity is linked to the guilt, paranoia, anxiety and self-hatred resulting from sexual addiction. Carl (TP) an addiction counsellor and specialist in sexual addiction counselling, says sexual addiction can push people to the 'edge of insanity':

From my experience I have seen addictions and I have seen and witnessed sexual addictions and I have seen people going to the edge of insanity around addictive behaviour (TP 3, page 15).

There is often a cyclical interplay between anxiety and sexual addiction according to Ultan (TP), a forensic psychologist specialising in addiction. Even when individuals realise that they have a problem with sexual addiction they may continue to use sex to alleviate their anxiety, as Ultan (TP) explains:

That's a disturbing moment [when they realise that they have a problem with sexual addiction] because its confirmation of the fact that you have indeed lost control. And people can become kind of overwhelmed by that and quite anxious about it and depressed and of course, they can continue to use the [sexual addictive] behaviour to cope with those additional negative feelings (TP 21, page 4).

Some sexual addicts reported that it was because of their depression or during the process of seeking help for their mental health that their sexual addiction was identified. As a result specific
help for the sexual addiction was then sought as Agnes (TP), an addiction therapist who specialises in sexual addiction counselling, explains:

So they mostly present when they're in trouble. Either on that level of family, the spouse finding out, which is the main way, or the other way is through depression or low mood and not feeling good about themselves but mostly it's through crisis (TP 1, page 19).

The data suggest that sexual addiction is both a cause of, and a consequence of, depression, highlighting the complex relationship between mental health and addictive sexual behaviour and which corresponds with previous studies (Kafka & Hennen 2002, Bancroft & Vukadinovic 2004, Reid 2010, Samenow 2010, Kafka 2010). Some sexual addicts in this study appeared more aware of this complex relationship between sexuality and mental health than the treatment providers.

4.3.3 Neurology and 'Sexual Addiction'

Brendan (TP), a trauma therapist who works with sexual addicts, explains how repetitive sexual behaviours can be connected to neurological trauma such as physical injury, brain injury, and traumatic surgery. In trying to resolve past traumatic experiences Brendan (TP) claimed that the individual may develop repetitive behaviours, which may be sexual:

By trauma I mean, a situation where the nervous system gets overwhelmed ... either you are knocked unconscious or your faint or you pass out or you lose track of time or you're forced unconscious through surgery or other means ... asphyxiation ... any of those situations then produce a traumatic imprint on the reptilian brain and the amygdala and the brain stem which controls autonomic functions ... it makes a literal recording of what was happening at that time of being overwhelmed and it deregulates the nervous system ... and there's a tendency for traumatic events like that to be repeated in order to try to go through the activity again without being overwhelmed and if you can do that then the trauma is released, but if you don't, then it just keeps there and it keeps trying to bring you into it ... It's one of the reasons that someone can have a trauma around an early surgery and go into repetitive behaviours and compulsive behaviours that may be sexual in nature ... because when somebody is probing around in your insides doing surgery in the groin area or anything like that it can lead to a connection ... an association of those with sexual behaviour ... and the person is trying to recreate that through various kinds of sexual behaviour ... especially surgeries which involves the genitals or anything inside the body since ... you know ... punctures, invasions, violation of the body can all end up with sexual components (TP, 28 page 2).

This cycle reflects Horowitz (2001)'s work who suggests that the traumatised individual frequently engages in repetitious behaviour with the hope of resolving the trauma. Repeating sexual behaviours can result in the development of sexual addiction.
4.3.4 Psychosocial Influences and ‘Sexual Addiction’

Research subjects discussed the psychosocial influences associated with the development of sexual addiction. The data suggest that sexual addiction is often associated with the individual’s family of origin, sexual trauma, parental attachment and childhood sexualisation. Sexual orientation, education and religion are also discussed as possible influences which contribute to the development of sexual addiction. It was also noted that the process of explaining human problems, in this instance sexual addiction, with reference to past experiences, a process referred to as ‘effort after meaning’ (Garro 2007) is a common human occurrence. Individuals, in order to make sense of difficult situations, often try to understand and explain them retrospectively, but such explanations are not necessarily accurate.

4.3.5 Family of Origin and ‘Sexual Addiction’

Many research subjects reported that the family of origin is a significant influential factor in the development of sexual addiction for a variety of different reasons. 29 (64%) sexual addicts described their home environments negatively, using terms such as ‘tense’, ‘unpredictable’ and ‘dysfunctional’. The negative description typically referred to difficult childhood experiences and included issues such as violence, neglect, addiction, abuse and parental separation. 22 (48%) sexual addicts reported that they experienced domestic violence which they claim generated fear and insecurity regarding relationships. The data imply how domestic violence affects trust and creates obstacles in communicating emotions, a trait associated with sexual addiction (Carnes, 1983). 10 (22%) sexual addicts believed that there is a definite relationship between their experience of domestic violence and their sexual addiction.

The data also reveal that 30 (65%) sexual addicts experienced emotional neglect. Sexual addicts explained emotional neglect in terms of rejection, feeling unloved and developing low self-esteem. This resulted in some seeking comfort in sex, suppressing emotions and isolating themselves, which it is suggested, are all classic symptoms of sexual addiction (Carnes 1983). 26 (56%) of the sexual addicts who experienced emotional neglect say that it limited their ability to form relationships and to express emotion. 25 (54%) of the sexual addicts who experienced emotional neglect claimed that their experience of emotional neglect was a causal factor in the development of their sexual addictive behaviour.

Research subjects reported additional family of origin issues as being significant in terms of the development of sexual addiction such as substance misuse, loss, and secrecy. 14 (30%) sexual addicts grew up in families where they experienced substance use and claimed that their childhood experience of addiction created difficulties regarding safety, trust and role modelling in formative relationships. Sexual addicts also reported the experience of loss in their lives. 19 (41%) claimed that they experienced the death of a loved one, typically a parent, sibling or grandparent. At
least 14 (30%) of the sexual addicts stated that they were under twenty-one years of age when they experienced such deaths. Nine (20%) experienced loss in terms of parental separation and two (4%) sexual addicts were adopted. The data also reveal that many sexual addicts are accustomed to holding and carrying family secrets, such as sexual orientation, sexual abuse and sexual addiction. The findings indicated that there is a significant connection between the sexual addict’s home environment and the origin and development of sexual addictive behaviour. Brendan (TP), a trauma therapist who works with sexual addicts, believes that the ‘biggest’ cause of sexual addiction is associated with the family of origin and with the unmet needs of the individual as he explains:

*I think there’s a lot of different causes [of sexual addiction] but I think the biggest one is some basic human need that isn’t met. So for instance we all come into the world expecting to be loved, to be cared for, to be touched, to be held, to be fed properly, to be kept warm and so forth. When any of those fundamental needs aren’t met, then the need essentially persists and as a person gets older they tend to try to substitute other behaviours by what was missed in early childhood and it doesn’t work (TP 28, page 1-2).*

Some children experience emotional pain as a result of their needs not being met. Such pain is sometimes soothed by a reliance on sexual behaviour which in Oliver’s (SA) situation developed into a sexual addiction as he explained:

*My developmental needs were not met ... my need for reassurance, my need for safety, my need for continuity, my need to feel loved ... those were not met in my formative years, and for a child that is an exceptionally painful place to be. I believe that my mind came up with strategies to get round that pain and the strategies that I came up with were dependent on compulsive behaviours, including sex and a range of other emotional behaviours* (SA 15, Page15).

Sex becomes the primary coping mechanism to deal with the emotions of fear, anger, anxiety and loneliness. Ironically the sexual addict who uses sex to escape pain often discovers that over time this solution becomes the problem, as it creates additional pain resulting from the negative consequences associated with sexual addiction.

The data indicate that many sexual addicts grew up in an environment where they witnessed a lack of intimacy, domestic violence, extra-marital affairs and fractured relationships, a pattern observed in previous studies (Schneider 2000). Many of them believed that the absence of good role models interfered with the sexual addict’s capacity to create healthy intimate relationships. Rose (SA), a thirty-nine-year-old single sexual addict, referring to role models and her own sexual addiction, said:

*It was never demonstrated what a good relationship looked like between two adults in terms of my parents. So I had this really warped idea of what it means to be. I thought*
you had to be attractive, put on a front, never show that you had a need, a want or a care, and because if you did, in my experience of that, men would leave which my dad did when my mum showed any type of need (SA 18, page 8).

As a result the sexual addict creates a belief system which says, ‘relationships are not to be trusted’ or ‘I can only rely on myself’, or ‘the purpose of sex is to get what I want’. It is on these beliefs that the cycle of sexual addiction is based (Carnes 1983). Brid (TP), who offers cognitive behavioural therapy (CBT) and who specialises in sexual addiction counselling, described how a young child had a traumatic experience of sexuality involving his parents which led to a negative perception of relationships and sexuality and which developed into a sexual addiction. Brid (TP) explained that her client’s father was alcoholic and was sometimes violent towards his wife. The father would return home from the pub and want sex from his wife. The wife withheld sex in order to get money from her husband. The client, as a young boy, became the go-between and negotiated the money that his father would give his mother for sex, as Brid (TP) explained:

The mother withheld sex so he [the client] became the go-between where his father would say, ‘tell her to come up to me’ and he’d [the client] go, ‘Mam, daddy wants you’ and the mother would say I’m not going up near him and it would turn into bargaining for money. So she’d say, ‘He’s out drinking in the pub all the time and he thinks he can, you know, so tell him to put some money on the table so I can feed you guys’. So my client would end up going between his father and his mother passing the money over and then realising that his mother was going up for sex (TP 2, page 4-5).

Brid (TP) described how the situation became more traumatic when Brid’s (TP) client as a young child was sleeping with his mother:

The father came into the room one night and argued/bargained with the mother for sex and he [the client] was asleep in the bed beside her or so they thought. And he stayed lying, pretending to be asleep in bed while his mother and father had sex right beside him (TP 2, page 4-5).

Brid’s (TP) client was introduced to sexuality by his parents as a commodity to be traded, a possession to be withheld or a power to be used. Brid’s (TP) client experienced a combination of fear, confusion, and insecurity resulting in deep psychological pain particularly regarding sexuality. This childhood pain was not attended to sufficiently and the child resorted to using sex as a coping mechanism and which over time has developed into a sexual addiction. As an adult, Brid’s (TP) client is currently receiving sexual addiction counselling and has recently encountered legal consequences due to his sexual addictive behaviour.
4.3.6 Parental Attachment and ‘Sexual Addiction’

Sexual addictive behaviour was further understood in terms of the child-parent relationship and research subjects believe that the lack of strong attachment was a predisposing factor which led to the development of sexual addictive behaviour. Many research subjects state that sexual addicts’ primary experience of intimacy is flawed resulting from the absence of parents, either physically or emotionally, especially in early childhood. This disconnection between the child and the parent figure, it is suggested, creates an emotional vacuum where the child’s need for intimacy is neglected and where early attachment difficulties begin. It is suggested that in some instances like these a vulnerability towards sexual addiction is created, an issue which is observed in Zapf, Greiner & Carroll (2008)’s study.

In this study, the lack of attachment is observed through a number of factors. Nine (20%) of the sexual addicts reported that their parents separated, two (4%) addicts were adopted and nine (20%) lost their parents or parent figure through death before they were twenty-one-years of age. Addiction, domestic violence, illness and employment are other influential factors which created relational instability between the addict and their parents. The lack of parental attachment was expressed about both parents. Sexual addicts reported lower levels of attachment to their father in comparison with their mother. The sexual addicts’ description of their relationships with their parents highlights the sexual addicts’ need for more parental love during their childhood. These findings are consistent with other studies indicating the lack of attachment as an indicator of sexual addiction (Giugliano 2003). William (SA), a twenty-eight-year-old sex addict with a history of drug addiction and child trauma, believes that his pattern of sexual addictive behaviour is associated with the relationship he had with his parents. William’s (SA) father, who died by suicide when he was eleven, was violent towards him as a child. William’s (SA) mother suffered from depression and the parental relationship was unstable. Referring to his mother, William (SA) said:

*She did her best with food and clothes but I never felt she was there for me emotionally or to protect me (SA 23, questionnaire).*

William (SA) developed an addictive pattern of sexually engaging with older women and described part of the motivation for sexual addiction as a way to get what he did not get at home:

*It’s not just the sex . . . it’s everything else that goes with it. I think it’s the good feelings and the attention and all that kind of stuff that I didn’t get at home or not having friends. I get all that from being close and having sex with a woman and if I’m doing that I don’t have to feel or think about feeling lonely or different or no-one likes me (SA 23, page 8).*

Many sexual addicts in this study associated the negative relationship with their father as a significant factor in their sexual addictive behaviour. Many fathers were physically absent while 22
(48%) of the sexual addicts said that their fathers were emotionally absent. Some sexual addicts claimed that the absence of a dependable and emotionally stable father figure is directly linked to their sexual addictive behaviour as Rose (SA), a thirty-nine-year-old single sexual addict, referring to her father, explains:

I didn’t have a relationship with him. He was very cold, very unaffectionate, very tyrannical in the way he behaved so I sought that affection from somebody else. But the issue was, I mixed sex up with affection and intimacy (SA 18, page 2).

Sarah (SA), a twenty-one-year-old sexual addict who was also addicted to alcohol and drugs, understands her sexual addiction in terms of her absent father as she explains:

On an emotional level, it’s like my dad was there but he wasn’t. He never connected with you emotionally and never tell you that he loved you or give you a hug or anything like that. He was very shut down, cold. Like I remember even then, like 16 or 17 going to bed and saying ‘Goodnight Dad, I love you’ and all I got was ‘huh’ and after that I said, you know what, fuck him (SA 19, page 13).

Sarah’s (SA) pattern of sexual addiction was a search for her absent father. In her own words she was seeking:

...a father figure, someone to be close with, looking to get that love that I never got before. I craved it; the only attention I got off my dad was when I was acting up even as a kid (SA 19, page 14).

Ivan (SA), a twenty-six-year-old sex and food addict, understood his sexual addiction in similar terms regarding an absent father figure as he says:

My father walked out and left us from a young age and I was always looking for a father figure even though I had a stepfather from the age of about ten onwards and he is still there. I always craved male attention, male love (SA 9, page 18).

At eighteen years of age Ivan (SA) began a sexual relationship with a man who was seventeen years older than him and from that age onwards Ivan’s (SA) sexual addiction developed. Ivan (SA) claimed that his sexual addiction was an expression of his need to be rescued and cared for. Similarly, Raymond (SA), a thirty-four-year-old gay sexual addict who is HIV positive, claimed that his sexual addiction was associated with his absent father. Raymond (SA) as a child longed for love and attention from his father who was unavailable. Raymond’s (SA) pattern of sexual addiction, involved seducing straight, handsome men who were unavailable, a possible likeness of how he perceived his father. His sexual addiction was an expression of his search for his absent father as he explains:
4.3. ‘SEXUAL ADDICTION’: THE PRE-DISPOSING INFLUENCES

I always thought he [my father] was a very handsome man and my drug [was] people [who] would have to be young and handsome and unavailable in some way and if they were straight then I had a feeling that I was seducing them, do you know. There was even more of a buzz so maybe in some kind of psychological way ... I was using sex as a way to kind of hook-in those men as a substitute for my Dad (SA 44, page 4).

Jim, (TP), a psychotherapist, trained in sexual addiction counselling, acknowledges that the quest for the father figure may express itself in multiple sexual relationships as he explained:

Maybe it’s a father who abandoned them when they were very young, and so therefore, you know ... part of being with all these different men ... maybe somewhere along the line, I might find that it was the father who wasn’t there (TP 10, page 9).

These data reflect Samenow’s (2010) research who states that the capacity to form adult romantic relationships is influenced by strong attachment in the primary relationships typically between parent and child.

4.3.7 Childhood Sexualisation and ‘Sexual Addiction’

The data demonstrate a complex relationship between sexual addiction and childhood sexualisation. The term childhood sexualisation is a generic term that is used to describe any experience of childhood sexual trauma. Such trauma is typically experienced in two major ways. Firstly, a child may experience child sexual abuse (CSA). Secondly, the child can accidentally or purposefully witness sexual behaviour or material that is age inappropriate. Childhood sexualisation is reported as a primary gateway into sexual addictive behaviour. 26 (47%) of treatment providers identified a significant connection between CSA and sexual addiction in adult life which parallels a number of other studies (Carnes 1991, Schwartz, Gilperin & Masters 1995, Hunter 1995). The most common expression of sexual trauma remains CSA. 19 (41%) sexual addicts reported that they experienced sexual abuse, 14 were male and 5 were female. Sexual addicts described their sexual abuse in terms of genital abuse, rape, penetration and sexual abuse with violence. In order to deal with the psychological pain of abuse individuals frequently resorted to sex, and this pattern became addictive. The element of secrecy, which was typically a feature of their sexual abuse, became a key feature of their sexual addiction. 16 (35%) sexual addicts who experienced sexual abuse state that their abuse has a direct relationship with their sexual addiction. 2 (4%) sexual addicts who experienced CSA said that their sexual abuse was not related to their sexual addiction, and 2 (4%) sexual addicts were not sure. 16 (35%) sexual addicts said that they did not experience child sexual abuse.

The impact of sexual abuse on adult sexuality was varied. Xavier (SA), a sexual addict, who experienced substance use and depression, was sexually abused. During one encounter Xavier (SA) explains that the female abuser complained that his sexual performance was not good enough,
creating a doubt in him about his sexual ability. As a result Xavier (SA) pursued multiple sexual partners to prove that he was sexually capable, a pattern which resulted in sexual addictive behaviours:

*She was 34 and I was about 13 ... We had sex but it only lasted a couple of minutes and when I finished she was like, 'Is that all? And I was in a panic just wanting to go home you know ... just what she said when I was leaving, 'Is that all? Are you finished? I think that has really affected me in relationships and you know having sex in a relationship and you know whereas I wouldn't be looking to pleasure myself or please myself, it's all about who ever I'm with. It's really even with relationships now. I don't stay in one relationship even if I'm really happy in a relationship. I was engaged in America and you know a beautiful girl. I couldn't stay faithful to her (SA 24, page 6).*

Many research subjects stated that the experience of sexual abuse created confusion between sex and intimacy. As children many sexual addicts sought natural affection but instead they were sexually abused. As a result, the sexual addict believes that sex is the only way to be loved. In adult life sexual addicts frequently seek an intimate relationship but they end up choosing sexual encounters which can lead to the development of a sexual addiction as Karen's (SA) situation indicates. Karen (SA), a thirty-two-year-old single sexual addict, was sexually abused by her nineteen-year-old uncle when she was three years of age. At the later age of fifteen, Karen (SA) was raped and continues to have difficulties distinguishing sex and affection, as she explained:

*At fifteen [years of age] I had a boyfriend at the time ... and I put boyfriend in inverted commas because he was much older than me ... he was twenty-nine years of age and effectively he raped me at the age of fifteen ... so that would have been my first experience of penetrative sex. I think by that point ... I kind of believed that was how love and affection in an adult relationship was shown ... so as much as one part of me was saying that was right and it shouldn't be happening ... the other part almost expected that was what a relationship was (SA 11, page 2).*

In addition to those who experienced sexual abuse, the data reveal another sub-group of individuals who were sexualised in a non-physical way at an inappropriate age and in an intrusive manner. It is increasingly common to view non-physical sexualisation in terms of sexual abuse (Finkelhor 1994). Research subjects in this study reported instances of inappropriate sexualisation such as children viewing pornography and children seeing adults having sex. These experiences of childhood sexualisation were identified as influential experiences which created pathways towards sexual addictive behaviour. Xavier (SA), a sexual addict, who experienced sexual abuse, substance use and depression, explains that his adult sexual addiction reflects what he witnessed as a child regarding his mother's sexual behaviour as he recalls:
4.3. ‘SEXUAL ADDICTION’: THE PRE-DISPOSING INFLUENCES

Mother started bringing strange men home and having sex, and when my mother was having sex she was very loud you know, very loud and it was very disturbing. It would wake me up and I would just be terrified you know and then like some of the fellas she would bring home would be very physically abusive towards her and I tried to get in the middle of that and my mother kept telling me to get out and mind my own business you know, as if she wanted this to happen. So yes, I found that very difficult you know as a child (SA 24, page 7).

As a result Xavier (SA) grew up believing that women wanted to have abusive sex. He developed a pattern of addictive sexual behaviour replicating his childhood beliefs that women were to be sexually abused which he described as follows:

I went to train stations and picked up women; didn’t really care who they were, had sex with them and got paid for it, if not I would just rob them (SA 24, page 10).

Warren (TP) a specialist in genitourinary medicine, working in sexual health and addiction, says that there is a high co-relation between sexual abuse and addiction and he predicts that a similar pattern may be repeated regarding sexually addictive behaviour. Warren (TP), referring to a previous Irish study, said:

A previous study showed that thirty percent of the [substance related] addicts who attended this clinic were sexually abused and there is a link between sexual abuse in the past and addictive behaviour in the present. My feeling is they cross over to sexual addiction as well (TP 23, page 2).

Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, identified the developmental stages from sexual abuse to sexual addiction in the case of her client:

When he [client] was nine he was seduced and raped by an older lad and he had been introduced to pornography at the same time. His sexual response was to pornography and to encounters where he was controlling the encounter and there was a sense of needing to dominate within the encounter … There was an urge to perform sexually and to do the things that he had seen in the pornographic magazines with his partners … The sexual experience was less and less and less satisfactory but the compulsion to have some form of sexual release became greater and greater so he began to get into more and bizarre practices … more say … masochistic practices in order to get the feeling to be able to become aroused and ejaculate. His ability to work became compromised and eventually his relationship with women deteriorated to the extent that he was using prostitutes twice and three times daily (TP 25, page 2).

Xena (TP), an addiction therapist who specialises in addiction and sexual behaviour, suggested that the sexual addictive behaviour is a way of re-enacting or resolving the sexual trauma as indicated in previous studies (Parsons et al. 2008). Xena (TP) says:
It's like the child trying to make sense of something and they keep doing it again and again and again and so they keep getting into this and they're still not making sense (TP 24, page 3).

Despite the suggested association between sexual abuse and sexual addiction, the data also reveal that not all who experience sexual abuse develop a sexual addiction. Many survivors of sexual abuse are capable of living sexually fulfilling and happy relational lives as other studies have shown (Lew, 2004). It is also important to note that in this study 16 (35%) sexual addicts were not sexually abused and yet they have developed sexual addictive behaviours. Further research is required to understand the full extent of the relationship between sexual abuse and sexual addiction.

4.3.8 Homosexuality and ‘Sexual Addiction’

Homosexuality was discussed as a possible predisposing influence in the development of sexual addiction. 18 (39%) sexual addicts identify as being homosexual, 15 (32%) male and 3 (7%) female and 2 (4%) identify as bisexual. A number of others who identified as heterosexual said that they experienced homosexual encounters. Some treatment providers worked with gay clients on a regular basis, others occasionally, while some have not worked with a gay clientele. The relationship between homosexuality and sexual addiction was primarily discussed by gay men and women, bisexuals and men described as men who have sex with men (MSM) and treatment providers who have worked with these combined populations.

The data suggest that gay individuals may be more susceptible than others to developing sexually addictive behaviour because of a number of socio-cultural factors. Many gay people grow up in a hostile homophobic culture where they feel compelled to deny or suppress their sexual orientation. Research subjects reported incidents of gay-bashing and social exclusion even as late as the 1980s, indicative of the prevailing attitudes in schools, churches and families of origin, which deemed homosexuality as unacceptable. These gay-related difficulties created anxiety among many gay individuals and often led to a pattern of secretive sexual behaviour where they engaged in clandestine relationships. The result of gay orientated negativity impacted the individual's self-esteem, sexual development and capacity to develop intimate relationships, which are traits associated with sexual addiction. As a consequence of these negative influences, research subjects suggested that gay individuals are more vulnerable to developing sexual addiction. Finbar (SA), a fifty-two-year-old single gay sexual addict, claimed that as a result of the unacceptability of his homosexuality, he suppressed his sexuality in a way that was unhealthy:

*In many ways I think this [homosexuality] is part of the problem as well. It was as if I went underground and I didn't allow this side of my personality to develop in a healthy way* (SA 6, page 6).
4.3. ‘SEXUAL ADDICTION’: THE PRE-DISPOSING INFLUENCES

Finbar (SA) identified the combination of shame and secrecy, associated with his homosexuality, as primary influences regarding the development of his sexual addiction. Research subjects also suggested that suppression of one’s sexuality and low self-esteem in terms of homosexuality are possible factors that may lead to the development of sexual addiction, which corresponds with previous studies (Dew & Chaney 2005). Quintan (SA), a middle aged gay sexual addict who is in recovery from substance use, said that many gay boys who grew up in Ireland during the 1970s experienced a homophobic culture and suppressed their sexuality. This suppression impeded the development of regular relationships and created a vulnerability for casual sexual encounters which has become Quintan’s (SA) pattern of sexual addiction:

Gay men of a particular generation didn’t have the opportunity to develop a normal sexual emotional relationship in adolescence because of repression and oppression . . . when we actually got into adulthood and we could start engaging in these relationships it was like we were stuck in the adolescent phase. There was an awful lot of . . . particularly my generation . . . problems with acceptance of self, with one’s own sexuality and possibly even self-hatred which meant that it became much more difficult to endure long term relationships (SA 17, page 11).

Trevor (SA) a sixty-year-old gay sexual addict, felt culturally obliged to suppress his sexual orientation from early adolescence. As a result he claims that he married a woman, and his marriage ended when he was fifty years old due to a combination of his homosexuality and a developing sexual addiction, as he described:

There were plenty of one night stands when I broke up with my wife but that’s because I was going through adolescence . . . arrested development . . . all this suppressed stuff from childhood . . . deeply suppressed so that in my mid-fifties when I suddenly kissed my first man I thought . . . holy fuck, what have I been doing all these years . . . you know I was making up for lost time basically. I was starting my adolescence all over again . . . well it was fast becoming a sexual addiction until I discovered my first relationship . . . because I was addicted . . . I was on the Internet all the time . . . I was like a kid in a candy store . . . but I think it depends on the person and on an awful lot of factors . . . I mean you didn’t have the fear because you came out and you knew what you were doing . . . it was the relationship that I established that stopped me becoming addicted (SA 46, page 1).

4.3.9 Sexual Education and ‘Sexual Addiction’

The data suggest a significant association between sexual education and sexual addiction, and intimate that negative sexual education is a predisposing factor in the development of sexual addiction. The sexual addicts in this study reported that they received their sexual education
from various sources including nine (20%) from home, 10 (22%) from media, 11 (24%) from school, and 15 (33%) from peers. 19 (41%) of sexual addicts were dissatisfied with their sexual education. The sexual addicts explained that their dissatisfaction with sexual education is based on issues such as the fact that sex was frequently not spoken about either at home or in school. When sexuality was spoken about in the sexual addict’s family home, it was usually the mother who spoke about it. The sexual addicts’ fathers spoke very little about sexuality and when they did, they generally spoke about sexuality in terms of discipline or religious purity. Occasionally, some sexual addicts reported that their fathers talked openly about sexuality and other sexual addicts say that they received school seminars on sexual education that were satisfactory. Nonetheless, the common narrative in this study about sexual education was negative, symptomatic of the sex-negative attitude which permeated the Irish culture, the educational system and the home environments of many sexual addicts. This negativity was confounded by the restrictive influence of the Roman Catholic Church whose moral code influenced many of the sexual addicts’ social and cultural attitudes to sexuality. The sexual addicts explained that this religious and social milieu of negativity led many of them to repress, deny and disassociate from their sexuality, resulting in deprivation and impairment of normal sexuality, intimacy and relationships. Darren (SA), a fifty-one-year-old sexual addict recently divorced, described the restrictive nature of sexuality which he experienced when he was growing up:

In Ireland we don’t like to talk about sex, we’re not as open about it. It’s not a topic for ordinary conversation or family conversation generally, it wasn’t for me growing up ... a certain amount of it I suppose comes from the Catholic Church and the strict dogma that’s passed down, definitely through the education system. I went through with the Christian brothers you know. I don’t even remember there being sex education. I remember there being reproductive descriptions in the biology session but no association of that with sex or sexual relationships or personal relationships so there was no effort to educate people or deal with people as a whole ... in primary school there was a very strict Catholic dogma where complete segregation from the opposite sex was the order of the day so you never had a chance to form any form of relationship or just to meet girls (SA 4, page 46-47).

Many of the treatment providers said that sexual education was generally inadequate in Ireland as Gerry (TP) a clinical psychologist specialising in child sexual abuse, explains:

Sex just didn’t get talked about and therefore it was underground. You know, it just was never going to be talked about, and the only time it was talked about it was in the context of marriage and making babies. The priest was probably the only one you could talk to about it who, ironically, in theory, should never had any understanding of it. I mean it was only up to the late ‘80’s, early ‘90’s priests were still teaching sex
education ... alternatively it was a science teacher who taught it through biology so the whole concept of emotional connection and sex was never brought together (TP 7, page 11).

Hanna (TP), a psychotherapist with sexual addiction training, explained the consequences of poor sex education among her adult clients and said:

What surprises me is not just working with clients with sexual addiction but with clients in general, in their thirties, forties, how limited their sex education was and how shy they are about talking about sex, do you know. They don’t talk about it and it will be one of the last if there’s a problem in a relationship with sex, it is quite difficult for the couple particularly, for them to bring that, you know. One or other of them will be quite shy (TP 8, page 6-7).

The consequence of inadequate sexual education resulted in the inability of many sexual addicts to discuss sexuality openly, to deal with their sexual lives or to be comfortable with their sexuality. The data imply that the experience of a negative sexual education creates a vulnerability for some individuals to develop sexually addictive behaviour which has been suggested in previous studies (Earle & Earle 1995).

### 4.3.10 Religion and ‘Sexual Addiction’

The data highlight the strong influential role that the Roman Catholic Church holds in Irish society and the consequential role it played in relation to sexuality. In a few instances the Church was viewed as being helpful, while the majority of participants identified the Roman Catholic Church as being responsible for creating a negative, moralistic and damaging attitude towards sexuality which impacted injuriously on their relationships and sexual development. Religious negativity regarding sexuality was a powerful force communicated in churches, schools and in the addict’s home. The Church’s negativity influenced the sexual addict’s perception of sex, self and God which generated fear, shame and guilt. The religious influence has been a powerful component in creating a pathway towards the development of sexual addiction. 36 (78%) of the sexual addicts identified as Roman Catholic and 5 (11%) as belonging to other Christian traditions including Anglican, Methodist, Presbyterian and Baptist. Brendan (TP), a trauma therapist who works with sexual addicts, argued that addictive sexual behaviour is certainly related to:

... things like the Catholic Church, most of the churches, the education system, that all promote this view of sexuality as being something shameful and hidden and secretive and can’t really be talked about in a normal manner or dealt with in a reasonable manner (TP 28, page 12).

18 (39%) of the sexual addicts in this study are homosexual, of which some reported that the churches’ message of negativity towards sexuality created a cultural homophobia. This resulted
in confusion, self-rejection and suppression of their sexuality. Some sexual addicts claimed that the church deprived them of a normal sexual education, robbed them of a loving relationship with God and created a multitude of negative hang-ups regarding sexuality; as Ciaran (SA), a forty-five-year-old gay sexual addict, with a history of child sexual abuse, explained:

_The Church’s condemnation of me as a gay man created such guilt and drove me underground for years. It caused enormous problems and definitely added to my sex addiction_ (SA 29, Questionnaire).

However, Val (TP), a consultant genitourinary physician who specialises in sexually transmitted infections (STI), remarked that anxiety regarding sexuality is not limited to Christians:

_Muslims suffer intensely from the moral dilemma that arises for them in relation to sexually addictive behaviours_ (TP 22, page 3).

The data highlight the significant role of religion in Ireland and the influence it has had on the development of sexuality. Many research subjects believe that the Church’s negativity produced shame, guilt and secrecy about sexuality which (Carnes 1983) suggests creates the ideal environment in which sexual addiction develops.

### 4.3.11 Miscellaneous Events and ‘Sexual Addiction’

In addition to the major predisposing factors towards the development of sexual addictive behaviour, some research subjects claimed that there are a host of what might be considered minor factors that contribute to the development of sexual addiction. These include events like the birth of their child, the collapse of a business, a response to conflict or the death of a loved one, events that other individuals manage without resorting to sexual addiction. Kate (TP), a psychosexual therapist who deals with sexual addiction, recalls a client who was sexually addicted to rubber. The origin of his addiction was possibly linked to the untimely death of the client’s mother and the keepsake he had of his mother’s rubber swimming cap, as Kate (TP) explained:

_I remember one story about a man who had an addiction to rubber, like a fetish and his story was that his mother died when he was five and the father was getting rid of all the clothes and he went to the back of the garden to pick out pieces, bits and pieces of his mam’s stuff and the one thing he saved, that he remembered for years, was her swimming cap which is rubber, you know, the ones with the flowers on. So you know, you just wonder about how much that feeds into that addiction later on in life_ (TP 11 page 1).

Research subjects claimed that sexual addiction is also associated with boredom, loneliness and a need for human connection. Others said that they pursued their sexual addiction because they had the opportunity to do so while others say that they their sexual addictive behaviour began by
accidentally discovering pornographic sites on the Internet which became more addictive over time. Research subjects discussed sexual addictive behaviour in the context of an intimacy disorder, a social phobia or both and treatment providers emphasised the importance of including these issues in a clinical assessment.

In general, these data suggest that the alleged origins of sexual addiction are complex with many predisposing influences combining intrinsic and extrinsic factors such as the neurochemical, physiological and psychological dynamics. The data imply that it is never one single factor that 'causes' sexual addiction. Research subjects reported that in many instances it is the combination of issues that coincide and which together predispose an individual to sexual addiction. Treatment providers appeared more aware of the range of pre-disposing issues, perhaps due to their training and professional experience. In comparison, some sexual addicts appeared to subscribe uncritically to the model of sexual addiction.

4.4 Realisation of 'Sexual Addiction'

Addicts said that they came to a realisation about their sexual addiction in many different ways. Generally it was a process that happened slowly and coincided with their behaviour becoming more addictive and resulting in increased negative consequences. Some addicts found it difficult to understand and accept that they could be addicted particularly to sex, which they perceived as a normal dimension of life. In trying to understand their addictive sexual behaviour some believed that they had a high sex drive or a lack of self discipline. As a result of an escalating need for sex Ivan (SA), a twenty-six-year-old sex and food addict, realised the existence of an addictive pattern:

> It was only when the addiction went up a level and I started going to saunas for anonymous sex that I really realised I had a problem. And still I didn't call myself a sex addict. I didn't call myself a sex addict until I went to my first meeting at SLAA, and I don't think I truly believed I was a sex addict for a couple of weeks after that. I thought I had a problem with sex (SA 9, page 7).

Other sexual addicts realised that they had a problem with their sexual behaviour for a considerable length of time but did not acknowledge it nor did they seek help immediately but continued to repeat their behaviour as Darren (SA), a fifty-one-year-old sexual addict recently divorced, explained:

> I had become very conscious of the fact that it was consuming ridiculous amounts of time. I was losing track of time, I wasn't focused on my work, I wasn't focused on my family. I was letting things slip that I normally would manage very very efficiently and despite recognising all these symptoms, I would still repeatedly go back and spend three to four hours on the Internet, three or four nights in a row. And you become absolutely
exhausted and then you had to stop because you physically couldn’t keep it up because you would fall asleep. So I spotted that, but didn’t know what to do about it (SA 4, page 3).

In many instances the sexual addicts deny the sexual addictive behaviour until it escalates. Typically, the sexual addiction is identified as a result of a crisis. Sexual addicts typically seek help when they experience a crisis, as Rory (TP), a psychotherapist who specialises in sexual addiction counselling, explained:

Initially they would have come in . . . maybe in some crisis . . . quite often it’s some crisis that has brought them to seek help you know. They have got into some trouble at work or home, they have got into trouble with the police for cruising, or something, or the wife has found out something. So they arrive in quite a battered state usually in some crisis and needing to deal with something or to get something off their back (TP 44, page 7).

The realisation of a sexual addiction was further confirmed by the continuous lack of intimacy and emotional fulfilment regarding their sexual relationships. Referring to the lack of intimacy with his girlfriend and the over concentration on the sexual aspect of the relationships, Edward (SA), a thirty-one-year-old sexual addict who is also addicted to gambling, said:

That relationship was unhealthy because sometimes I was nearly too tired to see that particular girl . . . but I would still do it because the sex was there. There were times that I wanted to get out of that relationship, but because of the sex I was stuck. I was addicted to the sex, and I could never finish it [the relationship] (SA 5, page 4-5).

In some instances it was necessary for a major incident to occur, such as being arrested for committing a crime, before the individual sought help. Finbar (SA), a fifty-two-year-old single gay sexual addict, explained that he had become accustomed to taking risks and had been cautioned by the police for sexually cruising in public parks in pursuit of sex. Despite the police caution, it was only after a more serious incident that he realised that he was out-of-control. After consuming some alcohol in a pub Finbar (SA) explained what happened:

I made an inappropriate pass on a male in a straight pub. That scared the hell out of me. By making the inappropriate pass on that guy I felt that I assaulted him. When I say it scared me, it was an alarm bell. I realised I was out-of-control (SA 6, page 4-5).

Ivan (SA), a twenty-six-year-old sex and food addict, realised that he was addicted to sex when he had acquired all that he wanted in life but continued to crave anonymous sex everyday:

I still had this need to go and have causal anonymous sex everyday and if I didn’t have it, I would crave it. I knew at that point after about a year that something wasn’t right (SA 9, page 11).
Other research subjects like Xavier (SA), a sexual addict, who experienced sexual abuse, substance use and depression, realised the presence of his sexual addiction when he could not do without sex, as he explained:

>I couldn't do without it...it was like a drug to me you know. I got a good feeling from it, it took me out from myself and whoever I was with or whatever we were doing, it was a safety net...it was a comfort...nothing else mattered at the time just what was going on. So yes it was really...it took me away from myself. It was definitely...it was like a drug, you know. I got great feeling from it, you know, even afterwards it was like, you know, my body was just buzzing, you know and I loved that feeling and it would just...I constantly was searching for it, like (SA 24, page 22).

Sexual addicts also said that a realisation of their sexual addiction sometimes came through other people who suggested that their behaviour was addictive such as family members, or professionals. Val (TP), a consultant genitourinary physician who specialises in sexually transmitted infections, explained that some of his patients have insight and realise that their sexual behaviour is addictive:

>I see people who come to me to be screened for transmitted infections. Some of the people who come to me, come to me because they are habitual visitors to escorts and prostitutes and some of them have insight, and they appreciate they have an addiction (TP 22, page 1).

In Val's (TP) experience most patients are receptive to his clinical advice regarding sexual addiction:

>Most patients are relieved when you address the problem [sexual addiction] and point it out to the people concerned. They express relief that you identify the problem and that there are ways of dealing with it and that is that they're not alone in this. They are aware of the compulsive nature of their behaviour and they try to fight against it (TP 22, page 5).

Val (TP) also said that some patients ignore the clinical advice to seek help for sexual addiction and for some the sexual addiction develops. For others the realisation that a sexual addiction exists is frequently the catalyst for change, and usually marks a significant turning point regarding the sexual addict's behaviour.

4.5 The Development of ‘Sexual Addiction’

It is believed that over a period of time the addiction to sex gradually develops. Eventually the sexual addicts recognise that there is something wrong with their sexual behaviour. Some
sexual addicts who recognise that their behaviour is problematic and who have experienced serious repercussions as a result are still able to ‘manage’ their sexual addiction for a certain period and many continue to ‘function’ externally at home and at work while internally they experience conflict and dissonance. After a period of trying to manage the sexual addiction, the situation invariably becomes worse. Darren (SA), a fifty-one-year-old sexual addict recently divorced, described how his sexual addiction gradually developed:

*I suppose looking back now, it’s easy to sort of say there was an underlying issue going back quite a number of years. But the real truly addictive behaviour probably only became obvious to me about two years ago … I became obsessed with Internet pornography, viewing images, staying up late to watch them* (SA 4, page 1).

Oliver (SA), a fifty-six-year-old sexual addict who is in recovery from alcohol, as a young married man in his early twenties was not able to manage his sexual addiction which was expressed in the ongoing multiple affairs:

The affairs started, in fact they never ended. The one I was having before I got married continued. So there was never a time in my marriage when I wasn’t seeing another woman, sometimes two or three (SA 15, page 9).

Despite his effort to cut down and control his behaviour, the sexual addiction escalated and as a result his marriage ended and he lost his wife, children and his job. Sexual addicts explained that the development of the addiction is often expressed in the increasing need for more intense sexual experiences. Their sexual appetite is increasingly difficult to satisfy. Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution and whose first marriage broke down, explained how over time he required more intense experiences to satisfy his sexual desire:

*Well you know, it would’ve started off with for instance straight sex with a prostitute, and then I would be looking for prostitutes that would offer more than that. And then it became two prostitutes at once and then eventually what really sort of caused me major concern was that I started to look for prostitutes that would offer unprotected services. So that was when it became really dangerous and extreme and life threatening* (SA 12, page 3).

Another indication regarding the development of the sexual addiction was that the addict frequently tried to stop but failed. The sexual addict, after realising that their behaviour was going out-of-control would often make a commitment to stop. Nevertheless, as the craving for sex returned the commitment to stop would not last long and they would return to their addictive pattern within a short period of time. Peter (SA), a forty-nine-year-old sexual addict who was sexually abused and who is divorced, explained the experience of not being able to stop:

*I would walk out from a paid for sex experience and say … I don’t want to go back there again … but I’ll just masturbate instead, and thinking that that would kill the craving,*

"cut it down ... no, it would always return a few days later ... or whatever, you know"
(SA 16, page 5-6).

Taking of higher risks is also another indicator of the development of sexual addiction. Over time the risks increased such as meeting prostitutes, using work resources to access pornography, or engaging in unprotected sex. As the risks increased, the negative consequences of their behaviour escalate. Rory (TP), a psychotherapist who specialises in sexual addiction counselling, described some of the high-risk situations which clients present in clinical practice:

*I worked with people who would take huge risks around their own personal safety and around their health. I mean, I suppose a classic example of that is someone who would be compulsively visiting prostitutes and cruising around parts of town late at night, taking strangers into their car. I have worked with people who have been attacked, who have been beaten up, who’ve had syringes held to their neck and robbed, all that sort of thing; and these would be married men who would be going home to climb into bed with their wife as well. So there are huge consequences in terms of someone’s circumstances, but also in terms of someone’s health and safety as well* (TP 44, page 12).

The data suggest that a sexual addiction commonly develops over a period of time and usually becomes more difficult to control and more obvious as time progresses.

4.6 C h a r a c t e r i s t i c s o f ‘S e x u a l A d d i c t i o n ’

The concept of sex viewed as an addiction is relatively new. The distinction between addictive and ‘normal’ sexual behaviour is frequently disused by research subjects, demonstrated by Darren (SA), a fifty-one-year-old sexual addict recently divorced:

*I don’t know if it was out-of-control or if it was normal. It is hard to judge normal because you had nothing to judge yourself by. Is what I’m doing normal?* (SA 4, page 9).

The data suggest that the concept of sexual addiction can be distinguished from ‘normal’ sexual behaviour by the following characteristics.

4.6.1 O u t - o f - C o n t r o l S e x u a l B e h a v i o u r

Sexual addiction is often identified when an individual admits that their sexual behaviour has gone out-of-control. Sexual addicts usually have a desire to stop their pattern of sexual behaviour but repeatedly fail to do so. Brid (TP), who offers cognitive behavioural therapy (CBT) and who specialises in sexual addiction counselling, suggested that recognition that their sexual behaviour is out-of-control and a request for professional help are common indicators that a sexual addiction exists:
When somebody comes to me, they have usually recognised themselves that their behaviour is out-of-control and that they need help (TP 2, page 1).

The out-of-control characteristic of sexual addiction is frequently acknowledged by sexual addicts as Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution, explained:

I call myself a sexual addict because I have in my life had times when fantasy about sex and sexual acting out of one kind or another has completely taken over and been impossible for me to control. So I have been at times just completely in its power trying to stop, desperate to stop and completely unable to stop ... and it has come very close to destroying my life so that's what why I would call myself a sex addict (SA 12, page 1).

4.6.2 Secrecy

Secrecy is another key characteristic associated with sexual addictive behaviour. Secrecy protects the sexual addiction from being revealed and therefore allows the sexual addict to continue engaging in their addiction uninterrupted. The secrecy is also used to minimise the negative consequences associated with the sexual addictive behaviour. The element of secrecy is also linked to the complex perceptions of sexual addiction. Some view prolific sexual behaviour positively and see it in terms of being 'macho' and admirable. On the other hand, the concept of sexual addiction is generally regarded as a cultural taboo and is perceived as being abnormal. As a result, there are few people with whom the sexual addict can truthfully speak and as a result the sexual addiction becomes more secretive as Matt (SA), a forty-five-year-old married sexual addict, explained:

I couldn't talk about it with a lot of my male friends because they just thought I was macho in terms of the kind of stuff that I was up to. So a lot of people around, I wouldn't have been able to talk to them about it (SA 13, page 16).

A number of factors coincide to create and sustain a culture of secrecy which militates against the sexual addict from speaking about their behaviour, and which causes further secrecy. The sexual addict becomes caught into a complex covert network where they often feel trapped into a secretive double life as Finbar (SA), a fifty-two-year-old single gay sexual addict, explained:

It's like a double life; it's like Jekyll and Hyde. A double life because in other areas of your life, you are very professional in your functioning and you're being valued. You had friends but there was a huge camouflage going on between that and my sexual behaviour (SA 6, page 5).
4.6. CHARACTERISTICS OF 'SEXUAL ADDICTION'

4.6.3 Shame

Shame is a significant characteristic associated with sexual addiction. It is presented as both a cause and a consequence of sexual addictive behaviour. Shame is typically connected to issues such as negative childhood experiences, disapproval, past mistakes or feelings of inadequacy. Others reported that their shame is explicitly connected to their sexuality in terms of shame resulting from sexual abuse or the inheritance of a cultural or religious based shame as Arron (SA), a thirty-eight-year-old sexual addict who experienced sexual abuse and depression, explained:

I grew up in a Catholic family so it was incredibly shameful. Anything to do with sex was not spoken about or frowned upon or negated on some level. It wasn't something that was encouraged or spoken about or something that was liked (SA 1, page 10).

The dynamic of shame and sexual addiction is complex. Gary (SA), a forty-two-year-old, gay male sexual addict in recovery from substance use, explained that the locations where he chose to have sex were associated with shame. These locations reflected and compounded his inner shame which reinforced a negative self-image. In an effort to cope with this self-disgust he engages in 'numbing sex' which continues the self-sabotaging cycle of sexual addiction:

I would have sex in saunas or parks or public places, toilets, that sort of thing where there was an element which I think was probably important for me, an element of danger or an element of shame ... Like, I mean, to have sex in a toilet with somebody you don't know, there is something crude about it ... that it wasn't a classic sexual situation. So there always had to be ... it was almost as if I needed to compound what I was feeling about myself by acting out in a situation that represented that for me ... I think that is probably a rejection of me, an element of me being disgusted with myself and I don't want to present that disgusting or disgusted side to somebody else ... So it just appeared to be easier to have numbing sex (SA 7, page, 14-15).

Ironically, the result of the process of using sex to numb out difficult feelings of shame or self-disgust only produces more shame. Consequently, many sex addicts become entangled in a spiral of shame as Noel (SA), a fifty-one-year-old sexual addict, who is also recovering from alcohol addiction and whose second marriage has ended, explained:

I masturbate to take me out of the feelings but the very act of doing that locks me into a cycle of shame and feeling bad and so I have to continue the activity to keep medicating the feelings and on it goes (SA 14, page 8).

Jane (SA), a thirty-nine-year-old gay sexual addict in recovery from substance use, explained the intensity of shame related to sexual addiction:

Sexual addiction is a much more secretive, covert, hidden, shaming addiction for me than alcoholism ... There's nothing like the shame associated with sexual addiction
...it’s very different in that way. I’ve vilified and hated my own sexuality and how wrong I made it, instead of seeing it as something that is light, joyous, fun and free, which is what I’m feeling now. But my God I’m coming up to forty. It’s been a long journey. I struggled for years with the shame... shame I didn’t even understand (SA 10, page 8-9).

4.6.4 Compulsion

Compulsivity is a common feature associated with sexual addiction. Compulsivity expresses itself in a variety of ways and impacts people differently. Some sexual addicts described their sexual addiction as something that they did not look forward to but were ‘compulsively’ driven to. For others it became something that they began to hate, but felt compelled to do as Brian (SA), a thirty-four-year-old sexual addict, who is bisexual and recovering from substance use, indicated:

Sexual addiction has been a big struggle in my life. It has caused me a great deal of pain and insecurity you know, acting out sexually but not wanting to but not being able to stop (SA 2, page 1).

Brendan (TP), a trauma therapist who works with sexual addicts, explained the compulsive nature of sexual addiction:

It’s just a strong feeling to satisfy an impulse which becomes more and more demanding. The pressure builds and they feel like they have to do this behaviour and when they do it sometimes they have feelings of euphoria but invariably it never really satisfies (TP 28, page 1).

Compulsivity observed in sexual addicts often leads to a preoccupation with sex which then becomes their sole pursuit and results in out-of-control behaviour.

4.6.5 High-Risk

The final major characteristic of sexual addiction identified by research subjects is the association of sexual addiction with high-risk behaviour. These data suggest that the sexual addict’s high-risk-taking behaviour generates a combination of danger, excitement and fear. This typically creates an adrenaline rush which features as a significant component for some sexual addicts. Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy and who works with sexual addicts explains the dynamics relating to the high-risk behaviour and said:

The thrill is kind of like escaping and getting away from things with a bit of the adventure. Whom am I going to meet, what it’s going to be like? A bit of danger, if there was cruising or cottaging in public areas. A bit of apprehension but mixed with a bit of excitement (TP 32, page 10).
As the sexual addiction develops the sexual addict takes increasingly higher risks which are often linked to chasing a 'buzz' which mirrors a similar dynamic experienced in substance abuse. The combined mixture of danger and excitement generates the buzz factor which Frank (TP), a treatment specialist with sexual offenders, some of whom are sexual addicts, explained:

Another interesting part of it [sexual addiction], is the buzz factor. It's not just the sexual aspect of it. Quite often they'd be surfing and looking at these images and it's the buzz and the excitement of finding it and of possibly being caught ... the excitement of it. Not wanting to be caught ... but the illicit part of it (TP 6, page 1).

As the sexual addiction develops, the individual may take higher risks in order to achieve a more intense sexual experience. This can result in dangerous behaviours as Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, explained:

People who engage in more extreme sexual practices like sexual asphyxiation ... often a behaviour that is engaged in by those whose ability to sexually respond has been eroded in the same way as someone who takes drugs ... you have to take more and more, and they have to be stronger and stronger in order to achieve the effect (TP 25, page 9).

Some addicts also spoke about the relationship between high-risk behaviour and self-punishment. This is more obviously observed by those who engage in high-risk sexual activity, while knowing about the possibility of causing harm to their health. Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction, described one of his patients whom he speculates is using high-risk sexual addictive behaviour to punish himself:

I have a patient who goes to a sauna and he knows what he's doing is very, very wrong. He has unprotected sex with men, one after the next ... and he's going to get HIV. There's no doubt in my mind ... and he knows he will, but there's nothing he can do to stop it. He just feels totally disempowered. I think part of him wants to punish himself (TP 23, page 3).

The high-risk behaviour was also described by some research subjects as a possible desire to get caught, or as an unconscious cry for help.

The sexual addict's pattern of sexual behaviour is typically characterised by out-of-control behaviour, secrecy, shame, compulsion and high-risk behaviour. The combination of these factors facilitates the creation of the cycle of sexual addiction.

### 4.6.6 The Cycle of ‘Sexual Addiction’

Many research subjects referred to a cyclical pattern or a typical routine which the sexual addict habitually follows, and which reflects the cycle of sexual addiction frequently associated with Carnes (1983). Research subjects described the cycle beginning with a 'trigger' of some kind which
ignites sexual desires and thoughts. These thoughts may include the sexual addict fantasising about the outcome of their sexual thought or planning a sexual encounter. The sexual addict ruminates over these sexual thoughts which lead to the next stage involving pre-sexual rituals. This typically culminates in sexual addicts engaging in their sexual addictive behaviour. It was suggested by research subjects that the ritual is almost as important as the sexual encounter. The aftermath of the sexual encounter frequently produces temporary relief. Despite the initial relief, the sexual addict typically experiences feelings of disappointment, emptiness, regret and shame in the aftermath of the entire sexual cycle. It is suggested that sexual addicts find it difficult to manage negative feelings and often use sex to regulate their emotions. These negative feelings are usually the trigger which instigates the entire process all over again and consequently the cycle of sexual addiction begins as suggested in previous studies (Estellon & Mouras 2012). The central elements of this cycle of sexual addiction were observed in Liam's (SA), pattern of sexual behaviour. Liam (SA) is a forty-five-year-old married man who is addicted to a ritualistic process of making arrangements with prostitutes to have unprotected sex, as he explained:

*I planned for literally a month in advance to set this meeting up [with a prostitute]. I put an ad out on this Internet site saying that I was looking for a prostitute that offered unprotected sex on that night and I had a number of responses, maybe 15 to 20 responses and started to contact them. And then I cancelled them all at the last moment and thought I had managed to beat it. And then on the night, I phoned one of them at the last minute and arranged it and had unprotected sex with that prostitute* (SA 12, page 4).

Noel (SA), a fifty-one-year-old sexual addict, who is also recovering from alcohol addiction, and whose second marriage has ended, said that his cycle of sexual addiction, which is motivated by anxiety, contains specific rituals. Noel (SA) explains that the rituals which reflect previous studies (Black, 2009) are equally as important as the sexual behaviour itself:

*Inevitably, it follows when I'm very anxious or worried and I resort to the old remedy of acting out sexually, because it takes me out of me for a period of time. It's as much about the routines leading up to it. It starts with Internet pornography and I will only have one quick look and two hours, three hours, four hours go by and I get into a mesmeric trance . . . then I will act out. I will either masturbate or I will start phoning hookers . . . sometimes I would then go to see the hookers but in most cases there's no actual sex involved . . . or there's maybe only masturbation involved* (SA 14, page 2).

The cycle of sexual addiction often results in an unsatisfactory sexual experience rather than producing a sexually fulfilling encounter, as Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, explained:
4.7. Conclusion

Clients who are describing sexual addiction say that, it’s not a satisfactory sexual experience . . . it’s a temporary release . . . it’s getting rid of the compulsion which then lets you function for another while . . . it’s not in any sense a satisfactory or complete sexual encounter (TP 25, page 1).

The cycle typically ends in an unsatisfactory sexual experience which creates further despair and leads the sexual addict to seek relief by seeking more sex which begins the entire cycle again. The data demonstrate that the continuation of this repetitive cycle typifies sexual addiction and the breaking of this cycle indicates a process of recovery from sexual addiction which is discussed in chapter six.

4.7 Conclusion

This chapter presented a limited set of data, containing explanations regarding the aetiology of this putative condition namely, sexual addictive behaviour, from the research subjects’ perspective. The data have primarily focused on the origin, development and continuation of compulsive and out-of-control sexual behaviours. There are obvious differences among sexual addicts and treatment providers in the way they understand the origin and maintenance of sexual addictive behaviour. There are also similarities in that both groups of respondents are operating in an area which is relatively new and in which there are limited research findings which offer objective explanations for the fact that some people appear to become trapped in highly-risky sexual behaviours.

In summarising this chapter’s findings, it seems necessary to restate what has been said earlier about ‘effort after meaning’ (Garro 2007): a concept which refers to the tendency which some people have retrospectively to find explanations for difficult events or situations which they experience. In terms of causality, the sexual addicts, whose explanations tend to be more personal and emotional, explain their sexual addictive behaviour as a maladaptive response to childhood trauma. It should be emphasised, therefore, that the causal explanations offered in this chapter, particularly by sexual addicts must be interpreted with caution, since they represent the concept of ‘effort after meaning’ (Garro 2007). These explanations make sense to those who make them and from a counselling perspective, the views expressed by sexual addicts must be treated with respect; this is not to say that they should be automatically accepted as having scientific validity. In contrast, the treatment providers typically assume a more detached and scientific approach to this topic.

The causal explanations for sexually addictive behaviour which have been presented in this chapter draw both on wider cultural and social circumstances, such as ambiguity about what constitutes ‘normal’ sexuality or prejudices against homosexuality, and on specific difficult life events, such as poor bonding with parents or childhood abuse or neglect. Addictive sexual behaviour may be a plausible explanation to difficult childhood experiences for some. However, such explanations are non-specific, and it would be illogical to accept them as conclusive evidence of the causes of
sexual addiction. Many individuals who experience similar difficulties, such as abuse or neglect, do not develop sexual addictive behaviours. There is no reason to believe that difficult life events or broader cultural factors are either necessary or sufficient for the emergence of such an addiction. Conversely, some individuals who experience early childhood difficulties often develop strong coping skills and demonstrate resilience in managing life successfully.

On the basis that research subjects have indicated that sexual addiction is a dysfunctional and counterproductive coping mechanism for managing emotional difficulties, perhaps the most that can be said is that early-life traumas predispose some people more than others towards this particular form of maladaptive behaviour. It may also be the case that many individuals who have experienced early-life traumas are protected by an individual temperament or personal resilience from developing either sexual addiction or other maladaptive behaviours to life. In conclusion, then, the causal explanations for sexual addiction presented in this chapter must be regarded respectfully as having meaning for those who propose them, and they may offer practical help in treatments aimed at resolving or managing such addiction. This is not to say, however, that causal explanations of this kind should be privileged with scientific status.
Chapter 5

The Lived Experience of ‘Sexual Addiction’

5.1 Introduction

Chapter Five, the middle of three findings’ chapters, is intended to provide a rich detailed account of the ‘lived experience of sexual addiction’. This account is from the perspectives of the two groups of research subjects interviewed for this project: self-defined sexual addicts and treatment professionals who work with these addicts. The findings in this chapter are broadly organised around key features of the addiction process which correspond with the diagnostic criteria and general clinical accounts of what constitutes addiction to psychoactive substances, as discussed in the literature review. The key features of the addiction process in terms of sexual addiction are: 1) the use of progressively higher or more extreme forms of sexual behaviour in order to maximise pleasure, broadly comparable with the experience of drinkers whose raised tolerance for alcohol demands increased consumption in order to achieve the desired level of intoxication; 2) a sense of compulsion to engage in sexual activity and an accompanying sense of loss of personal control over this behaviour, again comparable with the alcohol dependent’s ‘loss of control’, and 3) persistence with this type of sexual behaviour in the face of clear evidence of its harmful consequences, comparable with continued drinking by an alcohol-dependent drinker despite the realisation that drinking is damaging significant aspects of the drinker’s life.

As stated in Chapter Four it is necessary to acknowledge that the data contained in this Chapter, in terms of the research subjects’ understanding of the concept of sexual addiction, is influenced by their backgrounds. The treatment providers’ views on sexual addiction are obviously shaped by their professional education and training, and in particular by the application of models of addiction which have largely been developed in relation to the ingestion of psychoactive drugs. The self-defined sexual addicts in this study generally constitute a ‘treatment population’, that is
people who are (or have been in the past) exposed to treatment processes. Those who are, or have been, in treatment of one kind or another are, by definition, people who demonstrate a certain willingness to accept health system labelling of this kind and who are prepared to define themselves as sexual addicts. As a result their understanding of the concept of sexual addiction is influenced by the treatment philosophy, which many of them positively subscribe to.

Once again it is important to highlight the difficulties which exist in relation to the labelling of any forms of sexual behaviour as pathological or symptomatic of disease in light of the lack of cultural consensus as to what constitutes ‘normal’ sexuality. As mentioned repeatedly, applying DeLamater (1981)’s framework, which identifies three main perspectives (procreational, relational and recreational) on human sexuality, it is clear that what constitutes pathological forms of sexuality is likely to be relativistic and culture-bound rather than based upon objective medical scientific criteria. For instance, to those whose views about the functions of sexuality are confined to the procreational and relational spheres, the use of modern forms of electronically accessible pornography may well seem as ‘sick’. In contrast, to those whose views are mainly of the recreational type such use of pornography is normative and healthy. As a result all accounts of sexual addiction presented as pathology in this chapter must therefore be seen as reflecting shifting and often contentious cultural norms rather than scientific consensus about disease states.

While this sense of sexual addiction as a social construct rather than an agreed disease entity is applicable to all of the accounts of sexual addiction presented in this chapter, the contested nature of this construction becomes particularly pointed in relation to the presentation of data on sexual addiction as found amongst homosexual or gay men. As will be discussed later in the chapter, there are radically differing views as to what constitutes a normal sex culture for gay men. For some gay men the very essence of gay sexuality is its emphasis on recreational sex, revolving around clubs and bath houses and involving multiple partners and a general hedonism. For other gay men, to whom sex is primarily relational, hedonism or promiscuity of this kind is abnormal or pathological and may be perceived as addictive. As with other conflicting value systems, there is no scientific basis for deciding which of these two perspectives is correct, and the views of treatment providers reported in this chapter give a sense of the subtlety and sensitivity required to work clinically with gay men and others in the absence of cultural consensus or absolute clinical guidelines.

5.2 Expression of ‘Sexual Addiction’

The data identify multiple expressions of sexual addiction. Sexual addicts in this study used paid-for-sex, Internet, phone and anonymous sex, pornography, exhibitionism, voyeurism, masturbation and fantasy. Sexual addicts used these behaviours alone and with others and with varying degrees of frequency. Sexual addicts spent a considerable amount of time pursuing their sexual addiction. Others spent a significant amount of money on their sexual addiction and this is often more
noticeable for those who engage in paid-for-sex. The sexual addictive pattern often involved a series of continuous, multiple, concurrent and or, once off sexual relationships. Sometimes the relationships were with individuals that were known to the sexual addicts and other times the sexual encounters were anonymous. The sexual addict's behavioural pattern changed over time and often involved a gradual movement from one sexual activity to another type. This change of behaviour may indicate the development of the addiction where sexual addicts seek an increased amount of sexual activity to satisfy their appetite. Edward (SA), a thirty-one-year-old sexual addict, who was also addicted to gambling, referring to the relationship that he had with his girlfriend, described some features associated with his sexual addiction. In addition to sex with his girlfriend, Edward explained how his sexual addiction developed from casual sex to paid for sex:

> I picked her [girlfriend] up one day from a fella's house that she was seeing. She was seeing other people as well and so was I ... I brought her back to her house and I just knew it wasn't right. I remember saying to her ... 'this has to stop like, it's crazy' ... and she was someone that I didn't want a relationship with but she was someone I couldn't give up because of the sex ... that sort of developed ... like easy sex developed into paying for sex as well ... you know, no emotional sort of contact you know (SA 5, page 4).

The expression of sexual addiction is usually focused exclusively on the pursuit of sex and it frequently excludes the development of emotional intimacy. Jane (SA), a thirty-nine-year-old gay sexual addict in recovery from substance use, distinguished sexual addiction from healthy sexuality as she explained:

> The self-enforced distancing from any healthy sexuality which is like ... meeting regular women to go for a coffee or to hangout or hold hands or any stages of intimacy before sex ... I had none of that. It was like seeking sex ... There was nothing with stages of flirting or any kind of levels of intimacy prior to that ... so it all fixated on orgasms and nothing before it ... I didn't give a fuck about anything like that [intimacy] (SA 10, page 7-8).

The inability to develop intimacy was reported as a recurrent pattern among sexual addicts in this study, a pattern reflected in previous research. Schwartz and Galperin (2002) state that some individuals have an aversion to sexual intimacy in close relationships while at the same time they can be sexually active with people who are unfamiliar. This is often more noticeable among individuals who have been sexually abused. Other sexual addicts spoke about how they sought out anonymous sexual partners. To achieve this, the sexual addict purposefully went to bars and nightclubs to 'pick-up' a sexual partner. Many gay and bisexual addicts pursue anonymous sexual encounters in public places such as parks, toilets or saunas in the hope of having anonymous sexual encounters. Adult sex shops, swingers' clubs and orgies were also used to engage in anonymous
sexual behaviour. Rose (SA), a thirty-nine-year-old single sexual addict, explained that for her the pursuit of anonymous sex was a very calculated process which entailed concealing her true identity in order to secure sex:

... drinking enough to go over to them or make them come over to you and then being a completely different person to the person you are ... lying about maybe your age ... lying about what you do ... lying about where you live ... because you know in a way this is only going to be an anonymous thing so you don’t want to tell them who you are. So you have to ... kind-of-be on high alert to make sure that your story fits and put on a massive act (SA 18, page 12).

In contrast to anonymous sexual encounters, Ursula (SA), a twenty-two-year-old sexual addict, who was recovering from substance use, explained that she sexually engaged with people with whom she was acquainted such as work colleagues:

In the nightclub that I worked in, I was with just two or three of the people that were there ... and even the job I got after that ... I was only there about two weeks and I was with the boss (SA 21, page 8).

Sexual addiction often resulted in the breaking of social and sexual boundaries. Ursula (SA) claimed that as a result of her sexual addiction she had sex with her friend’s father when she was in her late teens:

I was coming home one night from my friend’s [house] and I wasn’t even drinking. I met someone down at the bottom of the road. It was my friend’s father ... like, do you know what I mean ... and she [her friend] still doesn’t know. You know he’s married and all ... in the park down the road (SA 21, page 9).

Another major expression of sexual addictive behaviour was paid-for-sex scenarios. The main types of paid-for-sex situations include Internet and telephone sex, pornography, saunas and prostitution. The paid-for-sex behaviour was sometimes perceived as an indication that the sexual addiction has reached a more advanced stage of development and a sign of the addict’s need for increased sexual intensity. Paid-for-sex is expressed differently in terms of gender and sexual orientation. In this study 14 (30%) male sexual addicts used paid-for-sex, and one incident of a gay woman addict using paid-for-sex in terms of using female saunas is noted. The amount of money used on paid-for-sex varies but generally it ranged from 20 to 200 euro a week. Quintan (SA), a middle aged gay sexual addict who is in recovery from substance use, explains how financially difficult his addiction became:

I couldn’t get satisfaction so the behaviour was becoming more extreme. It was becoming financially ruinous on us because of the prostitution ... spending money with prostitutes is a very expensive business so it was becoming financially ruinous (SA 17, page 20).
In this study, prostitution was most frequently used by heterosexual male sexual addicts, but a minority of gay male sexual addicts also paid for male prostitutes. The most common routine among those who used prostitutes was to use the Internet to make initial contact with an agency or an individual prostitute. This typically led to making an appointment with the prostitute, followed by a sexual encounter and payment for the sexual services received. The paid-for-sex scenario is different for the gay male sexual addicts who typically used the Internet and sexual saunas. The Internet was commonly used by gay sexual addicts to access prostitutes, buy pornography, and for on-line dating sites such as Gaydar to pursue sexual partners. The sexual sauna, often referred to as a bathhouse, is a venue where men can have sex with other men, and it was generally used by gay and bisexual men. The payment is made by way of an entrance fee to use the sauna, and payment to an individual with whom the sexual encounter happens is not usual but may happen.

A different pattern of paid-for-sex emerged for females. One gay female sexual addict in this study used a female sexual sauna in the USA but there was no case of a female sexual addict hiring a prostitute in this study.

The treatment providers in this study also described a number of scenarios where prostitution, substance use and sexual addiction coalesced and created a very complex situation. The data reveal that some self-identified female sexual addicts have worked as prostitutes, many of whom had a concurrent substance use addiction. Prostitution was a means of feeding their drug and alcohol habit. It is generally common for women who once engaged in substance use and prostitution, to stop prostitution after they have successfully stopped substance use. However, this does not always happen as Orla (TP), a project worker working with female substance users, some of whom experienced sexual addiction, explains:

*I worked with one [sexual addict] who had a lot of abuse as a child and this woman presented with addiction, had been prostituting, had an awful lot of money as well... but still, you know... still would go back to her addiction and selling herself again even though she didn’t need it [the money]* (TP 15, page 7).

Orla’s (TP) clinical case described above, about the continuation of prostitution after the substance use is stopped may indicate the presence of sexual addiction as an independent entity, but further research is required to investigate this type of phenomenon. The data in this study suggest that sexual addiction may be understood as a residual pattern of behaviour of those in recovery from substance use. The concept of prostitution and sexual addiction, particularly among females and specifically among substance users is a very complex and controversial issue. Research subjects drew attention to the need for educational input regarding sexuality for substance users in recovery, which is also addressed in recent research (Siegel 2011). Ann (TP), a social worker with prostitutes, some of whom were substance users, said that there is little evidence among prostitutes to suggest the presence of sexual addiction (TP 27, page 11). Ann (TP) argued that many individuals who engage in prostitution are ‘sex-workers’ who freely choose prostitution as a profession, an opinion
which is not accepted by all research subjects. The pattern of prostitution, in terms of selling sex in order to obtain money, is predominantly associated with females in this study but not always. 2 (4%) males, one heterosexual and one homosexual, prostituted themselves and in both instances money was a motivating factor. Gary (SA), a forty-two-year-old gay male sexual addict in recovery from substance use, explained his experience of prostitution:

I would have sex with them and they would give me money. And I remember spending quite quickly afterwards because I would feel really guilty about...you know what was happening and then there was one or two men that I would meet regularly and it just kind of became the thing that happened. And then there was the couple of times when I actively engaged in prostitution and that was set up by somebody else (SA 7, page 9).

The data reveal that many male heterosexuals expressed their sexual addiction by buying the sexual services of prostitutes. There was a lack of clarity surrounding individuals, typically female substance users, who prostitute themselves. The data imply that many of these individuals engage in prostitution in order to secure drugs or accommodation, but clearly the relationship between prostitution and sexual addiction is complex.

In contrast to the popular association between sexual addiction and anonymous sexual encounters, sexual addiction was also reported within permanent relationships. The data indicate that sexual addiction within a permanent relationship was difficult to identify but may be recognised by observing the sexual addicts’ motivation, and their pattern of sexual behaviour. In terms of motivation, the sexual addict in a permanent relationship may objectify their partner for the function of sexual gratification. Sexual addiction in a permanent relationship may also be observed in situations when sexual addicts request their partner to have an open relationship which gives the sexual addict permission to engage in casual sex outside the relationship. Quintan (SA), a middle-aged gay sexual addict who is in recovery from substance use, explained:

My partner would have actually preferred to be in a monogamous relationship but he sort of went along with my sexual mores. There were huge stresses because I wanted to act out all the time and I was saying, 'this is an open relationship and this is the way to lead a gay life and he went along with it and our life became quite debauched' (SA 17, page 9).

Voyeurism is another expression of sexual addictive behaviour that 9 (20%) sexual addicts reported using. Voyeurism involved the sexual addict covertly watching others, who are engaged in activities, usually deemed as private, in order for the sexual addict to receive sexual pleasure. Some sexual addicts say that voyeurism is their primary expression of sexual addiction and for others it may only be an ancillary issue.

Another expression of sexual addictive behaviours was described in terms of exhibitionism. 8 (17%) of the sexual addicts in this study claimed that exhibitionism is a behavioural expression of
their sexual addiction involving some type of sexual exposure in order to generate sexual pleasure. In the data, exhibitionism expressed itself in a variety of different ways such as sex in public places, in group sex situations, strip clubs and cybersex. Sarah (SA), a twenty-one-year-old sexual addict who was also addicted to alcohol and drugs, used exhibitionism as a primary expression of her sexual addiction. Sarah (SA) started work as a strip-o-gram when she was eighteen years of age, as she described:

\[\text{The week I left school after my Leaving Cert I started doing strip-o-gram and I loved it. I liked the buzz... I liked the excitement you know. Everyone's eyes on me... I am the centre of attention. You were paid to take your clothes off and dance around going out singing happy birthday to whoever it was... reading a poem... stripping down to your bra and knickers (SA 19, page 3-4).}\]

Masturbation was also identified as an expression of sexual addictive behaviour by 9 (20%) sexual addicts in this study. The data suggest that masturbation was usually undertaken as a solitary sexual behaviour. Sexual addicts frequently use an archive of mental images and fantasy from previous sexual experiences to intensify the masturbatory act. Some sexual addicts say that they experienced compulsive masturbation, even to the point of genital injury. Other sexual addicts like Edward (SA), a thirty-one-year-old who was also addicted to gambling, became concerned about the frequency and intensity of his masturbation behaviour:

\[\text{My masturbation would have increased and I would have done it maybe twice before I saw her and I saw her most evenings and we would have sex and I would masturbate maybe once or twice when I went home... but that relationship it was unhealthy because I knew that sometimes I was nearly too tired to see that particular girl, but I would still do it because of the sex (SA 5, page 4).}\]

The reference to masturbation highlights the lack of consensus regarding what constitutes ‘normal’ sexuality. Masturbation is perceived as sinful by some and labelled as a disease by others. More recently, sexologists dispute many of the myths associated with masturbation and it is often recommended as a remedy in sex therapy and viewed as a legitimate form of sexual expression (Hyde & DeLamater 2010). Using DeLamater (1981)’s framework of understanding human sexuality in terms of procreational, relational and recreational sexuality, it may be true to say that viewing masturbation as pathological may indicate conflictual cultural norms rather that a bone fide disease.

28 (61%) sexual addicts said they use pornography as an expression of their sexual addiction. Some sexual addicts used pornography in a traditional way by going to bookstores, and looking at the general media for sexual pleasure. The use of pornographic magazines and videos is mentioned frequently, but is typically associated with the addict’s younger life and are not commonly mentioned as a current medium. Pornographic magazines and videos seem to have become obsolete
with the availability of Internet pornography. Frank (TP), a treatment specialist with sexual offenders, some of whom are sexual addicts, described below what he typically hears from his clients in terms of pornography addiction:

‘I’m addicted to pornography ... I’m addicted to the Internet ... I think about sex all the time, you know ... I wait until my wife goes to bed ... my husband goes to bed and I spend hours and hours surfing the net for pornography for no particular reason.’ There can be some sexual satisfaction, sometimes, you know. After the initial masturbation or whatever it [surfing for pornography] continues. It’s obsessive and compulsive. In my opinion it’s almost like looking for the perfect photograph ... the perfect video ... the perfect fantasy which none of them can ever find, you know ... and that can lead to, you know, downloading thousands and thousands ... probably of photographs and videos. But it does seem to be a search for the perfect ... filling that relationship that they can never fill through pornography or sex (TP 6, page 2-3).

Some sexual addicts, who report being addicted to pornography, claim that their increasing need for more hardcore pornographic material demonstrates the development of their sexual addiction. Mindful of their escalating sexual desire, some of these sexual addicts were afraid that they may accidentally access illegal pornographic material. Designating pornography as an addiction, once again, raises the contentious nature of what actually constitutes normal sexuality. Traditionally, pornography was generally viewed in negative terms. In recent times, pornography has become a popular and more socially acceptable dimension of life, mainly due to the Internet (Löfgren-Mårtenson & Månsson 2009). Hald & Malamuth (2008) explain that some people find pornography beneficial to their sexual lives and relationships.

25 (54%) sexual addicts in this study used sexual fantasy as an expression of sexual addictive behaviour. Sexual fantasy is described as an emotional craving for love and a pattern of obsessive thinking regarding sex and love (Carnes 1991). The data in this study describe sexual fantasy as romantic and fictional fantasies of meeting the perfect partner and living happily ever after. Rose (SA), a thirty-nine-old single sexual addict, explained how she uses sexual fantasy to escape into a perfect world:

_I became addicted to getting the perfect partner ... I was addicted to the whole fantasy of finding the one ... finding the person that would kind of make my life fantastic ... make my life complete. I was addicted to the whole idea of getting somebody to love me or getting that ultimate relationship_ (SA 18, page 5).

Despite the difficulty encountered by Rose, it is understood that most individuals, at least occasionally, engaged in some type of sexual fantasy. Sexual fantasy was once considered a sexual deviation but more recently it is considered as a dimension of a healthy sexual life by some (Zurbriggen &
The fantasy described by Rose is merely a reflection of romantic love popularised in Western society over the past century.

The final major expression of sexual addiction is cybersex. 29 (63%) sexual addicts used the Internet as part of their sexual addiction. The sexual addicts used the Internet in a variety of ways such as to view and download pornography, to engage in on-line dating, to arrange off-line sex such as prostitution, for virtual or interactive chat. The use of, and the motive for, using the Internet for sex appears to be influenced by a number of factors such as age, gender, sexual orientation, education and social class. There was a higher use of the Internet among sexual addicts who are younger, from upper socio-economic backgrounds with higher education. The Internet was used more frequently by male sexual addicts, rather than female sexual addicts. Agnes (TP), an addiction therapist who specialises in sexual addiction counselling, says that many clients who present with cybersex issues are those who have 'got into computers early on' in life (TP 1, page 8). A number of her clients work in the information technology sector and use computers regularly for work. Sexual addicts spent a considerable amount of time on Internet sex, ranging from one to forty hours a week but they were less clear about the amount of money that they spent on Internet sex. Treatment providers reported that the expansion of sexual material on the Internet is reflected in the increasing number of individuals presenting with issues related to Internet sexuality. The Internet is commonly used by sexual addicts for reasons such as access, anonymity and the seductive nature of the medium and the material. In addition to the accessibility of the Internet, there are other factors such as loneliness or relational breakdown, which facilitated the development of cybersex. Darren (SA), a fifty-one-year-old sexual addict, recently divorced, said:

It [relationship deterioration] became more and more of an issue after the birth of our second child. My wife became more and more withdrawn. I in turn became more withdrawn from the relationship and it was a vicious circle and I turned more and more to escape. My form of escape was either staying up late at night watching TV until you became oblivious . . . and eventually I suppose when Internet came in and broadband came into the house . . . it was much easier just to access Internet pornography . . . and that in turn becomes a vicious circle . . . you become so withdrawn from the other person (SA 4, page 2).

The use of the Internet also appeals to sexual addicts who frequently perceive sexuality as a commodity for sale. Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution, explained that the Internet afforded him the opportunity to make direct contact with the prostitutes and to choose what he wants:

A particular Internet site that I used . . . where you could contact a lot of prostitutes via email . . . so you could email them . . . you could look at pictures of them. They would then email you back. You could enter dialogue through email with them. You could
also post up a date and a time and say you are interested in meeting a girl at that time
... at that date ... in that place and look for offers ... so you might get sixty responses
to that one ad if you like from prostitutes (SA 12, page 3).

Another appealing dimension of the Internet for the sexual addict is that it provided a high degree
of anonymity. Cybersex users can hide their true identity by using anonymous profiles while using
chat rooms or webcams. Cybersex was discussed as an option for those who have social phobias
or poor interpersonal skills. This was illustrated by Ivan (SA), a twenty-six-year-old sex and food
addict, who explained how the Internet was helpful for him to access sex without the fear of
rejection:

I wasn’t enough ... I wasn’t good looking enough which actually prohibited me from en-
gaging in this world that was out there particularly the gay scene. So, I found anonymity
in the chat rooms and the personal ads and I could engage for a couple of hours and
you know I could tell them all the good things about me and they would validate me.
They would make me feel good and they would meet up with me and then if we had sex
it felt great because I felt wanted and needed (SA 9, page 3-4).

Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction, said
that an additional feature associated with cybersex includes ‘the buzz’ factor. Warren (TP) spec-
ulated that the dynamics of Internet sex is associated with a pre-sex ritual involving thrill, danger
and excitement:

Some people are on the computer for up to eight hours a day purely with the sole
function of having sex later on. My impression, is whether rightly or wrongly, that a
lot of people actually enjoy setting up the date rather than the sex itself. I think it’s all
about getting a hit or getting a high. I think there’s a danger aspect to it ... the thrill
that they might think it’s covert ... the fear of getting caught (TP 23, page 21).

The data demonstrate the negative consequences for sexual addicts who use virtual sex, particularly
in terms of ethical and legal issues. Ted (TP), a psychotherapist and a lawyer, who specialises in
sexual addiction counselling, was concerned about the use of the Internet for illegal sexual activity.
This may include behaviours such as child pornography and the use of anonymous profiles in order
to meet others in cybersex chat rooms, as he explained:

He [a client] had a huge amount of on-line addiction going on. He was going on-line,
chatting, going into chat rooms and sometimes he’d meet with people, which can be a
problem. Others wouldn’t meet with anyone ... it would be just on-line but they could
be on a website all night or for hours and hours you know (TP 20, page 2).

Furthermore, it was suggested that exposure to the vast amount of Internet sexual material is
creating a higher sexual tolerance and an increased appetite which can push individuals beyond
their normal tolerance level. This may cause the sexual addict to repeatedly require increased stimulation which may cause them to take higher and higher risks. Brid (TP), who offers cognitive behavioural therapy (CBT) and who specialises in sexual addiction counselling, said:

A lot of the time now we’re seeing compulsive use of pornography, Internet pornography more than years ago. It might have been DVDs ... now the availability of the Internet seems to have triggered like ... an explosion of material ... no matter what size, shape, creed, colour you want you can get it and it kind of facilitates people pushing their own boundaries and that’s often a worry that would come out in therapy. They’re worried, you know saying; ‘I’ve looked at images that I never thought I’d look at or I’m now searching the Internet for a particular image ... yeah, so their tolerance of what would have previously stimulated and aroused them to sexual satisfaction now doesn’t ... so that they’re pushed to another level and pushed on another level again and that often, you know, sets somebody into a place where they’re really worried (TP 2, page 2).

The use of cybersex creates multiple negative consequences as Darren (SA), a fifty-one-year-old sexual addict recently divorced, explained:

The obsessive compulsive nature of the behaviour was such that it was affecting my ability to function on a daily level. I was letting my health go. I was finding excuses to stay up late at night. I neglected the work I should have been doing to try and keep the company running ... just the routine stuff ... paying bills ... getting stuff out. I’d do a portion of it and then decide I needed a treat for myself and I’d go off and spend one hour doing the work and four hours on the Internet. I realise while it wasn’t hurting anybody ... it didn’t involve anybody else ... but it definitely was hurting relationships with other people because I was depriving myself of sleep ... of the ability to think and function clearly (SA 4, page 16).

Some sexual addicts, like Darren (SA) above, who used the Internet for virtual sex, believe that because they do not physically meet a sexual partner that their sexual encounter is not ‘real’. In such circumstances sexual addicts may tend to deny or minimise their sexually addictive behaviour. Virtual sex as a sexual addiction is difficult to manage, particularly for those who use the Internet for work on a regular basis. Some sexual addicts who were addicted to virtual sex disconnected from the Internet, while others blocked certain sites and limited their online behaviour by setting up restricted passwords to help them stop their addiction. In contrast to those who were sexually addicted to using the Internet for sex, a considerable number of sexual addicts reported no interest in virtual sex. Indeed for many research subjects the Internet was a significant source of information for those seeking help and support with sexual addiction. Research subjects also noted an atypical pattern of sexual addictive behaviour observed among some sexual addicts, which is a need to ‘binge and purge’. This involves the sexual addict using a large amount of sexually addictive
behaviour for a short intense period of time and immediately afterwards they will deny themselves any sexual contact at all.

The behaviours outlined above represent the major expressions of sexual addiction discussed among the research subjects in this study. The behavioural pattern of sexual addiction was varied and was influenced by a number of factors. Sexual addicts often experimented with different behaviours and the experimentation frequently increases as the sexual addiction develops and may indicate the need for a more intense sexual experience. Even when sexual addicts stop their usual expression of sexual addictive behaviour, some research subjects claimed that the addiction may express itself through another form of sexual behaviour. Many of the expressions of sexual addiction discussed above are also behaviours that non-sexual addicts use in pursuit of enjoyment and pleasure in their sexual lives, but who do not become sexually addicted. This raises the question of how any sexual behaviour can be addictive for one individual and not for another. Goodman (1998) argues that sexual addiction is not determined by the type or frequency of the sexual behaviour. The addictive nature of the behaviour is more accurately determined by the impact, motivation, the individual’s disposition and their ability to stop the behaviour (Goodman, 1998).

5.3 Function of ‘Sexual Addiction’

The data infer that sexual addictive behaviour was used in order to meet a range of psychological needs. It was frequently associated with issues such as emotional management, childhood deprivation, sexual abuse, loneliness, self-esteem among others and may or may not be associated with sexual pleasure. Frank (TP), a treatment specialist with sexual offenders, some of whom were sexual addicts, summarised some of the major functions associated with sexual addiction:

Well it’s self-soothing ... I think for a start ... it’s also a way of regulating your emotions as well. People are emotionally stressed and sex is pleasurable and it distracts from those distressful emotions. I know quite a few clients who would do that ... mainly go cruising ... look for prostitutes or go to nightclubs, you know ... purposely to get away from their emotion. They are not able to regulate their emotions in any other way except through sex. My belief is ... that’s learnt at a pretty early age, you know ... puberty or thereabouts (TP 6, page 5).

The use of sexually addictive behaviour was also associated with a host of internal psycho-social issues experienced by the sexual addict and involved factors such as low-self esteem and self-punishment among others. Some individuals such as William (SA), a twenty-eight-year-old sex and drug addict with a history of child trauma, experienced social isolation from a young age. William (SA) claimed that drugs and sex were helpful in managing his experience of loneliness:
5.3. FUNCTION OF ‘SEXUAL ADDICTION’

I've never had great friends ... I've never had a best friend and I felt lonely a lot of the time and not good enough and all those types of feelings ... but then when a woman wanted me those feelings left me and I wasn't dealing with it [loneliness] ... then I was just escaping from it or getting high from it ... so the more times that I was with a woman or women, I didn't think about any of that stuff ... and that's what drugs used to do for me (SA 23, page 3).

Others believed that the sexually addictive behaviour was a means of self-punishment. One typical trait associated with sexual addicts in this study was that they perceived themselves in negative terms and frequently experienced high levels of shame and negativity. They often believed that they were bad and therefore felt unlovable, and not deserving of a caring relationship. The sexually addictive behaviour that they used, served to remind the sexual addict that they were as bad and unworthy as they perceived themselves to be. Fergal (TP), a social worker and psychotherapist, specialising in gay-positive therapy, explains that sexual addictive behaviour is often used to confirm sexual addicts’ negative image of themselves:

> I think if you look at the [sexual addicts] pattern ... the behaviour and the origin ... it is a reinforcing message saying that he [the sexual addict] is bad (TP 32, page 9).

Research subjects also described sexual addiction as a means of escapism from emotional issues such as fear, loss, and mental health issues. Ironically, the use of sex which is popularly perceived as pleasurable, was used by some as an escape and often generates self-loathing as Fergal (TP), a social worker and psychotherapist explains:

> He [the client] loathes himself when he thinks about it [Internet pornography]. He does it ... in a sense, kind of ... out of desperation. He’s not anticipating and looking forward to it in a pleasurable sense ... like this is something that I’m going to enjoy and I’m going to pleasure myself. He goes on [Internet] when he’s feeling tired or when he’s feeling ... you know ... kind of depressed or when he’s feeling that life is going nowhere ... so he kind of resorts then to the Internet as a way of escape. So it has a big kind of escapist element to it for him (TP 32, page 1).

Arron (SA), a thirty-eight-year-old sexual addict who experienced sexual abuse and depression, used his sexually addictive behaviour to alter his mood. In Arron’s (SA) situation sexual addictive behaviour was used to modify his mood, and he used it to bring him up or down depending on what he wanted, as he explained:

> A lot of mine [sexual addiction] was getting a buzz and I would do it before I would have to go to work. I would have 10 minutes online ... just to get myself a bit of a buzz ... to wake up ... to get hyper ... to perform ... to get going ... and the other side I would actually masturbate or actually have sex to put me down (SA 1, page 17).
Edward (SA), a thirty-one-year-old sexual addict who also had a gambling addiction and suffered from depression occasionally, used his sexual addiction to generate good feelings particularly on his bad days:

> Realistically it gave me that good feeling ... possibly if I wasn’t feeling great ... if I had a bad day ... you look for something positive and golden ... orgasms give you a good feeling ... so it’s as basic as that (SA 5, page 8).

The data indicate that another function of sexual addiction was to express power and control which was conveyed in a variety of different ways. It was generally understood by the research subjects that sexual addiction demonstrated a loss of control as Warren (TP) a specialist in genitourinary medicine and addiction explained:

> I think normal sexual behaviour is under control ... you’re in control of yourself and I think when you’re addicted ... you’re not in control. It’s like something inside you is driving you on (TP 23, page 3).

Leanne (TP), a nurse and sexual abuse specialist, working with sexual addicts, some of whom are survivors of sexual abuse, says that her clients often seek to regain control of their sexuality by engaging in sexual behaviour. They believe that by choosing who, where and how to sexually engage that they will regain control over their sexuality:

> I think for a client who has been abused at an early age ... they say, ‘Well at least I’m in control’ but they’re not in control ... but that’s what they see ... they see that ... ‘Well I’m the person now ... I’m the adult now ... so I’m actually sleeping with this person ... I am masturbating myself ’ ... so they think that this is control but of course when they rationalise it and when they work through, it’s not control (TP 12, page 3-4).

Sexual addiction behaviour was also viewed as the sexual addict’s method of exerting power over another individual. Vincent (SA), a twenty-eight-year-old sex addict, who experienced childhood trauma and who was recovering from substance use, explained that many of his sexual partners have commented that his sexual behaviour was ‘controlling and powerful’ (SA 22, page 4). Vincent (SA) explained that as a child much of his life was out-of-control and made him feel vulnerable and afraid. He claimed that his ‘controlling’ pattern of sexual behaviour was an expression of his need to be in control and this increases his sense of safety and security. The expression of power was sometimes observed in relation to specific sexual practices engaged in by sexual addicts such as ‘barebacking’. Barebacking is commonly understood as deliberate, unprotected, anal intercourse between men irrespective of their HIV status (Berg 2009). Raymond (SA), a thirty-four-year-old gay sexual addict who is HIV positive, believes that barebacking is high-risk behaviour involving a power dynamic, which drives one person to exert power over another and forces another individual to give their power away (SA 44, page 13-14).
Another key function of sexual addiction, according to the data, is that it served as a means of human contact and was used to secure attention, affirmation and acceptance. Many sexual addicts experienced bleak situations where loneliness and isolation were compounded by shame and fear that their sexual addiction would be exposed. In such instances sexual addiction provided a certain level of intimacy as Finbar (SA), a fifty-two-year-old single gay sexual addict, explains:

*The majority of times I acted out would have rarely felt good. I would have had feelings of shame, guilt and exacerbate the loneliness. When I look back at those situations it was a desperate attempt to be held, to be recognised, to be loved. Very often it wasn’t just the sex, it was just contact with a human being* (SA 6, page 4).

Sexual addictive behaviour was also used, particularly by some ‘high powered’ individuals, to manage high levels of stress. Describing sexual addiction as an opportunity for privacy, control, secrecy, and for enjoyment, Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution, said:

*At the time it [sexual addiction] gave me a sort of focus in life. This was my little, sort of my private world, nearly a hobby …private sort of world that I could control and that was secret from everybody else and that I enjoyed* (SA 12, page 9).

The function of sexual addiction was also understood in terms of child sexual abuse (CSA). The complex relationship between CSA and sexual addiction was discussed more extensively in Chapter Four. Some sexual addicts who were sexually abused say that the function of their sexually addictive behaviour was a way to avoid facing their own experience of sexual abuse. Others said that they gave themselves permission to have addictive sex as a compensation for the experience of being sexually abused. In some instances the pattern of sexually addictive behaviour mirrors the pattern of child sexual abuse which they experienced suggesting that the sexual addiction is an effort to re-enact their abuse in order to resolve it. In such instances it often results in the development of a cycle of sexual addiction. Brendan (TP), a trauma therapist who works with sexual addicts, stated that sexual abuse in childhood may result in repetitive sexual behaviour and consequently lead to the development of a sexual addiction:

*If someone has sex with a small child, perhaps a girl … who then grows up and especially if it was a parent or a loved one … then you have the trauma, which has this repetitive quality to it, as well as a misplaced sense of love … There’s that sense of a parent as a source of love and affection … that it [affection] may be then associated with sex, and sex becomes the way to get love and affection and so that can lead to nymphomania and those kinds of addictive qualities* (TP 28, page 2).

Another alleged function of sexual addiction is that it is used as an excuse by some individuals to explain or seek pardon for their unacceptable sexual behaviour, as Gerry (TP), a clinical psychologist specialising in child sexual abuse, said:
I think that some people might use it as a cop out, you know, ... again where’s this sense of personal responsibility? ... You know, you had the choice (TP 7, page 10).

The data suggest that sexual addictive behaviours serve a variety of different functions. An individual’s sexual behaviour may reflect the typical characteristics associated with the concept of sexual addiction while the underlying issue may be indicative of a range of issues. From a counselling perspective, careful consideration is required to establish accurately the true meaning associated with out-of-control sexual behaviour of individual clients.

5.4 ‘Sexual Addiction’ and Other Addictions

31 (67%) sexual addicts in this study claimed that they experienced a variety of other addictions. 17 (37%) experienced addiction to alcohol, 12 (26%) to illicit drugs, 12 (26%) to nicotine, 11 (24%) to food, and 4 (9%) to gambling. A unique and complex relationship exists between sexual addiction and other addictive behaviours and substances. Treatment providers working in the area of sexual addiction observed that sexual addiction is frequently disguised and is often discovered when dealing with other problems, typically substance related issues. Brendan (TP), a trauma therapist who works with sexual addicts, explains:

No one has ever sought my help for this [sexual] addictive behaviour ... it’s always been for something else and then as a by-product, the other stuff [sexual addiction] is uncovered. Now it’s possible that some of them have come in wanting help for their [sexual] addictive behaviour but presenting with the alcohol or the drug ... but then in the process of working through that ... then the other things came up (TP 28, page 9).

Research subjects described similarities between sexual addiction and other addictions, including the individual’s motivation to manage emotional pain and the need to escape reality; as Agnes (TP), an addiction therapist who specialises in sexual addiction counselling, explains:

I think deep down at the core level of addiction, sexual addiction, alcoholism, food addiction, shopping addiction ... I think all addictions at the very basic are the very, very same ... I think they serve the same purpose ... I think they medicate that pain ... I think they find an altered way of living ... I think it presents ... it’s dressed up differently (TP 1, page 13).

The major differences between sexual addiction and other addictions were that sexual addiction was more shameful, secretive, easier to hide, harder to talk about, more compulsive, not as acceptable and more difficult to access help for. Research subjects explained that the most obvious distinction was that sexual addiction required no intake of a foreign substance into the individual’s body, which is an essential aspect with alcohol and drug addiction. In contrast, sexual addiction involves an
addiction to sex, which is a natural instinct and an unavoidable dimension of human nature. Brid (TP), who offers cognitive behavioural therapy (CBT) and who specialises in sexual addiction counselling, explained a fundamental challenge associated with sexual addiction:

We are sexual beings ... sexuality is something that's innately part of them so it's like a relearning of ... how can I be sexual without it taking over my whole life (TP 2, page 13).

The data imply a complex inter-relationship between sexual addiction and alcohol addiction. Carl (TP) an addiction counsellor who specialises in sexual addiction counselling, claimed that alcohol is often identified as a trigger which instigates the individual's sexual addiction as he explained:

From my experience, it's [alcohol] a gateway drug ... if somebody is drinking heavily in the bars it's much easier to go and contact a prostitute or an escort or go to a massage parlour or go to a sauna for sex. If you look at what is alcohol ... psychoactive and neurotoxic ... so it's a mood alterer and it's just a disinhibitor, so we tend to do and say things that we wouldn't normally do if we're sober ... so alcohol and drugs are mood altering ... so if somebody is taking cocaine ... they're going to be quite high and part of that high would be sexually acting out for some people ... again, some people would take alcohol and it's a disinhibitor ... so it gives them that sense of freedom to do whatever they want to do (TP 3, page 6).

Alcohol was also used as a means to deny the reality of the sexual addiction. Often times the sexual addict 'pretends' that their sexually addictive behaviour was a consequence of their alcohol consumption. Celine (TP), a clinical psychologist and treatment specialist with sexual offenders, some of whom are sexual addicts, said that alcohol may be a factor but it may also be overstated:

I think the alcohol plays a part there, either in allowing themselves and giving themselves permission to commit the offences or in justifying what they've done afterwards. So I think sometimes people might say ... 'I did it because I was drunk. I wouldn't have done it if I was sober' ... but what they fail to recognise is they drank to allow themselves to do it (TP 29, page 8).

A complex pattern of dynamics is identified between drugs and sexual addiction. Sexual addicts in this study have used drugs such as cocaine, ecstasy, acid, hash, speed, magic mushrooms, and amyl nitrate (poppers). Sexual addicts used drugs for different reasons such as to increase social credibility, to lessen emotional pain and to intensify the individual's sexual experience. Warren (TP) a specialist in genitourinary medicine, working in sexual health and addiction, explained that drugs like heroin may lower the individual's interest in sex, while cocaine or alcohol may trigger addictive tendencies:
Well the problem with drugs particularly... you can take cocaine for instance... if you take cocaine you're being very disinhibited... you know, you're not quite aware of what you're doing... so what happens I think... a lot of people who would normally have control to watch addiction... if they're disinhibited... if they take cocaine or alcohol they're more likely to act out on their addictive tendencies (TP 23, page 6).

In some situations, it was only after individuals stopped their substance use that they were able to manage their sexual addictive behaviour successfully; as Agnes (TP), an addiction therapist specialising in sexual addiction counselling, explained:

But he [the client] presented here with hash and abuse of hash and alcohol so we worked on those addictions and when he's free from those addictions then he doesn't sexually... he didn't sexually act out (TP 1, page 5).

Another significant factor which was raised, in terms of substance use recovery and out-of-control sexual behaviour, was that individuals recovering from substance use often regain an interest in their sexual and relationship life. This includes regaining their libido, which can be difficult for them to manage, especially in early recovery. Erik (TP), a social worker specialising in addiction and who works with sexual addicts, said:

The majority of heroin addicts, you know, they lose total interest in sexual activity. While they are... you know... actually engaged in heroin abuse they can go for weeks, months without engaging in any kind of sexual activity. When they come into treatment the whole thing goes into reverse... it's like their whole libido suddenly comes back and hits them like a boomerang on the side of the head and they suddenly become very conscious about their own appearance and about how they present themselves. There is a tendency for clients to sort of... you know... to jump at relationships... sexual sort of encounters very much... you know (TP 5, page18).

Another feature that was identified regarding those who are recovering from substance use was their need to compensate for the addiction which they are stopping and the tendency, in this instance, to switch from substance use to sexual addiction, as noted in other studies (Blume 1994). Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction, observed this 'switching' dynamic in clinical practice:

It's very easy to cross over addictions. In some instances I find if somebody had been addicted to alcohol and then... you know, gets into recovery... I think what happens then... they switch addictions and they become addicted to sex (TP 23, page 2).

The increased appetite for sexuality among substance users may be further understood in terms of a search for 'good feelings' which were once generated by substance use. The out-of-control sexuality may not be indicative of a sexual addiction in itself. The increased sexuality may be a reflection
of an emotional emptiness which was observed among some individuals in recovery from substance use. They subsequently sought to fill their feelings of emptiness with sex, which developed into a sexual addiction. Pauline (TP), a psychotherapist specialising in addiction and who works with female sexual addicts, explained the complex dynamics, which emerge in the aftermath of giving up substance use:

A lot of the women in here when they have done with the drugs or alcohol ... that's what they do ... go after men ... now I don't know if that's a sexual addiction or do they think a man's going to fill this piece of their life that's missing (TP 16, page 9).

Sexually addictive behaviour may indicate a number of issues such as a process of emotional, sexual and social readjustment for those recovering from substance use.

Finally, the relationship between sexual addiction and other addictions such as gambling and food were noted. Erik (TP), a social worker specialising in addiction and who works with sexual addicts, explained that the element of risk-taking is similar in terms of substance use, gambling and sexual addiction (TP 5, page 18). Edward (SA), a thirty-one-year-old sexual addict who was also addicted to gambling, described some of the similarities:

It's [gambling] not something that you are putting into your body like a drug or alcohol. The buzz is around the behaviour ... placing a bet ... like the thoughts and the excitement that goes around it. It's similar around the sex ... like the thoughts ... the ifs and the buts and ... the what ifs ... it's very similar, I believe in that respect. I suppose at times there's an element of big risk in both ... the unknown ... so it's really a buzz created within ... without putting any sort of stimulants back into your body (SA 5, page 10).

Furthermore, 11 (24%) sexual addicts in this study claimed that they have a food and sex addiction. Ivan (SA), a twenty-six-year-old sex and food addict, recognised the complex relationship between food and sexual addiction:

It's significant to note that if I'm in withdrawal from my sex addiction ... my food addiction kicks in ten times worse and vice versa ... so they do substitute for one another (SA 9, page 15).

Many individuals in this study experienced a multitude of addictions and as a result a complex set of dynamics develops. The data suggest that individuals who were in recovery from dual addictions were a vulnerable group. From a counselling perspective the challenge was to determine accurately the exact nature of the individual's out-of-control sexual behaviour and to identify if a sexual addiction exists or not. If a sexual addiction exists, further exploration is required to determine if it is a primary or secondary issue and to assist the individual deal with it in conjunction with recovery from any other addiction. Treatment providers, particularly those working
in addiction recovery work, suggest that there is a therapeutic value in examining the issue of sexuality among those in recovery from all addictions.

5.5 ‘Sexual Addiction’ and Homosexuality

The concept of sexual addiction emerged as a significant issue among the sexual addicts in this study who identified as homosexual, and among treatment providers who work with them. 18 (39%) sexual addicts identified as being homosexual and 2 (4%) identified as bisexual. A number of others who identified as heterosexual said that they experienced infrequent homosexual encounters. 12 (22%) of the treatment providers raised the issue of sexual addiction and homosexuality. Some treatment providers work with gay clients on a regular basis. Others work occasionally with gay people, or not at all. The population of individuals who sought help with their sexual addictive behaviour in this category included gay men and women, bisexuals and men who have sex with men (MSM), a term given to men who have sex with other men, regardless of how they identify themselves.

The data imply that there were distinct cultural traditions regarding sexuality among the gay community which contrasts with the sexual behaviours and attitudes among the heterosexual community. Research subjects said that there was a higher tolerance for unconventional sexual activity in the gay community which sometimes includes anonymous sex and multiple partners. Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction explained:

*I think there’s always been a culture in the gay world ... of an acceptable culture of having multiple sex partners or whatever ... that would have been perceived as the norm for a lot people so I don’t think that would be acceptable in the straight community ... so what might be normal in the gay world might be termed as sexual addiction [by others]*

(TP 23, page 11).

Gary (SA), a forty-two-year-old, gay male sexual addict in recovery from substance use, drew attention to the different attitude regarding sexual behaviour among some within the gay community. He recalled advice given to him by his gay partner with whom he was living at that time:

*He [his partner] suggested that I go to a sauna to have sex because we weren’t having sex, and he thought that it was quite normal for gay men, one of them to go off and have sex while one was sat home and watched Coronation Street* (SA 7, page 5).

The behaviour associated with gay sexual addicts in this study included sexual activities, such as cruising for sex in public parks, dark rooms, public toilets and saunas activities which corresponded with previous studies (Champenois et al. 2013). Raymond (SA), a thirty-four-year-old gay sexual addict who is HIV positive, said that there are more opportunities for sexual addiction in the gay community:
I would see that there’s a lot more opportunities for gay men to thrive in sexual addiction in a gay community as in ... you’ve got saunas, you’ve got parks ... its [sexual addiction] huge in the gay world ... in the sense that it’s a lot more permitted as part of ... like if you go to gay clubs ... you know ... there’s rooms ... there’s dark rooms so it seems a lot more prevalent in gay social spots than it is in heterosexual social spots as a proportion and on the Internet in terms of Gaydar and all that (SA 44, page 8).

Contrary to the general perception that anonymous sex and multiple partners were the general pattern of sexual behaviour for all gay people, Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction explained:

Not all gay men work those rules ... just some do, but a lot of gay men wouldn’t be involved in sex addiction or wouldn’t be involved in multiple sex partners. I think it’s a period in your life probably when you’re young and good looking (TP 23, page 11).

Research subjects reported many damaging consequences resulting from sexual addiction which impact negatively on the gay sexual addict. Many gay sexual addicts engaged in high-risk sexual behaviours, including late night cruising and unprotected sex. The consequences of their high-risk sexual behaviour led to incidents where individuals experienced injury, hospitalisation, arrest or contracted a disease. In this study 11 (24%) sexual addicts, who identified as being gay, caught sexually transmitted diseases. 3 (7%) sexual addicts, who identified as being gay, contracted HIV which they all associated with their sexual addictive behaviour. Warren (TP), a specialist in genitourinary medicine, and working in sexual health and addiction, highlighted the high-risk and clandestine behaviours particularly associated with the often, hidden population of married men who have sex with other men (MSM). Warren (TP) drew attention to the medical consequences, especially HIV and other personal consequences, which result from sexual addiction:

The one I see is that a lot of them become HIV positive and that’s obviously huge. And of course their relationships, they lose their partners and especially I think a lot of married gay men for instance ... who start acting out with other men and not just acting out but would have sex with other men. They do it sometimes in a very risky way. They meet people ... we’ll say in the park in a cruising area. It’s not ideal, you know ... people in the dark ... a lot of the time I think it’s not planned, it just happens ... on the way home from work and they just get this urge and they feel you have to act out of it (TP 23, page 10).

Gary (SA), a forty-two-year-old, gay male sexual addict in recovery from substance use, associated the contracting of HIV to his sexual addiction, and he described the experience of living with HIV as a ‘fucking nuisance’:

I couldn’t say that everybody who is HIV is addicted ... is an addict ... that doesn’t make sense at all ... although for me it was addictive behaviour that brought me into
the places that I went to and it was addiction that I suppose encouraged me to have the sex that I had ... and that I picked up the virus I think (SA 7, page 28).

The data demonstrate that there was a lack of consensus among the research subjects regarding how to determine if the sexual behaviours were to be understood as recreational or addictive sexuality. The pattern of multiple partners is often cited (Carnes 1983) as a strong indicator of sexual addiction. In contrast, Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, and who has worked extensively with gay and lesbian individuals, explained that non-monogamous sexual encounters may indicate a behavioural ‘compulsion’ or ‘vibrant sexuality’. She suggests that each individual situation needs to be examined independently:

*There is the perception ... because gay men traditionally have had multiple, casual encounters ... that this is sexually addictive behaviour and I think that, you really have to speak to the individual person to find out ... if the multiple encounters that they’re engaging in are on the basis of momentarily satisfied compulsion or if it is an expression of a vibrant sexuality* (TP 25, page 12).

Yvonne (TP) also highlighted the added complexity of the ‘coming-out-process’ which may involve casual sexual encounters which is not necessarily a sexual addiction:

*Sometimes an encounter which can be a short encounter can also be an intimate encounter. It can be a meeting ... and you know one man that I was working with around his own sexuality and he wasn’t actually in any relationships but he was afraid in a sense to come out but he would kind of cottage and he’s describing it as a handshake ... that it was a recognition of one man for another man in an intimate way. Just because it was casual and that he might meet somebody else ... it wasn’t a sense of compulsion to go out and have a sexual contact. It was a wish to express and be with someone who would know him for who he was. So I think that there can be a misunderstanding that multiple partners equal sexual addiction. I think it really has to be explored. It may very well be but that’s on the basis of understanding the individual person. The same behaviour in two different people ... one may be sexual addiction and the other may be sexual expression ... so that’s also why I think it is about the person ... it’s not about the label* (TP 25, page 12).

Research subjects suggested that the ‘treatment’ of ‘sexual addiction’ among gay sexual addicts is similar to that used for all sexual addicts. In addition there are some specific issues that need careful attention with this population. The professional who helps the gay sexual addict needs to be aware of the culture, customs and behaviours that are specific to the gay community. Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, and who works with sexual addicts, stated that one key area is to facilitate individuals in becoming comfortable with
their sexuality and their sexual orientation. Additionally, Fergal (TP), hopes that such individuals will discover alternative ways of being sexual without resorting to sexual addiction:

There are other ways of being sexual with yourself and with other people and do you know... isn't that the pity that you're only able to have sex with the Internet and have sex in a bath house, and you know that sex could be about more than that, so let's kind of look at that and kind of explore that (TP 32, page 5).

Simon (TP) a psychotherapist, with sexual addiction training and who works with gay sexual addicts, claimed that many of the individuals he works with have low levels of acceptance regarding their sexual orientation (TP 45, page 1). This leads to the repression of their sexuality and internalised homophobia, resulting in negative consequences regarding self-esteem, mental health and sexual behaviour. Eileen (TP), a social worker working in sexual health and addiction, highlighted the possibly that suppression of one's sexual orientation among gay individuals may create a vulnerability towards developing a pattern of sexual addiction:

The other predisposition as well... and some of this I would have some experience in... is when people would not be so sure of their identity and their sexual orientation... and they may be gay and don't want to come out and may be trapped in that situation and in denial about that... and maybe moving on to do all sorts of other things... get involved with other people in a very casual kind of sexual way and it kind of moves a bit on to that next... how sexual addiction develops over time. That may go on for...... that they were gay or lesbian or whatever and then they would have gone on and then realised that they were just playing a game with themselves in denial really (TP 31, page 2).

Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, and who works with sexual addicts, said that it is essential that the professional working with this population be aware of their own personal issues regarding sexuality:

People need to be really, really mindful of their own issues around sex... we all carry homophobia... we all carry sex-phobia... we all carry our own ambivalence about sex and sexual behaviour and sexual identity and sexual relations, and so I think it's really around people needing to be aware of their own thinking and feeling and attitudes towards their own sexuality and sexuality in general and other people's sexualities because there's an infinite variety of sexualities and ways of expressing sex (TP 32, page 17-18).

Some treatment providers were knowledgeable and aware of the gay culture and the sensitivities that exist in the gay community regarding sexual behaviour and sexual addiction. There may be
other treatment providers whose experience of dealing with the gay community is limited, and whose knowledge is low.

Much of the data regarding sexual addiction and homosexuality focused on the male gay population due to the higher proportion of them who participated. However, 3 (7%) research subjects were female sexual addicts, and a number of treatment providers work with such women. Zara (TP), social worker in the lesbian community, who had worked in the USA and the UK, said that the lesbian sexual addict had a similar pattern of sexual behaviour to their male counterparts, which included casual encounters and multiple partners (TP 26, page 9). Despite the fact that sexual saunas for females are not available in Ireland, Jane (SA), a thirty-nine-year-old gay sexual addict in recovery from substance use, described her experience of using female sexual saunas in America and its impact on her life:

_I was in San Francisco and there were female saunas in San Francisco. I found myself tranced out as though I was drunk off my head... seeking sexual oblivion in women's saunas and I was so freaked out by that... My sister thought I was drinking again and it was just a terrifying feeling of being so mind and mood altered and being in a trance like state... It frightened me so much I got back on a plane. I came back to Dublin and I went back to that therapist that deals in this area_ (SA 10, page 14).

Zara (TP), contrasted sexual addiction among gay men and lesbian women and said:

_There's some women that flip from one relationship to another... to another... to another... Men are a lot more hornier... but that's only because they're more cerebral about it because women... I mean women talk about these things but women I think are more emotionally involved with their feelings whereas men are more cerebral involved with their emotions if you know what I mean_ (TP 26, page 8).

The data reveal that the concept of sexual addiction was a very sensitive and controversial issue within the gay community. Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, who works with sexual addicts and has worked extensively in the gay community in Ireland and America, observed an element of resistance within the gay community regarding the concept of sexual addiction:

_There might be a lot of protectionism within the gay community, in the sense that the members of that community might not want to admit freely that this is an issue lest they become stigmatised or labelled. It may be similar to the issue of domestic violence within the gay community where there is a lot of resistance and protectionism. Within the gay community there may be a lot of sexual addiction around the Internet, around Gay.com website and Gaydar where people spend a lot of time seeking connections and partners. The difficulty is how to distinguish between what is an essential area of routine gay sexual behaviour and addiction_ (TP 23, page 23).
Tom (SA), a twenty-eight-year-old gay sexual addict, was critical of the ‘gay sub-culture’, which he claimed lends itself to the creation of sexual addiction and avoidance behaviours:

*The gay scene is very open minded ... people like to say ... I think there are aspects of it that can be extremely shallow and superficial ... that helps people get into recreational sex or the other kind of avoidance things that go on in gay sub-culture* (SA 20, page 14).

Nora (SA), a female gay sexual addict, claims that there was a high level of sexual addiction among members of the gay community. She said that awareness about the difference between healthy sexuality and sexual addiction was low. She was concerned that sexual addiction was being normalised within the gay community:

*The normalisation and prevalence of sex addiction in the gay community ... more because this is the community I live among and experience. I feel this is so important because it covers both being gay, tied directly with the shame of sexuality, including sex addiction. The absolute core beliefs of most are that certain behaviours are normal, because the majority are acting this way* (SA 40, page 4, questionnaire).

Yvonne (TP), a clinical psychologist who specialises in sexual behaviour and who has worked extensively with gay and lesbian individuals, recognised the contrasting opinions regarding sexual addiction among the gay population. Yvonne (TP), advocated the value of clearly identifying and addressing the issue of sexual addiction where necessary:

*Some people perhaps within the gay community might fear being labelled negatively with this particular term ... and rightfully so ... however, within the community it would be important that there is an understanding of the difference between sexual addiction and sexual choice ... and that all sexual encounters need to be encounters on the basis of sexual choice; and if someone is having an encounter with someone who is a sexual addict and they don’t know it, then that interferes with the sexual choice of partner. But I think that while celebrating freedom of sexuality, it is important also to recognise the potential for abuses within that. Think of your responsibility within the community to protect the people who are sexual addicts from continuing ... just like you do if your friend is an alcoholic. You try to create other social experiences that don’t involve drink, so I think that it’s a conversation that would be very valuable to have* (TP 25, page 12-13).

Sexual addictive behaviour is complex among those who are gay and bisexual. There are specific factors including cultural dynamics among gay individuals that require attention in order to determine accurately the true nature of the behaviour. An awareness of these distinctive cultural entities is useful so as to avoid premature judgements or inaccurate diagnosis.
5.6 Consequences of ‘Sexual Addiction’

Research subjects attributed a variety of negative consequences to sexual addiction. These consequences impact the major areas of the sexual addict’s life such as their relationships, professional lives and personal development. Harry (SA), a sixty-three-year-old married sexual addict, who has bipolar disorder, explained how sexual addiction has impacted his career, created financial difficulties and damaged his mental, emotional and sexual health:

> It has impacted tremendously . . . it stopped me from having full ongoing relationships . . . I was quite isolated . . . very depressed. It affected my mental health . . . my work prospects. The affair I had meant that my career prospects ended so it finished my professional career for all intensive purposes. It had a financial cost as well I was spending thirty to forty pound a week on pornography, which over the years is an awful lot of money. It took a lot of my time . . . it took me away from doing creative things. It took me away from interests, all sorts of positive things so it had a big impact (SA 8, page 13-14).

The data demonstrate the impact of sexual addiction on the addicts’ relationships, particularly those in committed and married relationships. In some situations sexual addiction resulted in the breakdown of relationships. Oliver (SA), a fifty-six-year-old sexual addict who is in recovery from alcohol, explained:

> It makes intimacy impossible . . . it creates pathological lying, dishonesty and in fact reinforces the sense of being flawed rather than alleviating it, feeling a fraud . . . It ruined my marriage . . . My marriage ended. I was in a loving relationship with my wife and had a happy fulfilling relationship with my family . . . it made that impossible . . . from my promiscuity my wife decided that she wasn’t going to continue a marriage with a guy who’s womanising. She caught me having various affairs. That ended any possibility of a marriage or a healthy one . . . The affairs started on honeymoon, in fact they never ended. The one I was having before I got married, continued . . . so there was never a time in my marriage when I wasn’t seeing another woman . . . two or three . . . mostly just sexual with little emotional contact (SA 15, page 8-9).

In some instances where the relationship survives the experience of sexual addiction, a residue of mistrust, originating from the experience of sexual addiction, continues to impact the relationship. Harry (SA), a sixty-three-year-old married sexual addict, who has bipolar disorder, whose first marriage ended as a result of sexual addiction, explained:

> It’s affected the relationship with my present wife. It’s made it hard for us to have a relationship of openness and honesty because my wife is always suspicious of my motivation. Whenever we have a disagreement or a difference she will throw my sexual
5.6. CONSEQUENCES OF 'SEXUAL ADDICTION'

history into my face and say well you hid that from me for twenty-five years, what else are you hiding from me? (SA 8, page 16).

Harry (SA) also described how his sexual addiction impacted negatively on his professional life:

*I met several of them [sexual partners] through work contacts. Others I met through contact magazines. Two of the relationships were potentially quite significant ... the first one was with a woman that I had an affair with when I was still with my first wife. That carried on after my wife and I had split. I nearly lost my job through that affair because she was a client of mine, and the ethics at that time were a little looser than they are now. If it happened now I would have lost my job* (SA 8, page 8).

Many other sexual addicts talked about breaking professional sexual boundaries, using time or employment resources to access their sexual addiction, which often resulted in complaints, law cases and dismissal from employment. Some individuals in this study did lose their jobs as a result of their sexual addiction while others say that promotional prospects and productivity all suffered because their interest and concentration was on sex rather than on work.

The data suggest that many sexual addicts compromised their psychological, emotional and sexual health as a result of their sexual addiction. Mental health difficulties including suicidal ideation and depression resulted and the individual's sexual health was also negatively affected. Zabrina, (SA) a thirty-eight-year-old sexual addict with a history of sexual abuse, summarised the consequences of sexual addiction in her life:

*I had children to different men, broke up marriages, got hepatitis and had abortions* (TP 26, page 2).

Warren (TP), a specialist in genitourinary medicine, drew attention to the health and legal consequences involved:

*What I would see would be the fact that you're putting yourself at risk but you're also putting other people at risk. People who are HIV positive we'll say who are sex addicts are potentially infectious to other people ... so they could be, you know ... it's usually legal consequences if they're infecting other people. If you know you're HIV positive and you knowingly infect somebody else you could be charged* (TP 23, page 2).

Sexual addicts also sustained physical injury, because of their sexual addiction. Peter (SA), a forty-nine-year-old sexual addict who was sexually abused and who is divorced, explained:

*My first real point of awareness I would say would have been when I got ... I had to go to the doctor with an injury to my genital area and I knew in myself that it was a result of my paid for acting out behaviour and I knew there was a link between that ... and then my ex-wife and I tried to have children and I got a fertility test and that*
was ... there seemed to be a low sperm count and I began to realise that what I had been doing ... my behaviour had contributed to this particular consequence (TP 16, page 3).

Another significant consequence was the financial cost of their sexual behaviour, direct and indirect. Sexual addicts typically spend money on prostitution, saunas and pornography which increases over time but many sexual addicts in this study found it difficult to calculate an accurate figure of monies spent. Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution, described how financially costly sexual addiction became:

I couldn't stop myself using prostitutes but I did try to use prostitutes on the upper-end so I wouldn't have been kerb crawling you know. I would have been going to higher-end escort agencies and spending you know ... the most I spent in one session would have been 1200 pounds ... so I would have spent a lot of money on it when I had the money (SA 12, page 20).

The indirect financial costs associated with sexual addiction were spoken about in terms of absenteeism from work, health bills and legal costs among others.

A further negative consequence associated with sexual addiction is substance use. This was described in terms of sexual addicts who used alcohol or drugs in order to kill the shame they experienced as a result of their sexual addiction. The use of substances in this context usually exacerbates the negative consequences regarding the substance use and their sexual addiction. Other individuals in this study who were already in recovery from addictions such as drugs, alcohol or gambling, claimed that they relapsed into their drug of choice because of their sexual addiction. Quintan (SA), a middle-aged gay sexual addict who is in recovery from substance use, explained that sexual addiction led him back to using drugs which then triggered major negative consequences:

In 1996, I was spending a lot of time travelling on business and going reasonably well but I started to use prostitutes and one of them eventually offered me a joint. So in 1996 I started smoking dope by the end of 1997 the relationship [with his partner] was gone ... by the end of 2001 so had the business, my career and my mental health ... they were all gone. So that was a combination of sex and drugs, the two of them running in tandem ... so by 2001 I was almost gone (SA 17, page 9).

Finally, in this study a number of individuals experienced legal consequences arising from their sexual addictive behaviour. This was expressed in a variety of ways such as legal proceedings involving custody of children and property as a result of relationship break-ups. Darren (SA), a fifty-one-year-old sexual addict recently divorced, described:

Once I'd moved out my wife immediately initiated legal proceedings to start a separation and to have me barred from the house, and it just deteriorated from there ... just got
5.7. TURNING POINTS

worse and worse ... so once I'd left in September I haven't been back since (SA 4, page 5).

5 (11%) sexual addicts in this study encountered formal legal consequences associated with their sexual addiction regarding issues such as allegations of inappropriate sexual conduct, public order offences, and child sexual abuse. The impact of sexual addiction as reported by research subjects in this study is an accumulation of negative consequences, which has major repercussions particularly for the sexual addict, their families and society.

5.7 Turning Points

This section describes ‘turning point’ experiences, which marked the end of the sexual addicts’ addiction, and introduces ideas that will be further developed in Chapter six. These ‘turning point’ experiences usually involve a situation where the sexual addict becomes acutely aware that their sexual behaviour is increasingly problematic and that change is inevitable. In many instances the data reveal that it was typically a crisis that became the catalyst for change, often referred to as the experience of reaching ‘rock bottom’. The individual, in this context the sexual addict, begins a cycle of change. The cycle of change usually contains a series of stages such as contemplation and action leading to the termination of the behaviour required (Prochaska, Norcross & DiClemente 2010). Brian (SA), a thirty-four-year old, who is bisexual and recovering from substance use, recognised his sexual addiction when he was twenty-one years old. Brian’s (SA) sexual addiction developed for ten more years and he did not seek help for it. In the intervening years he developed an addiction to alcohol and drugs which eventually led Brian (SA) to a turning point regarding his sexual addiction:

I was very very very very close to ... losing my mind and suicide. They were the two biggest turning points because like I really really thought ... I used to go walking the streets high on cocaine ... I used to go walking in the parks looking for guys to get blow jobs off, you know. and I thought I was losing my mind because I had a combination of drink, drugs and sex and I really was fearing myself ... either losing my mind or my life (SA 2, page 17).

Finally, through the intervention of his family, Brian (SA) accepted help for his substance use and attended an addiction treatment centre. This became a significant turning point in his sexual addiction. It was in the treatment centre that Brian (SA) first spoke openly about his sexual addiction as he described:

The first thing that helped me [regarding sexual addiction] was when I was sitting in a group in a treatment centre and I said this is fucking me ... that was the biggest help ... just being accepted ... this is me, this is what happened to me, this is what I have
been doing for the last few years and just being accepted because you know . . . I used to think I was a pervert and just being accepted . . . the people giving me hope . . . people treating me nice after it you know . . . The biggest help is being me, being able to be free . . . not carrying it anymore (SA 2, page 18).

After a long history of sexual addiction, Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution, ironically welcomed the crisis which became a significant turning point in his life. Liam (SA) first went to a prostitute when he was seventeen-years of age, a practice which continued into his mid-forties. In the recent past after a sexual encounter with a prostitute Liam (SA) received a phone call from her informing him that she had contracted an STI which could infect Liam (SA) and his wife. This became a much longed-for turning point:

*I can remember I was driving home when I got the call from the prostitute. I was driving home from work and I knew as soon as the number came up . . . I knew what she was going to say pretty much. I don’t know why . . . I just had an instinct and when she told me . . . I just wrestled with the idea on the way home in the car and I just told myself you have done it . . . you have to face the consequences of what you have done. I wanted all the lies to end. I wanted to stop. I just felt that this would bring some kind of crisis and I knew it was going to happen. I actually thought on the way home that if my wife kicked me out I would commit suicide and that was firmly in my mind that I would top myself . . . that from the shame and the guilt so I was in a very desperate place. But I just wanted to end it you know . . . to end it somehow whether that meant death or something else . . . I wanted to end it . . . I was sick of the acting out (SA 12, page 5).

Despite the difficulties that resulted from the exposure of his sexual addiction, Liam (SA) explained that it was one of the best things that has ever happened in his life:

*So that’s when I told my wife . . . I had to tell my wife because I’d actually slept with my wife in the interim and that’s when my sex addiction came out and in a way it was a great relief . . . it was terrible because my marriage nearly broke down but in hindsight it was probably one of the best things that has ever happened in my life (SA 12, page 4).

These data infer that it was only after the sexual addicts hit ‘rock-bottom’ that effective change began to occur. In the aftermath of prolonged negative consequences many sexual addicts decided that they did not wish to continue their sexual addiction. They become willing to stop, but this process did not happen easily or quickly. Noeleen (TP), a psychotherapist working with substance users in recovery some of whom are sexual addicts, explained that the realisation that change is necessary is often a slow process:

*They’ve obviously hit some sort of rock bottom within themselves . . . you know where things are becoming too much for them . . . [I am] dealing with one or two of the clients
5.8. CONCLUSION

The first step that sexual addicts need to take regarding behavioural change is to recognise that their sexual addiction was problematic and then a process of change can begin as Noeleen (TP), a psychotherapist, suggested:

Admitting to themselves and to whoever is close to them that they have a problem . . . and then talking out about it to somebody and I know talking isn't enough . . . they need to identify, where it's coming from . . . why they're doing it and then change the behaviour . . . change the patterns (TP 14, page 7).

Turning points usually represented a moment when the sexual addict experienced heightened anxiety and shame typically as a result of a crisis. As a result some sexual addicts were sufficiently motivated and willing to deal with their sexual addiction while some were not. The individual's willingness to change was usually dependent on a number of internal and external factors that are inter-related such as the impact of the crisis on the individual and the consequences that occur, among others. A turning point, in terms of sexual addiction, signified the occasion when an opportunity for change was presented, and was positively accepted by the sexual addict. The sexual addict recognised the negativity of their sexual behaviour and the need for change and they began a process of fundamental behavioural change, commonly referred to as a process of recovery from sexual addiction.

5.8 Conclusion

Chapter Five contained a descriptive account of the 'lived experience of sexual addiction' from the perspectives of the self-defined sexual addicts and treatment professionals who work with these addicts. The data in this chapter are broadly organised around key characteristics of the addiction process which match with the diagnostic criteria and general clinical accounts of what constitutes addiction to psychoactive substances, as discussed in the literature review. In terms of sexual addiction the key characteristics of addiction are: 1) an escalating pattern of using more extreme forms of sexual behaviour in order to maximise pleasure; 2) a compulsive need to engage in sexual activity and a loss of personal control over this behaviour and: 3) the continuation of this type of sexual behaviour despite the harmful consequences. These key characteristics of the addiction process are all comparable with the alcohol-dependent drinker who continues to drink alcohol despite the realisation that drinking is damaging significant aspects of the drinker's life.
In summarising this chapter's findings, it seems necessary to restate what has been said in Chapter Four, that the research subjects' understanding of the concept of sexual addiction is influenced by their backgrounds. The treatment providers' views on sexual addiction are influenced by their professional education and training, and in particular by the application of models of addiction which have been primarily developed in relation to the ingestion of psychoactive drugs. The self-defined sexual addicts in this study, many of whom have undergone some type of treatment experience, generally constitute a 'treatment population'. As a result their understanding of the concept of sexual addiction is influenced by the treatment philosophy, which many of them positively subscribe to.

The descriptive accounts of the lived experience of sexual addiction highlight the difficulties which exist in relation to the labelling of any forms of sexual behaviour as pathological or addictive, given the lack of cultural consensus as to what constitutes 'normal' sexuality. The descriptive accounts of sexual addiction presented in this chapter are not based upon objective medical scientific criteria. Instead what constitutes addictive expressions of sexuality is likely to be relativistic and culture-bound and reflects shifting and often contentious cultural norms rather than scientific consensus about disease states. This corresponds to DeLamater (1981)'s framework, which identifies three main perspectives of human sexuality, namely the procreational, relational and recreational.

The notion of sexual addiction as a social construct rather than an agreed disease entity becomes particularly noticeable in this chapter in relation to how the concept of sexuality is perceived amongst homosexual or gay men. There are radically differing views as to what constitutes a normal sex culture for gay men. For some gay men the very essence of gay sexuality includes recreational sex, involving multiple partners and a general hedonism. For other gay men, to whom sex is primarily relational, hedonism of this kind is abnormal or pathological and may be perceived as addictive. Despite the absence of cultural consensus or absolute clinical guidelines to decide which of these two perspectives is correct, the views of treatment providers reported in this chapter highlight the subtlety and the sensitivity required to work clinically with gay men and others in such circumstances. The descriptive accounts of sexual addiction presented in this chapter must be regarded respectfully as having meaning for those who propose them, and they may offer practical insights in creating strategies aimed at resolving or managing such addictive tendencies. The management and treatment of such behaviours is the central focus of the next and final findings chapter.
Chapter 6

Treatment and Recovery from
'Sexual Addiction'

6.1 Introduction

The overall aim of this thesis is to investigate the contested concept of sexual addiction, specifically examined from the perspective of the self-identified sexual addict and the treatment professional dealing with this issue in clinical practice. The three findings' chapters, each one capturing a certain dimension of the concept of sexual addiction, when taken together present an overview of the concept as understood by the research subjects in this study. The three findings chapters present the concept of sexual addiction in terms of a specific trajectory with three major components. The first findings chapter considered the origin and development of a sexual addiction, and the second findings chapter investigated the lived experience of sexual addiction. As indicated in the previous findings chapters, it is acknowledged here that the views and beliefs of the research subjects reflect their involvement in, and acceptance of, an addiction treatment model which is largely accepting of the concept of sexual addiction.

The principal focus of this chapter is to present the data regarding the treatment of and recovery from sexual addiction. The process of recovery was normally initiated by a crisis or an intervention which helped to identify the presence of a sexual addiction. The crisis became the typical catalyst which led sexual addicts, voluntarily or under some compulsion, to seek help for their sexual behaviours. A number of specific therapeutic supports were identified and critiqued such as psychotherapy, 12-step fellowships and medical help among others. The data indicate that applying the concept of recovery to sexual addiction, in terms of the addiction model associated with psychoactive drugs, was complex but regarded as valuable by many. The data also reveal that some treatment providers and sexual addicts viewed sexual addictive behaviour from a variety of alternative perspectives rather than from the sexual addiction model. Some research subjects
were skeptical of the concept of sexual addiction and critical of how it was being presented in terms of an addiction or as a condition in need of diagnosis and treatment. The contested concept of sexual addictive behaviours was interpreted by some in terms of a multitude of social and cultural factors. Sexually addictive behaviours were also examined in terms of the biological and psychological influences among others which impacted on the individual's sexuality.

The challenge of how to define normal sexuality as opposed to abnormal or sexual addictive behaviour is particularly applicable within the context of the treatment of and recovery from sexual addiction. It was challenging for the individual who was trying to stop sexual addictive behaviour to determine what behaviour was normal or abnormal. Even when they successfully identified the addictive behaviour which they wished to stop, it was not always feasible to expect the sexual addict to abstain from all sexual behaviour forever given that sexuality is such an intrinsic dimension of human nature. The process of determining what type of sexuality remains acceptable for the individual who is recovering from sexual addiction requires careful attention.

This chapter begins by discussing the lack of clarity surrounding the concept of sexual addiction. This is followed by a description of the notion of 'recovery' in terms of sexual addiction. The major supports associated with sexual addiction such as psychotherapy, 12-step fellowships and medical help, are discussed and critiqued. Finally, the chapter concludes with a critique of the concept of sexual addiction.

6.2 ‘Sexual Addiction’: A Lack of Clarity

Research subjects said that the presence of a sexual addiction was generally difficult to identify, to label and to distinguish from sexual behaviour that was considered 'normal'. A number of socio-cultural and clinical factors, among others, were associated with the lack of clarity which surrounds this issue. Society regards sexual behaviour as a normal function of human behaviour and presumes that it is a manageable aspect of life by most individuals. Using this standard as the norm it is therefore difficult for many individuals to understand or accept that they cannot control their sexual behaviour. Many sexual addicts in this study who experienced out-of-control sexual behaviours initially attribute their behaviour to a number of plausible causes such as being 'over sexed' or 'not disciplined' enough. In some instances it was discovered that the plausible explanation often disguised the presence of what they claimed was a sexual addiction as Ivan (SA), a twenty-six-year-old gay sex and food addict, explained:

Well the ironic thing is that I never knew I was a sex addict or contemplated I could possibly be a sex addict when I was engaging in this form of acting out ... Again I blamed myself ... I thought that I am over-sexed and I am self-indulgent and I am not disciplined enough ... this is why I am acting out (SA 9, page 7).
The data suggest that the identification of sexual addiction was further delayed by the fact that the concept of sexual addiction remains a controversial issue about which there is neither a cultural or medical scientific consensus. The ongoing controversy about the validity of this concept results in the lack of agreed diagnostic criteria. This limits the recognition of sexual addiction both conceptually and clinically, as Frank (TP), a psychotherapist dealing with sexual offenders some of whom are sexual addicts explained:

*We don't have [diagnostic] criteria for sexual addiction and, as I said, it's a different type of addiction. I would probably be more inclined to call it a compulsion, rather than an addiction. I've had my doubts around it myself as regards whether calling it addiction is the proper thing but then how do you define it in terms of addiction* (TP 6, page 20).

The concept of sexual addiction was further scrutinised because of its regular association in the public mind with celebrities. As a result, individuals like Gerry (TP), a clinical psychologist specialising in child sexual abuse, questioned whether sexual addiction is a real addiction or simply an excuse for bad behaviour:

*Currently Tiger Woods is supposed to be in a sexual addiction clinic. Is that because he's about to have a divorce or is it because he cannot stop himself? You'd question a man who is in the public eye like that. He probably has a choice of stopping himself, if he wanted to, so . . . is that an addict or what? I think people play on it to some extent* (TP 7, page 10).

The data generally recognise that the concept of sexual addiction was also difficult to recognise within a culture which celebrates male sexual activity as an expression of machismo; as Matt (SA), a forty-five-year-old married sexual addict, explained:

*My male friends they just thought I was macho in terms of the kind of stuff that I was up to* (SA 13, page 16).

In summary, the data suggest that an accumulation of cultural issues create confusion as to how the concept of sexual addictive behaviour is identified or understood.

### 6.3 Beginning Recovery

The specific range of motivations for beginning recovery was mixed, but research subjects typically equated the introduction to recovery with a crisis including such issues as sexual disease, arrest, marriage break-up or mental health crisis. The motivation for recovery was a topic of clinical importance to treatment professionals; as Seamus (TP), director of counselling in an addiction treatment centre explained:
I think what motivates them is that they see a better quality of life. If they’re at the early stages, what motivates them might be the fact that they were caught and there’s an ultimatum and maybe they do see the consequences for themselves regarding health, finance, relationships . . . so that’s a big incentive to do something about it. We would always hope that, regardless of what the reason, that somebody comes into treatment for . . . you know . . . it doesn’t matter whether it’s because you’ve a gun to your head or not . . . we would always hope that at some point during the treatment that would turn round and that people would see the value in it for themselves, you know. It’s like a cliché . . . people say . . . ‘I have to get better for myself’ . . . but actually that’s the reality because if people don’t see the value in it for themselves . . . well my experience is that just doing it for the partner or for the family won’t work, you know (TP 19, page 10).

Many research subjects explained that the process of recovery provides the opportunity to deal with underlying issues, including self-esteem, childhood neglect and sexual abuse. Research subjects generally envisaged that the process of recovery would help the sexual addict discontinue from engaging in destructive sexual behaviour and, therefore, stop the recurrence of negative consequences. Nonetheless, the experience of recovery from sexual addiction was challenging; as Gary (SA), a forty-two-year-old, gay male sexual addict in recovery from substance use, explained:

I don’t think I have left it [sexual addiction] behind or anything. I suppose the behaviour . . . the acting out behaviour I have left behind for now and I suppose it’s difficult and it’s lonely and it’s frustrating and yeah . . . and sometimes I wonder . . . ‘is it worth it you know . . . really, I just wonder is it worth it and what the fuck am I doing?’ (SA 7, page 39).

Other individuals reported that they found the process of recovery from sexual addiction too painful and returned to their sexual behaviour frequently. Quintan (SA), a middle-aged gay sexual addict who is in recovery from substance use, attends a female therapist to deal with his sexual addiction, and explained that:

Every time I finish a session with her [psychotherapist] I would go to the bath house. It was an aesthetic . . . It was just away from whatever had been brought up (SA 17, page 13).

Fergal (TP), a social worker and psychotherapist, referring to a client explained that the long-term recovery goal is to deepen the individual’s understanding of their sexually addictive behaviour and explore new ways of being sexual:

He’s [client] trying to explore alternative ways of being sexual and is coming to those himself and we’re talking about that . . . even in terms of his self-image . . . of looking at himself in the mirror or becoming comfortable with his body, you know . . . how he
relates to his genitals. Other ways about relating generally...about going out more, trying to socialise more...so he's trying to. The other aspects of his life are kind of improving, and the isolation and the loneliness isn't driving him in anymore because other things are progressing and changing for him outside of that (TP 32, page 7).

In this study the concept of recovery from sexual addiction was generally viewed from a psycho-medical perspective which was determined by the treatment provider's professional training and the sexual addict's choice of support. Furthermore, the concept of recovery was frequently described in terms of commonly used supports such as psychological, 12-step sexual fellowships, medical and educational supports, among others, which are discussed in the next section.

6.4 Psychotherapy, 'Sexual Addiction' and Recovery

The data reveal that 21 (46%) of the sexual addicts sought help from a psychotherapist to deal with their sexual addiction. Research subjects used a variety of formats when using psychotherapy, including individual therapy, group therapy or couple therapy. 13 (28%) sexual addicts in this study chose to attend individual one-to-one therapy only. 7 (15%) sexual addicts attended both individual therapy and group therapy. 4 (9%) sexual addicts in this study attended individual therapy and couple therapy. In contrast to those who used psychotherapy, there were 12 (26%) sexual addicts who did not use psychotherapy as a source of support.

The data suggest that the choice of a psychotherapist was based on many factors, such as the availability of therapists and recommendations or referrals from other professionals. Some sexual addicts purposefully chose psychotherapists who had specific training, such as specialists in addiction, sexual addiction or trauma. Others chose generically trained therapists at random. Liam (SA), a forty-five-year-old married man, who is primarily addicted to prostitution, explained his experience of trial and error regarding his choice of therapist:

> When I got together with my Mrs I went to somebody for the guts of a year...but it was going around in circles talking...it was psychodynamic. Then I went to another purely addiction counsellor type of guy. He did the sexual addiction assessment on me and I was mildly addicted. I didn't connect with him and he was more or less trying to tell me...You're not really into this woman, leave and move on...That was not what I wanted...I wanted to make this work. I eventually stumbled across a therapist that worked for both of us...so it was trial and error (SA 12, page 17).

The data reveal that once the therapeutic process began most therapists followed a similar trajectory with their clients. The typical method was to identify the problematic behaviour, examine the underlying causes, stabilise the behaviour and supervise the impact of the therapy. Some providers viewed the therapeutic process in terms of an initial introductory phase and a later development-
tal phase. Michael (TP), an addiction therapist specialising in sexual addiction, described these phases as follows. He said,

*In the early stages what people seem to want is to learn more about the issue ... to understand how they can break the cycle ... to learn some sort of strategies that can help them to move forward, but the other thing that they need ... and of course this is the bit that they're less enthusiastic about ... is that they really, really need to process a lot of the emotions and even a lot of the relationship issues* (TP 39, page 9).

The second phase of therapy for sexual addiction, according to Michael (TP), an addiction therapist, entailed attending to specific issues which involved:

*Deeper developmental work comes into play really both past and the future ... issues around where all this came from and issues around their acting out in a destructive way which involves doing deeper developmental work ... looking back to the childhood and adolescence* (TP 39, page 10).

Sexual addicts generally preferred a style of psychotherapy which addressed underlying issues such as depression, substance use and trauma. Interactive psychotherapy which involved therapeutic tasks such as journaling, and reading was deemed particularly effective. The data from the interviews and the questionnaires reveal that a variety of therapeutic techniques, including cognitive behavioural therapy (CBT) and motivational interviewing (MI), were used which is in keeping with other similar studies (Shepherd 2010). One major challenge for sexual addicts in recovery was to help them stop their sexual addictive behaviour while they continue being sexual; as Erik (TP), a social worker specialising in addiction and who works with sexual addicts, explained:

*I think the danger for somebody who is a sexual addict trying to recover is that if they tend to engage in any sexual activity, there's a big danger that they would sort of fall back onto old, ineffective behaviours that they're trying to address or do away with* (TP 5, page 9).

The data identify certain factors which helped to make psychotherapy more effective and other factors that made it unhelpful. Jim (TP), a psychotherapist, trained in sexual addiction counselling, claimed that clients who experience a significant crisis were usually more amenable to dealing with their behaviour; as he explained:

*The further the addict falls down ... in other words the deeper the hole, the greater the recovery; whereas if somebody is coming into me and they haven't really got that effect going on, I really don't have much of a leverage to work with ... because what the addict is saying to me then is ... 'I haven't really gone too far down ... so there's a possibility I can still act out for another couple of years* (TP 10, page 4).
The effectiveness of psychotherapy for sexual addicts may also be influenced by the manner in which the individual begins the process. Kate (TP), a psychosexual therapist who specialises in sexual addiction, stated that individuals who attend voluntarily and already have personal motivation to change will benefit more:

A lot of them [clients] come here through referrals from the Department of Psychiatry and they also come through referral from their GP [General Practitioner / Medical Doctor]. Their partner might refer them but a lot of the time what we find is that they won’t really do much good work for themselves if they’ve been sent (TP 11, page 6-7).

In contrast Gerry (TP), a clinical psychologist specialising in child sexual abuse, believes that despite how the process begins, psychotherapy is a positive opportunity. And he also believes that most clients began therapy as result of social pressures rather than as a result of personal motivation; as he, explained:

It’s very rare that somebody will put their hands up of their own accord and say ...‘Listen I need help with this’. Usually somebody has a word in their ear ...whether it’s a Guard or a loved one or a boss. It’s usually a crisis and I think that’s where ...if they seek help therapeutically ...it’s up to the therapist then to motivate once they’re in there ...anything that gets a person into therapy is a good thing (TP 7, page 11).

Psychotherapy for sexual addiction is made more difficult by the absence of agreed scientific criteria for the concept of sexual addiction. This was observed in terms of referral among professionals; as Michael (TP), an addiction therapist, specialising in sexual addiction, explained:

Part of the difficulty in terms of referring clients to other professionals is that there’s some justified theoretical disagreement about the existence of sexual addiction. This is more of an issue with mainstream professionals in social work and psychiatry and even psychology. I think part of the difficulty is that sexual addiction might be seen as a fairly woolly concept within those professions, because it’s not in the DSM for example and therefore not scientifically ratified (TP 39, page 3-4).

6.4.1 Group Psychotherapy

Psychotherapy was also discussed in terms of group therapy and was used by 7 (15%) sexual addicts. Group therapy, in this study, was understood as a therapeutic group catering specifically for sexual addicts and facilitated by treatment providers, typically a psychotherapist or a psychologist. This form of therapy is new in Ireland and remains at an experimental stage. Others discussed group therapy in terms of a therapeutic group for individuals dealing with a variety of addictive and psychological issues in which sexual addicts are also involved. This option is usually used as part of a therapeutic programme within an institutional setting. The group can include up
to twenty members and includes one or two professionals who facilitate the process. 7 (13%) treatment providers in this study were involved in the provision of group therapy involving sexual addicts. Celine (TP), a clinical psychologist and group therapist working with sexual offenders, some of whom are sexual addicts, claimed that group therapy offers learning about interpersonal relationships which can be particularly beneficial for the sexual addict who struggles with intimacy and relationships (TP 29, page 11). Seamus (TP), director of counselling in an addiction treatment centre, explains a number of key features associated with group therapy regarding sexual addiction within an addiction treatment context:

Most of our work is done in group therapy . . . so it’s to try and separate what’s addictive compulsive behaviour from just acting out. Some of these people have a little bit of time working that out because somebody may be sitting in the group saying . . . ‘Ah Jesus, you know when I was drinking I’d be doing that’ you know but there’s a big difference . . . It also helps to kind of normalise it as an addiction . . . you know that it’s not a worse or a more shameful addiction than something else . . . it’s just another addictive behaviour. I think on the positive side it’s probably the first time that people have been able to relate to others in a healthy way and they have to relate to people of their own sex and the opposite sex . . . And we would have very strict rules about behaviours, so there’s a very strict boundary on all of that. So again it puts people into the situation where they have to work through intimacy difficulties. A lot of the work here is very emotional and very intimate, so people find themselves in a situation where they are actually relating to others in a very real and intimate way without there being a physical intimacy, do you know what I mean (TP 19, page 4-5).

The data reveal that the group therapy sessions which are specifically organised for sexual addicts are predominantly male, which reflects the gender mix associated with sexual addiction. As a result the therapeutic learning is limited particularly for men who wish to develop their communication and relationship skills with women. The gender imbalance is equally challenging for the female facilitator, as Brid (TP), who offers cognitive behavioural therapy (CBT) and who specialises in sexual addiction counselling, said:

I found it very hard from a therapist’s point of view to be the only woman in the room when I worked in therapy groups (TP 2, page 24).

Despite the perceived value of group therapy, York (SA), a sexual addict, separated from his wife and in recovery from substance use, reported a negative impact of group therapy. This occurred during his time in a treatment centre for substance use; as he explained:

I remember quite early on in my treatment there . . . after a few days seeking out one of the counsellors to have a chat with . . . you know I had a chat with this guy and I
said look there's stuff going on in my sex life and I explained what was going on with sex addiction and the guy just shut down and he said ... 'Well you know, that's fine but you need to come into group and talk about that because that's how we do things here' ... well I can tell you that wasn't helpful ... that wasn't helpful for me ... because the message that I picked up was that here you are in a house full of addicts ... there's twenty other addicts here and you're are the biggest addict of the lot ... and I can't help you ... you need to bring that to the group ... and what sex addict can sit in a group full of people and talk about this for the first time ... so that's an example of adding to shame, which didn't help me at all and in fact I think may have hindered my whole treatment (SA 25, page 18).

6.4.2 The Psychotherapist

In this study the psychotherapist emerged as a significant figure for those who are recovering from sexual addiction. A variety of experiences and perspectives were reported regarding the psychotherapist. Some sexual addicts, like Peter (SA), a forty-nine-year-old sexual addict who was sexually abused and who is divorced, experienced different therapists. He began with a generically trained therapist, before moving to a specialist in sexual addiction and finally he began group therapy:

That particular counsellor [the first counsellor] had no specific knowledge of sexual addiction but I hadn't really fully identified myself in that sense. I was just talking about the behaviour but he was just offering general support, because I had quite a lot of anxiety and a lot of panic and mental turmoil about the whole thing, and he gave me good support at the time I needed it ... Then I come across a therapist who was talking about sex addiction. So I made an appointment to see him and went to him for eight or nine months. That was pretty crucial in terms of just a therapist to help me ... that I could talk about what I wanted, and I seemed to be comfortable initially in a one to one but it took me a while to open up to a group setting (SA 16, page 7-8).

In contrast to generic counselling, others attended sexual addiction specialists. Liam (SA), a forty-five-year-old married man who was primarily addicted to prostitution, attended a therapist who viewed sexual addiction in terms of the disease model. The therapist encouraged the use of the 12-step programme and the use of specific literature in conjunction with psychotherapy; as Liam (SA), explained:

He [therapist] explained that sex addiction is a known disease and explained how people get over it ... and although it was depressing at the time ... telling me that this is not a quick fix and that it was no good just trying to tell myself that that's not going to happen again ... I had to do a lot of work ... and he introduced me to the 12-step programme
...and he gave me literature and the first book I read was Out of the Shadows, which gave me a bit of an insight to sex addiction, and then I started other reading so it started to give me knowledge on sex addiction (TP 12, page 25).

Rory (TP), a psychotherapist who specialises in sexual addiction counselling, believes that it is essential for therapists who work in the area of sexuality to complete personal self-development in the area of sexuality:

Therapists themselves can learn as much theory as is out there around this sort of thing, but unless a therapist is willing to do the work on themselves in this area they’re not going to be much help to anybody... explore their own shadows and their own hang-ups and their own baggage around things... that might get in the way of their work (TP 44, page 23).

In addition to completing personal self-development work regarding their own issues, Henry (TP), a specialist in couple counselling, emphasised the need for theoretical knowledge and suggested that:

Professionals in this field and especially the therapist should be aware of the issue, and have a good knowledge of the treatment models and be familiar with the support network in order to deal effectively with sex addiction (TP 34, page 3).

Many psychotherapists in this study discussed the need for, and value of, professional support. One major expression of such support is the use of clinical supervision which offered therapists an opportunity to review their work and discuss issues such as personal competence, bias and counter-transference among others, with their supervisor. Oisin (TP), an addiction therapist who specialises in sexual addiction counselling, explained that he uses a combination of peer support and professional supervision:

I am part of a peer group support and also I have a supervisor. I think it’s important to link in with other therapists working in the area of sexual addiction. I’m lucky in relation to supervision... my supervisor has a lot of training in addiction and she is also a couple trained counsellor (TP 41, page 9).

6.5 Critique of Psychotherapy

The data reveal that psychotherapy was generally perceived as a beneficial support for those in recovery from sexual addiction. Nevertheless, criticisms were voiced regarding psychotherapy both by sexual addicts and by members of the therapeutic community. Quintan (SA), a middle-aged gay sexual addict who is in recovery from substance use, was critical about the lack of awareness and the lack of recognition of sexual addiction among the therapeutic community:
A lot of therapists are not yet aware of it [sexual addiction]. There has been a debate in
the British press as to whether there is such a thing as sex addiction ... So I think what
would be of most service would be a recognition of the problem within the therapeutic
community (SA 17, page 21).

Some research subjects complained that psychotherapy did not help them to stop their sexual
addictive behaviour. Harry (SA), a sixty-three-year-old married sexual addict, who has bipolar
disorder, explained:

\[ I \text{ had a year's worth of therapy and, looking back on that, I've got mixed views about }
\text{the value of that therapy. It did help at the time to identify my early life experiences }
\text{and the relationship to my addiction and my present situation but it didn't particularly }
\text{stop me acting out} (SA 8, page 20). \]

Other research subjects, like Raymond (SA), stated that the psychotherapist was not sufficiently
challenging and avoided asking the difficult but necessary questions:

\[ I \text{ found a guy [psychotherapist] and he gave me a questionnaire and that put it to me }
\text{in black and white that I was a sex addict, but I felt that he wasn't sufficient. I needed }
\text{someone who would challenge and he didn't challenge me. He was addressing the issues }
\text{but he didn't get into the stuff that I was running away from ...like the HIV for example }
\text{and my own responsibility in it} (SA 44, page 43-44). \]

Psychotherapy was made all the more difficult by the therapist's negative attitude which often
lacked encouragement and emphasised the difficulties involved. Recovery was not helped by an
overly prescriptive attitude observed in some professionals; as Rory (TP), a psychotherapist who
specialises in sexual addiction counselling explained:

\[ \text{It doesn't help to try and force someone who's suffering and struggling ... it doesn't help }
\text{to be above them. I don't think it helps to be the expert in the chair saying ... I'm the }
\text{expert ... I know everything about this and this is what you need to do} (TP 44, page }
\text{19).} \]

Michael (TP), an addiction therapist, specialising in sexual addiction, believes that there is a lack
of knowledge and an underlying resistance among some therapists to deal with sexuality; as he
explained:

\[ \text{A lot of general counsellors don't know a lot about addiction and don't necessarily want }
\text{to know a lot about sexuality, and it partly reflects the culture in general. I mean }
\text{counsellors and psychotherapists should have a knowledge that goes beyond the general }
\text{culture around ... but there isn't a great awareness around sexual addiction beyond a }
\text{fairly trivial tabloid article} (TP 39, page 3). \]
The data indicate that the resistance among psychotherapists to deal with sexuality may be due to the perception that clients are generally reluctant to deal with the issue of addiction. Resistance is further added to by a combination of fear, lack of skill and a cultural negativity towards sexuality. Criticism of the financial cost of psychotherapy, which ranges from fifty to one hundred euro for a one-hour meeting, was made. The cost may be prohibitive for some sexual addicts, particularly when psychotherapists expect to see clients over a period of one to five years. Ivan (SA), a twenty-six-year-old gay sexual addict, who can afford to pay for individual therapy, was mindful of those who cannot afford to pay:

[Many] can't afford to pay eighty or a hundred euro to see a therapist, particularly for something where half their head is telling them it's not there anyway ... that they don't have a problem. I really think the service needs to be more attainable and more accessible (SA 9, page 27).

Some psychotherapists have received specialist training in this area while others have not. A variety of strategies and skills were identified as useful while other factors were noted as being unhelpful. The integration of ancillary supports in order to complement psychotherapy was seen as beneficial. Psychotherapists were viewed as significant figures and their level of awareness, training and attitude was influential in the process. While psychotherapy was viewed positively, a number of significant factors were highlighted which impeded the recovery process.

6.6 Residential Treatment and Recovery

The data reveal that 12 (26%) sexual addicts received help for their sexual addictive behaviour from residential treatment centres. 4 (9%) of these identified sexual addiction as a primary issue and consequently sought specific help while 8 (17%) others sought help for their sexual addiction while in residential treatment for substance use or gambling. Individuals received help in residential treatments centres in Ireland, England and United States of America. It is common to have dedicated treatment centres for sexual addiction in the USA, but in England and Ireland treatment centres until very recently have focused on treatment for alcohol, drugs and gambling. Many addiction treatment centres in Ireland and England are currently providing specialised treatment programmes for sexual addiction.

Seamus (TP), director of counselling in an addiction treatment centre, which provides sexual addiction treatment, explained how sexual addicts are referred for treatment:

I would say most of them come self-referred ... I don't know of anybody that's been referred by say the normal channels like through a GP ... or sometimes through a friend in recovery or something, you know. I suppose the other way of referral does come through a family where they would ask the question ... and they might say, I think
my son, my partner, my husband or my wife has a sexual addiction. What can I do about it or can you help me and in that case you could call that I suppose a family referral (TP 19, page 3).

Some individuals who present with substance addiction may discover that they need to examine sexual addiction as a primary or a secondary addiction; as Seamus (TP) explained:

Somebody comes in with a primary drugs or alcohol addiction, and during the course of the treatment it becomes very obvious that there are other issues around sex and pornography and relationships and sometimes that's masked. I think what happens is that sometimes people see it just as part of the bad behaviour, say particularly around cocaine. People often say ... 'Well actually it's [sex] part and parcel of it' ... but maybe when they start to look at it ... maybe then they start to realise that it's actually more than that, you know ... I remember last year, we had a guy in who talked about cannabis and sex. He would have presented as cannabis ... being the main one but it was the other way round ... sex was the big addiction ... cannabis was an add-on (TP 19, page 4-5).

Brian (SA), a thirty-four-year-old sexual addict, who is bisexual and recovering from substance use, reported that he was suicidal as a result of his sexual addictive behaviour. He said that psychotherapy within an addiction treatment centre provided him with the opportunity to speak about his sexual addiction:

I ended up in a treatment centre, and my family thought I was going there for drink or drugs but no one knew about the sex like ... and when I got out there I just spewed it all up. It was like there was this huge weight that I had been carrying on my shoulders for ... like twenty years was gone ... that's all I can say ... that it was just a huge pressure release (SA 2, page 16).

Ultan (TP), a forensic psychologist specialising in addictive and sexual behaviour, facilitates group therapy in a residential centre, highlighted the possibility of sensitive sexual issues arising among the group members:

The thing that I'm thinking about is if somebody is very sensitive to sexual behaviour in males, such as a female who's dealing with sexual abuse, sexual assault or that type of thing ... and in a group therapeutic situation if somebody is discussing their sexual behaviours and their sexual conquests if you like ... They're the kind of things that we would have to look at. I mean if we did have somebody with sexual ... quite specific issues where he was the perpetrator of something and we had a victim of exactly the same thing ... yes I think then there would be an issue but that hasn't happened (TP 21, page 11).
Similar to those recovering from substance addictions, sexual addicts are encouraged to attend an aftercare programme after they have completed their residential treatment. This typically involves a regular meeting with a psychotherapist on an individual basis and attendance at an aftercare group meeting. Seamus (TP), director of counselling in an addiction treatment centre, highlighted a number of issues specific to aftercare for the sexual addict:

\[\text{For an ex-client we have the continuing care support group which meets on a weekly basis and we would encourage people into that process. Again, this is just another addiction so you join the group. We did talk about having an aftercare specifically for sex addiction at one point and then we decided not to do it; and I think our decision not to do it was as much to do with logistics and getting people together but with hindsight I'm glad we didn't, you know. I think it mightn't have been the most helpful thing to do because, you know, people have done well (TP 19, page 8).}\]

Edward (SA), a thirty-one-year-old sexual addict who is also addicted to gambling, attended an aftercare group. He explained that it was more difficult to talk about his sexual addiction in the aftercare group in comparison with the sexual fellowship meeting.

\[\text{I suppose I felt weird sometimes talking about it [sexual addiction] in comparison to the fellowship [12-step fellowship group] where like it's not a big thing. I would go to the treatment centre to aftercare meetings and talked about me being a sexual addict. I didn't always feel comfortable with that, but it's possibly important to be open and honest about it rather than hiding it and keeping the shame (SA 5, page 7-8).}\]

The aftercare programme for the sexual addict may also include other recommendations as Ultan (TP), a psychologist working in a residential treatment centre, explained:

\[\text{You will continue to see a continuing care group once a week for twelve months, but I mean everybody who comes through here we would develop a discharge plan and that can involve many different things; and it might be family support or it might be attendance at SA meetings if it's sexual addiction (TP 21, page 13).}\]

### 6.6.1 Critique of the Residential Treatment of 'Sexual Addiction'

Some research subjects were critical of the failure of treatment professionals in residential substance abuse programmes to identify and respond to sexual issues. William (SA), a twenty-eight-year-old sex addict with a history of drug addiction and child trauma, regretted that he did not address the issue of his sexual addiction during the time when he was in a residential treatment centre for substance use. William blamed a culture of negativity towards sexuality and the lack of professional competence as major obstacles; as he explained:
I didn't actually discuss it much and I'm sorry I didn't now...because one of the counsellors in there said to me... 'This is all about your ego isn't it'... and I just felt awful and I didn't say anymore about it then. I also thought people were going to be saying... 'Oh he's only talking just because he thinks he's great'... so I didn't talk about it anymore. I talked about it in the one-to-ones a couple of times but I didn't really talk about it much at all (SA 23, page 8).

Vincent (SA), a twenty-eight-year-old sex addict, who experienced childhood trauma and who is recovering from substance use, explained that during his residential treatment for substance addiction he had a number of sexual liaisons with fellow residents. Staff members interpreted his out-of-control sexual behaviour as an indication of loneliness. Vincent (SA) conveniently agreed with their interpretation, but he admitted that he knew he had a problem with sexual addictive behaviour. He claimed that it was unacceptable to speak about it in the residential treatment centre. After successfully quitting his substance use, Vincent (SA) relapsed and attributed his relapse to the ongoing sexual addiction. After completing his second residential programme for substance use, he is currently in an aftercare group and his fellow members inform him that he is currently neglecting his substance recovery due to his sexual behaviour. Vincent (SA) described his pattern of sexual addiction as follows:

I keep using sex to suppress feelings... it's like any other drug. There's only a limited time that it's going to work for me and then I turn to something else. There's only so much stuff you can turn to in order to get that feeling before going back to drugs, and that's the last thing that I want (SA 22, page 7).

Edward (SA), a thirty-one-year-old sexual addict who was also addicted to gambling, explained that he went into an addiction treatment centre to deal with gambling, sex and alcohol. Edward claimed that the staff seemed unsure how to deal with the sexual addiction and offered him no specific treatment:

I suppose basically my issues on the table were gambling, sex and alcohol. I spoke about it [sexual addiction] quite openly and the behaviours that I was involved in... They even said themselves like... that it was new to them and they weren't sure... but they tried to deal with it in the same way as they would have my gambling, but it was given no special treatment (SA 5, page 7-8).

Garvan (SA), a fifty-nine-year-old sexual addict, who was dismissed from his employment as a result of his sexual addictive behaviour, described how residential treatment for sexual addiction did not appreciably change his behaviour:

I was pressurised to attend residential therapy for my sexual behaviour after an incident was reported to my employees. I was angry but I complied. I did benefit somewhat from
being there, and I knew that my behaviour was a problem for a long time but I have not changed my behaviour considerably (SA 33, page 3).

Kate (TP), a psychosexual therapist who specialises in sexual addiction, was critical of residential treatment centres which she claimed do not always complete sufficient therapeutic work with sexual addicts:

*It’s coming up time and time again that when they [sex addicts] have so many weeks completed in the [residential] clinics ... they’ve nowhere else to send these patients to, so they recommend that they go to the fellowships. It’s almost like ... we’re finished with you now ... it’s a revolving door syndrome and they may not really have done the work in groups in some of these clinics so then they send them to the fellowships* (TP 11, page 9).

### 6.7 12-Step Sexual Fellowship and Recovery

The data reveal that the 12-step fellowships were a popular dimension of the support structure used by those recovering from sexual addiction. 25 (54%) sexual addicts in this study used a sexual fellowship and a majority of the treatment providers discussed the role of the 12-step sexual fellowship meetings. The 12-step sexual fellowships groups are based on the model which originated with Alcoholics Anonymous (AA), but they are modified to specifically address the issue of sexual addiction. There are at least five specific support groups for those with sexual addictive behaviours. They are mostly American in origin and have slightly different criteria and appeal to different populations. There are two sexual fellowships in Ireland; namely, Sex and Love Addicts Anonymous (SLAA) and Sexaholics Anonymous (SA). Fellowship meetings are held regularly in the major cities including Dublin, Belfast, Galway, Cork and Waterford. A typical meeting consists of a number of individuals who voluntarily meet and speak about their experience of sexual addiction with the aim of improving their sexual behaviour. Unlike group therapy, these groups are organised by sexual addicts for sexual addicts and there are no professional facilitators.

Most of the sexual addicts in this study preferred to attend a fellowship meeting in person while only two sexual addicts use on-line meetings. The fellowship meetings discussed by research subjects included men and women but some sexual addicts had attended meetings which were designed for women only. Sexual addicts were introduced to the sexual fellowships in a variety of ways, including referral by a professional, self-referral, friends, partners, family members or accidently. Despite the individual’s fear of attending their first meeting the experience was generally positive. Once an individual makes contact with the sexual fellowship either by phone or email an introductory meeting was arranged. Members of the group meet the individual who was making the inquiry and explain the principles of the fellowship. Subsequently, enquirers were invited to attend a meeting whenever it suited them. The criteria for what constitutes sexual
addiction are predetermined in the Sexaholics Anonymous (SA) fellowship. In contrast, the criteria for sexual addiction are less defined in the Sex and Love Addicts Anonymous (SLAA) fellowship. In SLAA it is the responsibility of the individuals who attend to determine for themselves the sexual behaviours that are addictive and the behaviours that they wish to abstain from.

Research subjects recorded a catalogue of benefits resulting from the sexual fellowships, including encouragement, identification, belonging and acceptance. Membership of the fellowship reduced the sexual addicts' isolation (which was often the hallmark of their sexual addiction) and provided a forum where they learned how to be honest without the fear of being judged. Liam (SA), a forty-five-year-old married man who is primarily addicted to prostitution, explained how beneficial the fellowship has been in terms of recovery from sexual addiction:

_The fellowship has been a huge help. I think it's been the single-most important part of my recovery and it's helped me in many many ways . . . but I'd say first of all giving me a space where I can talk completely openly about my sex addiction and my life and anything . . . and also listening to other people who have been in recovery for a long time and listening to how they have done it, and how they have overcome certain challenges and how they have got through withdrawal and all the other things that you face as a sex addict (SA 12, page 25)._

Agnes (TP), an addiction therapist who specialises in sexual addiction counselling, viewed attendance at 12-step fellowship meetings and professionally delivered psychotherapy as complementary. She remarked that those who use the sexual fellowship meetings seem to achieve recovery in the long-term. Referring to one of her clients she said:

_He [client] also uses the 12-step meetings, so I think he keeps to his own kind of criteria of recovery through the meetings. I find that the guys I work with, who work out in the long-term, are the guys that continue going to the 12-step meetings because they have some kind of a back-up, I suppose. They can't, I suppose, continue to go to therapy for the rest of their lives and, you know, it's time consuming and it's expensive . . . but they tend to check in with the meetings (TP 1, page 11)._

Given the sensitive nature of the concept of sexuality, safety and confidentiality in the sexual fellowships were deemed to be extremely important. Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, suggested that there should be a safeguarding structure in the fellowships to protect individuals who use the sexual fellowships from unnecessary risk regarding sexual behaviour:

_The supervision around Sex and Love Addicts Anonymous needs to be quite containing, because the risk is that can become almost like . . . not like a dating agency but people could agree . . . just like people who are alcoholic in Alcoholics Anonymous can sometimes_
take one another out drinking. You know it’s a support group but it’s also an escape group, and you know that you’ve people who might escape along with you... because it’s about love and relationships and sexuality... bringing people together who are sharing this... there are going to be emotional reactions... there are going to be triggers for other people in the group who start feeling things and so I think that it does require the honesty, the commitment and the containment that nobody walks out from a session with the intention in their mind that they’re going to use (TP 25, page 14).

Spirituality is a feature of the 12-step fellowships movement although none of the sexual fellowships are associated with any specific religious organisation. A generic spirituality typically referring to a belief in a higher power was observed as a significant dimension of the sexual addict’s recovery.

Some research subjects were opposed to using the 12-step fellowship meetings; as Matt (SA), a forty-five-year-old married sexual addict explained:

*I have no idea how I would fit in there, but I’m not going there. I mean there’s no way on earth that I could come out and say... my name is John, I’m a sex addict and I’m in recovery...I would laugh at myself hearing that... I just couldn’t make that statement* (SA 13, page 15-16).

Maura (SA), a middle-aged married woman, who attends the sexual fellowship, acknowledged that a 12-step fellowship is not suitable for everyone and suggests that there is a need to:

*...promote and develop a holistic approach to recovery, because no one size fits all and the 12-step model may not suit everyone. Sexual addiction is so pervasive and deeply embedded that a multifaceted approach is essential* (SA 39, page 2).

A majority of the professionals were aware of the existence of the sexual fellowships, but some sexual addicts complained that professionals had insufficient knowledge about the operational dynamics of the fellowships. Psychotherapists were happy to recommend the 12-step sexual fellowships, and some psychotherapists at least were competent to guide their clients through the 12-step process and literature as a component of their individual therapy.

### 6.7.1 Critique of the 12-Step Sexual Fellowships

Some research subjects were critical of the 12-step sexual fellowship movement. One significant criticism centres on the definition of sexual addiction in the Sexaholic Anonymous (SA) fellowship. The criticism is based on the official literature associated with Sexaholics Anonymous (SA) which defines sexual addiction in terms of ‘any form of sex with oneself or with partners other than the spouse’ (Sexaholics Anonymous 1989, p.4). In this instance the term ‘spouse’ refers to ‘one’s partner in a marriage between a man and a woman’ (Sexaholics Anonymous 1989, p.192). Therefore by definition the Sexaholic Anonymous (SA) fellowship views sexual behaviour among those who were
6.7. 12-STEP SEXUAL FELLOWSHIP AND RECOVERY

not married, homosexual behaviour and masturbation as unacceptable for its members. AA, the fellowship upon which all other fellowships are based, has no comparable definition of alcoholism. AA sees itself as being available for people who believe that they are ‘powerless over alcohol’ and that their lives had become unmanageable (Alcoholics Anonymous 2001, p.59). This means that AA stays out of all controversy such as controversy about whether alcoholism exists, how alcoholism should be defined, what causes it and how the government should regulate alcohol. Maybe SA would be best advised to do something similar. Some research subjects, particularly sexual addicts who were not married or gay felt discriminated against in the SA fellowship. Ciaran (SA), a forty-five-year-old gay sexual addict, experienced a conflict regarding this 12-step sexual fellowship and his sexual orientation:

When I joined the fellowship first I went to SA because it was the only meeting where I lived. At the meetings I was really glad to hear that others had similar experiences to me. As time went on I realised that the SA fellowship did not really suit me as a gay man. If I was to stick by their rules, it meant I had to give up sex which I couldn’t buy into. I stayed for a while but finally I left. The members were decent but the rules were too strict (SA 29, page 4).

The sexual fellowships in Ireland are not as well established in comparison with AA and as a result display a lack of direction within the fellowship. Gary (SA), a forty-two-year-old, gay male sexual addict in recovery from substance use, referring to his own insecurity and the lack of guidance in the sexual fellowship said:

Like I don’t know where this is going . . .I’m a bit like ‘what happens next’ . . . like ‘what do you do now?’ . . . So it’s a young fellowship here, and I think people are a bit bewildered but I just try and do the next best thing that I think is to be done (SA 7, page 41).

Concerns were also mentioned regarding the negative impact of individual personalities and the group dynamics amongst those involved in the sexual fellowships; as Raymond (SA), a thirty-four-year-old gay sexual addict who is HIV positive, explained:

When I started the fellowship four years ago and I could see that there was a lot of stuff one could label as unhealthy . . . you’re talking about a group of addicts so there would be people obviously who want to control things and all that kind of stuff, but for me I was told by my own sponsor . . . you know, you take what you want . . . you leave the rest. And so that was my mantra; no matter how annoyed I was with certain people or the way things were working, it didn’t matter because I wasn’t there for anyone. I was just there for me . . . I mean there might be a lot of negativity . . . there could be, you know . . . people who are acting out and if they’re in the problem well they’re not in
the solution. You can imagine that people could be quite critical of themselves and of others and all that kind of stuff (SA 44, page 17-18).

Kate (TP), a psychosexual therapist who specialises in sexual addiction, has worked with clients who have been in the sexual fellowships. She claimed that the fellowships can be cultic, misleading and addictive. Referring to a male client who attends sexual fellowship Kate (TP), said:

_He [client] was going to the fellowship, and he was always told to abstain from masturbation. They [the fellowship] see masturbation as abnormal as opposed to normal (TP11, page 8)._  

Kate (TP), referring to individuals who have participated in treatment centre programmes, said that if they have not completed their therapeutic work sufficiently they can become totally ‘absorbed’ in the fellowship culture: [reminiscent of common complaints about excessive involvement in AA (Bufe 1998)].

_Well they [sexual addicts] either get totally absorbed in the fellowship and that becomes their life so that can cause the families even more difficulty. So now, you have the addiction you’re absorbed in … then you went to the clinic and now you’re in the fellowship and they [fellowship] become your life (TP 11, page 9)._  

Gaining access to the sexual fellowship meetings was also identified as problematic. Some individuals gained access through their knowledge of a person who was already a member. Other individuals initiated contact via the sexual fellowship websites where a delay in responding to requests was noticed. Quigley (TP), a psychotherapist who specialises in sexual addiction counselling, explained that the sexual fellowships in Ireland can be rigid. He preferred to recommend group therapy for individuals dealing with sexual addiction.

_I personally believe that the 12-step programmes around sexual addiction are very rigid you know. My job with a client is to bring them to this place of being aware that’s it’s OK to love and it’s OK to have a sexual relationship with somebody in all their imperfection. I think the 12-step programmes do not offer them that. I think they can formulate and explore that better in a group setting. (TP 43, page 2)._  

Edward (SA), a thirty-one-year-old who is a member of the sexual fellowship, complained that the sexual fellowships were resistant to new suggestions:

_Sometimes they don’t always appreciate suggestions but I think suggestions in this programme can be positive because it’s a difficult one to get a handle on (SA 5, page 15)._
6.8 Medical Support

Medical support was identified by a majority of the research subjects as a major source of treatment that has been or could be used to help individuals with sexual addictive behaviour. In this study over half of the self-identified sexual addicts actively sought medical help to deal with their sexual addiction which was expressed in a variety of ways. 4 (9%) sexual addicts sought help from their general practitioner (GP), 19 (41%) received help from a sexual health clinic, and 12 (26%) asked advice from a psychologist or psychiatrist. Some sexual addicts were afraid and embarrassed to speak about their sexual behaviour to medical professionals while others had no such reticence.

The data suggest a variety of responses to the concept of sexual addiction from the medical profession. Arron (SA), a thirty-eight-year-old sexual addict who experienced sexual abuse and depression, believes that some medical practitioners do not consider the concept of sexual addiction as a legitimate medical condition.

_The more establishment healthcare people did not know of this as a real issue and saw it as a funny little story or something that's silly. I think that was my biggest thing: that it wasn't taken seriously. It was seen as ... 'Don't be such a bold boy' ... instead of ... 'This is somebody who has lost control and is actually in need of help?' (SA 1, page 40)._ 

In contrast, other medical professionals were aware of the concept of sexual addiction and recommended that their patients should avail themselves of the sexual fellowship in order to manage their behaviour; as Harry (SA), a sixty-three-year-old married sexual addict, who has bipolar disorder, explained:

_I was seeing the same psychiatrist from 2004 onward; I found him very helpful. After I had attempted suicide I didn't know anything about SLAA and he [psychiatrist] said to me ... 'the only thing that works for your addiction is SLAA' ... and he told me to go to SLAA_ (SA 8, page 19).

Ivan (SA), a twenty-six-year-old gay sex and food addict, indicated that GPs often referred the issue of sexual addiction to a psychotherapist. Some professionals working in the area of psychotherapy and sexual health recognised the concept of sexual addiction and recommended the use of the 12-step sexual fellowships.

_I had gone to my GP and I had said that I am having too much sex, which was a really hard thing to do at twenty-one [years of age] and my GP was a woman. She referred me to a psychotherapist in the area, and I went and I saw him for a year. After I had seen him I met this counsellor when I was having the HIV test and I told her that I was seeing the psychotherapist and everything that was happening. She told me about a 12-step fellowship_ (SA 9, page 21).
In contrast Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, stated clearly her lack of confidence in the GP to deal with sexuality in general.

*I cannot see somebody bringing it up in a GP surgery. I don't think doctors talk about sex ...they don't like the whole thing. Occasionally you're supposed to check your testicles and make sure that there isn't anything wrong and if you find something you go to the doctor ...so my husband finds something, goes to the doctor and the doctor is immediately writing something and handing it to him ...So can you not just check? Oh no, no, no ...So we don't talk about that here ...and that's a complete physical health issue ...and the experience is, we don't do that here ...so I don't think that anyone would be encouraged to start talking in their GP's surgery, and probably wisely* (TP 25, page 15).

Sexual addicts in this study reported that, as a result of their sexual addictive behaviour, 17 (37%) contracted an STI and 3 (7%) became infected with HIV. 15 (33%) continue to engage in 'high risk' sexual behaviour and were concerned that they would infect others. 19 (41%) sought medical treatment from a sexual health clinic. Some research subjects attended public sexual health clinics and others chose private treatment. The level of satisfaction with the sexual health clinicians is good. During STI treatment some clinicians inquired about the patient’s pattern of sexual behaviour, while others did not enquire. If excessive sexual behaviour was identified, additional help was generally offered. Some clinicians recommended psychotherapy or the assistance of a social worker. In some situations the facility to meet a health advisor or a psychotherapist was available immediately at the sexual health clinic. Some patients did discuss their concerns about sexually addictive behaviour with the designated psychotherapist, and help and information were suggested including the use of the 12-step sexual fellowships. In situations where excessive sexual behaviour is identified, Val (TP), a consultant genitourinary physician who specialises in sexually transmitted infections, said:

*Most patients are relieved when you address the problem and point it out to the people concerned; they express relief that you identify the problem and that there are ways of dealing with it, and that is that they're not alone in this. They are aware of the compulsive nature of their behaviour and they try to fight against it* (TP 22, page 6).

However, some patients attending sexual health clinics remained unresponsive or negative. Some were angry at the clinicians for what they perceived as exaggerating or imposing additional labels and being judgemental. Sarah (SA), a twenty-one-year-old sexual addict who was also addicted to alcohol and drugs, said that she knew she had a problem but it was difficult to be reminded about it by the nurse in the sexual clinic:

*I was after getting chlamydia off Darryl when I was pregnant, because he was out cheating ...and herpes off an ex-boyfriend and yet I didn't care ...I was like, 'fuck it*
6.9. PSYCHO-EDUCATIONAL SUPPORT

...if I have it I have it' ...not caring about passing it on to someone but yet worrying about hepatitis or AIDS ... and the nurse was saying to me ... ‘maybe you should see the social worker in here or a counsellor’ ... and because she was saying ... ‘it’s problematic what you are going through’ ... and then I was kind of saying ... ‘for fuck sake I know I have a problem’ ... and she’s telling me that it’s worse than it is ... and it’s all a bit disgusting like (SA 19, page 39).

Other clinicians were more focused on the disease and its treatment and less focused on the patient’s behaviour. Some sexual addicts expressed surprise that all clinicians did not discuss their out-of-control behaviour in more detail. 3 (7%) sexual addicts in this study were HIV positive and have stated that they were more vulnerable to getting HIV because of their sexual addictive behaviour. They now rely on the medical services as an ongoing source of support regarding check-ups and medication when required.

From his experience Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction, recommended that sexual health professionals become more attentive to the non-verbal signs which present in clinical practice. He advised clinicians to heighten their levels of awareness regarding sexual addiction when he said:

Be aware of it ... if somebody is repeatedly coming in for a treatment for sexual health, you know ... get chlamydia one day and gonorrhoea the next ... you have to be aware that there might be an addictive trait and addictive problem ... and maybe it is something that needs to be addressed (TP 23, page 12).

6.9 Psycho-Educational Support

Psycho-educational supports, such as literature, lectures, worksheets, journaling and group discussions, were used by some research subjects in this study as a support mechanism in dealing with sexual addiction. The provision of psycho-education was usually associated with the addiction treatment centres but not confined to them alone. Ciaran (SA), a forty-five-year-old gay sexual addict, with a history of child sexual abuse and substance use, described his experience of psycho-education in a treatment centre:

We had different types of therapy ... art, drama and different classes ... different topics like sexual development and we were given homework which we would discuss in class and work in small groups (SA 29, page 5).

Increasingly, many professionals in private practice, usually psychotherapists, use literature or group meetings as an additional form of support. Finbar’s (SA) experience of psychotherapy demonstrated how psycho-education had become a significant dimension of one-to-one counselling.
Finbar (SA) described how his psychotherapist used a textbook and a workbook on sexual addiction over the period of eighteen months:

*I was introduced to ‘Facing the Shadow’ by Patrick Carnes and that workbook, and she [psychotherapist] took me through it over a period of about a year and a half and I think that book was the dawning for me* (SA 6, page 4).

Research subjects also referred to an abundance of non-specialist recovery literature in the area of self-help, popular psychology, 12-step and recovery in terms of psycho-education. This literature was aimed at helping sexual addicts to accept that their behaviour was problematic. It also informed readers that other people had experienced this issue previously. The literature was typically written and presented by an ‘expert’ in the field and includes professional expertise, anecdotal examples and workbooks. The literature usually focused on topics such as therapy, spirituality and psychology. The aim of the literature was to help gain a deeper understanding of the individual’s sexual behaviour and offered strategies towards recovery. Niall, (TP) a psychotherapist with sexual addiction training, explained how he used literature in his psychotherapy work.

*I will encourage them to read the literature and to identify if they wish … ‘Facing the Shadows’ is what I usually use and some people will actually work through it with me. They will take it away … they will work through the questions and come back and say this is what I’ve done … there are questions in the book around their behaviour, around what they’ve been doing around, how they have been doing it, how it affects them. There’s also a very interesting book called ‘Sexual Anorexia’ which is well worth reading … you find a lot of people would oscillate between sexual addiction and sexual anorexia … the self-loathing and they almost starve themselves sexually?* (TP 40, page 9).

In contrast to those who received help from the literature available, there were others who said that they had bought copious amounts of self-help material in an effort to find the ‘answer’ but it became a source of negativity. Karen (SA), who bought many self-help books, became overwhelmed by the thought that her life was as bad as the literature suggested.

*For years I was looking for something and I didn’t know what it was, you know. God knows how many self-help books and shite I’ve bought that I’ve never actually read but have sat on the shelf … because it was the language around the books that used to scare me off, because I didn’t want to think of myself as being controlling or being obsessed, because I viewed all those words as extremely negative and so that kind of scared me off* (SA 11, page 24).

Another source of psycho-education was associated with the Internet. Despite the fact that the Internet was a source of problematic sexual behaviour for many individuals in this study, it was
also a source of support used by the treatment providers and research subjects. The internet provided confidential information, counselling, details about the 12-step sexual fellowships, and other resources. Peter (SA), a forty-nine-year-old sexual addict who was sexually abused and who was divorced, explained that he finally accepted the reality of his excessive sexual behaviour when he used the internet to seek help.

*I looked up 'sexual problems' on the internet and discovered 'sex addiction' and I got immediate identification with some of the websites that were talking about sexual behaviour and it being destructive . . . it was like reading my own story in terms of some of the behaviour and paid for sex . . . so that was the first time I said, 'Oh my God this is actually a problem' (SA 16, page 4).

6.10 Family Support

The issue of family support varied from individual to individual and the level of support changed over time. Some sexual addicts said that the support they received from their family members was a significant dimension of their recovery. Family support was expressed in a variety of ways. This often included forgiveness, helping to organise treatment or attending psychotherapy together; as Liam (SA), a forty-five-year-old married man who was primarily addicted to prostitution, explained:

*My wife and I both knew that this was impossible for us to deal with alone. At first we thought that we would talk to a marriage guidance counsellor when it first came out and I told my wife that I had slept with a prostitute and I thought that I may have given her a sexually transmitted disease and we both had to get tested . . . it was a terrible shock obviously . . . appalling shock for her but we . . . at first it was only in the couple of days after that . . . that this deep realisation came to me that I was a sex addict . . . and it was only by explaining that to my wife and really drawing it out of myself to tell her how I was feeling . . . and what had happened . . . and what had led up to this . . . it was only by drawing that out that we were both able to see together that this was a sex addiction . . . and it wasn't just some bloke going off and being unfaithful with a prostitute . . . it was much much bigger . . . so that's what initially we looked at, marriage guidance counselling . . . then we realised that it was much more about me and sex addiction so we sought help from that sex addiction counsellor* (SA 12, page 23).

Harry (SA), a sixty-three-year-old married sexual addict who has bipolar disorder, engaged in multiple affairs which resulted in the breakdown of his marriage. Harry (SA) remarried and his affairs continued and have damaged his second marriage relationship. Despite all, Harry's (SA) second wife remained supportive to him and his recovery from sexual addiction:
My relationship with my wife has helped. She has been very supportive of the effort I've made. She has been very loving and very caring. She said, the first thing that has to be in my life is recovery and she means that ... and having that support has been tremendous (SA 8, page 20).

In contrast to those who received family support many others experienced anger and negativity from their families. Darren (SA), a fifty-one-year-old sexual addict, claimed that his sexually addictive behaviour led to an irreconcilable breakdown with his wife and a severing of his relationship with his children. After discovering that Darren (SA), was using the Internet to view pornography his wife confronted him:

So she waited until I came home that evening to confront me and I admitted it ... I said look ... 'I have a problem and I need to do something about it ... I need help for it ... but she stormed out and said 'it's not my problem ... it's your issue and you deal with it ... get it sorted' and within a week of not talking to me she decided 'right that's it ... the marriage is over ... one of us is leaving ... you can decide who it is' (SA 4, page 4).

Family support is often deemed as a highly desirable component of sexual addiction therapy by writers on this topic (Carnes & Adams 2002). Gerry (TP), a clinical psychologist specialising in child sexual abuse, said that psychotherapy was most effective for those individuals who have supplementary support such as family support:

The people who get it [recovery] quickest and get it best are people who have support around them as well. It's not just the therapy and the individual. It's the therapy and the wife or the mother. The person who finds it more difficult is the person who's been kicked out ... ends up in a bed-sit ... maybe has lost his job and all they have is the therapy (TP 7, page 12).

Research subjects also talked about additional sources of support that they used to help them to recover from sexual addiction. These supports were often recommended by their professional therapist or discovered independently. Alternative supports included mediation, yoga, exercise, diet, helplines, homeopathy, and spirituality. Research subjects were aware of the benefits of Internet counselling but none had yet used it. Internet counselling is believed to provide an extra level of anonymity and confidentiality that was seen as important for those who find it difficult to seek help for sexual addiction openly.

Contrary to the majority of self-defined sexual addicts who relied on professional help or 12-step fellowships to change their addictive behaviour, a minority of individuals overcame their problems through the process of self-change. Despite the dominance of the disease concept there is a view that self-change is the norm which can facilitate dependant individuals in achieving long-term
sobriety without any formal treatment (Klingemann et al., 2010). Three research subjects said that they never sought any formal help to deal with their problematic sexual behaviour but have managed to deal with their sexual behaviour alone by confiding in friends and have been helped by reading about the issue. These individuals were recruited as a result of snowball sampling which was part of the recruitment process as discussed in the methodology chapter. Zabrina (SA) says that she was able to change her problematic sexual behaviour, without any formal therapeutic help or support, when she realised the negative impact of her behaviour; as she explains:

\[\text{I didn't seek help ... I just spoke to close friends ... I just hit a really low place within myself where I wanted to end my life ... I talked to my friends and looked at my behaviour and what I was doing to myself ...} \text{(SA, 26, page 2, Questionnaire).}\]

Trevor (SA) believes that the reason why he was able to change his sexual behaviour on his own, which was becoming addictive, was due to the establishment of a committed relationship; as he explains:

\[\text{Well it was fast becoming a sexual addiction until I discovered my first relationship ... Because I was addicted ... I was on the Internet all the time ... I was like a kid in a candy store ... it was the relationship that I established that stopped me becoming addicted} \text{(SA 46, page 1).}\]

The notion of self-change was not discussed by treatment providers, highlighting the lack of awareness about self-change (Klingemann et al., 2010) and the limited recruitment process used in this research which resulted in interviewing professionals mostly associated with the treatment philosophy.

### 6.11 Recovery Progress

Sexual addicts in this study generally said that they have made considerable progress. Peter (SA), a forty-nine-year-old sexual addict who was sexually abused and whose marriage ended because of his sexual addictive behaviour with prostitutes and the Internet, sought therapeutic help ten years ago. Peter (SA) was happy with the progress he has made:

\[\text{I haven't had paid-for-sex in nine years and in the area of Internet I have had regular slips since I came into recovery} \text{(SA16, page 7).}\]

Peter’s (SA), understanding of progress was also linked to an understanding of himself as a sexual person and his perception of how that should be expressed:

\[\text{I have got in touch with some level of understanding of myself sexually and I understand when it's healthy to masturbate and when it's not} \text{(SA16, page 15).}\]
The outcome of the recovery process was an individual issue where some were able to stop their problematic behaviour while others found it more difficult to stop. Ted (TP), a psychotherapist and a lawyer who specialises in sexual addiction counselling, explained:

Some would have stopped [sexual addictive behaviour] others would reduce it, certainly while they’d be with me, but there would be occasions then if their life changes greatly regarding their work situation or whatever there would be occasional dipping into it but I would have no problem with that in the sense I think that’s part of all addictive recovery that there are slippages (TP 20, page 9).

Warren (TP), a specialist in genitourinary medicine, working in sexual health and addiction, suggested that therapeutic support should be maintained by those who experience sexual addiction and that recovery should be seen in terms of a ‘lifelong’ process similar to recovery from alcohol (TP 23, page 8). Arron (SA), a thirty-eight-year-old sexual addict who experienced sexual abuse and depression, anticipated a positive outcome from his recovery and wanted:

To enjoy a new freedom and a new happiness to free myself from the past free me from trouble and emotions like guilt and remorse and insecurity. My only aspiration is to be free of the unhealthy behaviours and the desire to behave in that way. I believe after that as a healthy person life will unfold on to me whatever possibilities are out there (SA 1, page 13-14).

Not all the research subjects share the same enthusiasm regarding recovery from sexual addiction. Garvan (SA), a fifty-nine-year-old sexual addict who was dismissed from his employment as a result of his sexual addictive behaviour, said:

Therapies of various kinds have helped to gain insight but not control nor the desire to control thoughts and masturbation (SA 33, page 3).

The treatment and recovery of sexual addiction was viewed by many of the research subjects in this study as a process which is beneficial. The data also reveal that the validity of the concept of sexual addiction and the corresponding notion of treating sexual addiction was critically questioned by many research subjects. In the next section the research subjects’ critique of the concept will be presented and alternative ways to explain out-of-control sexuality are outlined.

6.12 Critique of the Concept of ‘Sexual Addiction’

Just as the concept of sexual addiction has been criticised by some researchers and academic commentators, some of the research subjects in this present study were also guarded in their acceptance of the validity and practical effects of this contested concept.
6.12. CRITIQUE OF THE CONCEPT OF 'SEXUAL ADDICTION'

6.12.1 ‘Sexual Addiction’ or Social Construction

Social scientists and philosophers, among others, argue that the concept of sexual addiction is a ‘pseudoscientific codification’ which has been socially constructed and which lacks sufficient evidence to validate it as a scientific condition (Levine and Troiden, 1988: 349). This perspective is observed in the data as Dara (TP) clinical director of addiction services in a residential addiction treatment centre, explained:

*I would have thought it’s a bit of a myth and a bit of a construct . . . it’s an American thing to label things but that’s my inclination to feel that way* (TP 4, page 21).

The notion that sexual addiction was merely a label created by therapeutic professionals was also observed among some sexual addicts; as Jane (SA), a thirty-nine-year-old gay sexual addict in recovery from substance use, explained:

*I was two years in recovery for my alcoholism and it had been suggested to me by the therapist that I had issues around sexual addiction and intimacy issues . . . I questioned the man’s professionalism and thought that he was label happy and he was slamming a label on me that he truly didn’t understand* (SA 10, page 12).

As discussed in the literature review, the construction of the concept of sexual addiction emerged in the aftermath of the sexual revolution of the 1960s, a period associated with sexual upheaval. This anxiety-driven period created an atmosphere where the concept of sexual addiction became an acceptable explanation for some of the out-of-control sexual behaviour and created a conducive environment ‘to repathologise forms of erotic behaviour that became acceptable in the 1960s and 1970s’ (Levine & Troiden 1988, p.349). Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, discussed the need for professionals to be aware of their attitudes and understanding of sexuality particularly regarding negative biases:

*It’s probably a bias I have about the pathologisation of sex and sexual behaviours and attitudes towards sex and sexuality and sexual identities. People need to be really, really mindful of their own issues around sex. We all carry homophobia . . . we all carry sex phobia . . . we all carry our own ambivalence about sex and sexual behaviours and sexual identity and sexual relations, and so I think it’s really around people needing to be aware of their own thinking and feeling and attitudes towards their own sexuality and sexuality in general and other people’s sexualities because there’s an infinite variety of sexualities and ways of expressing sex* (TP 32, page 17).

In contrast to those who pathologise sexuality, there were others who viewed sexuality within a broad social context. Yvonne (TP), a clinical psychologist who specialises in sexual behaviour and who has worked extensively with gay and lesbian individuals, argued that the term ‘sexual addiction’ is a restrictive social construct:
I don't think that labelling it as a sexual addiction is particularly helpful... it's not the sexual addiction that's the problem... the sexual addiction is a response to a person's story that they have lived and the sense that they have made of it, and also how their lived experience predisposes them in particular ways... so I think there's something kind of depersonalising about the term 'sex addict'... there's an individual and it has to be understood within the context of that individual making sense of how this has become their expression and how they can reclaim sexuality (TP 25, page 6).

Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, explained that some clients like to use labels such as sexual addiction, particularly in the beginning of the therapeutic process, as it provides a framework for them to understand their behaviour:

Now he [client] would use that kind of language around his use of alcohol and he has started to categorise himself... he talked about how when he came into therapy he wanted a label so that he could understand himself but now he doesn't want a label because he's more than a label (TP 32, page 5).

On the other hand, Fergal was reluctant to use labels such as sexual addiction and preferred to understand the behaviour in terms of the meaning it has for the individual and within the context of the individual's life history:

So I'd more try to frame it in a way that is it's about the behaviour that has meaning and that has a history, maybe origins (TP 32, page 6).

6.12.2 'Sexual Addiction' or Moral Construction

The concept of sexual addiction is often understood as being motivated by strong religious beliefs. In reaction to the perceived decline of sexual morality, a moral indignation was experienced by some in the 1980s who deemed any form of sexual behaviour which is not in keeping with the social norm of heterosexuality as promiscuity. This view was held by the right-wing religious movements, who protested against the liberal sexual agenda associated with the 1960s and 70s, and who believed that sexual behaviour was out-of-control. Such people accepted the concept of sexual addiction as a framework to understand and treat 'out-of-control' sexual behaviours (Irvine, 1995). These views were reflective of the Roman Catholic Church who understood sexuality solely in terms of procreation and who condemned homosexuality as an 'objective disorder' as discussed in the literature review (Congregation for the Doctrine of the Faith, 1986). The association of sexuality and morality was frequently observed in the data and it emphasises a strong moral negativity in Irish society towards sexuality which was commonly associated with the teaching of the Roman Catholic Church. The data reveal that such messages were typically communicated through the educational system and have created a general suppression of sexuality in Ireland among many; as Finbar (SA), a fifty-two-year-old single gay sexual addict explained:
In a country like Ireland . . . over recent decades . . . particularly where the churches had a hold and such a powerful influence . . . I grew up with the perception that sex was bad and dirty (SA 6, page 21).

Sexual behaviours within a married monogamous relationship were designated as acceptable and all other expressions of sexuality were unacceptable. The domination of religious institutions resulted in the infusion of morality into the social consciousness. Indications of this were observed among some comments unconsciously made by research subjects. Brid (TP), who offers cognitive behavioural therapy (CBT) and who specialises in sexual addiction counselling, speaking about a male client with alternative sexual preferences, referred to his lack of 'moral' concern. Brid's comment seems to indicate that she favours sexuality in terms of procreation or relational rather than recreational sex:

He [client] was involved in a swinging scene and in group sex and he had no problem, morally with it at all . . . you know, that was where he was coming from but he had no issues with it morally (TP 2, page 17-18).

Further evidence of a moral code determining the type of sexual behaviour that was acceptable or not was captured in how Matt (SA), a forty-five-year-old married sexual addict, described his own sexual behaviour:

I gradually progressed from pornography to acting out but once I had crossed the line then I had justified it to myself morally . . . [crossing the line] . . . I suppose it's my own morals or society's construct . . . cheating on somebody is a line not to cross (SA 13, page 4).

Matt (SA) perceived that he had crossed a moral line because he engages in a certain type of sexual behaviour that was morally unacceptable within his social group. In situations like these where moral codes are clearly delineated it may be plausible to explain any behaviour that deviates from the standard moral code in terms of sexual addiction.

The concept of sexual addiction was particularly contentious during the AIDS epidemic in the 1980s. The epidemic provided the perfect opportunity for some to moralise about deviant sexual behaviour which was frequently aimed at members of the gay community. In contrast, there were others who warned that the concept of sexual addiction was a moral attempt to socially regulate sexuality which would generate homophobia and self-loathing. Yvonne (TP), a clinical psychologist who specialises in sexual behaviour, and who has worked extensively with gay and lesbian individuals, said that it is necessary to examine the context, motivation and meaning which the sexual behaviour holds for the individual before designating it as a sexual addiction, (TP 25, page 12).

The influence of repressive morality which only favoured recreational sex is described in this study as extremely powerful and one which produced many negative consequences. It created a
suppression of one’s sexuality, pathologised behaviours that were not agreeable to the dominant moral code and often led to the creation of unhealthy responses to sexuality.

6.12.3 ‘Sexual Addiction’ and the Medicalisation of Society

The development of the concept of sexual addiction was also viewed in terms of the growing medicalisation of society. Medicalisation of sexuality was particularly visible in the areas of addiction where treatment centres, addiction experts, and the replication of 12-step fellowships specifically for sexual addicts began to develop rapidly. An expanding addiction industry has continued to grow which is viewed by some as a cynical strategy created by pharmaceutical and therapeutic corporations intended to increase their share of the market. A debate concerning the prolific application of the 12-step model, its validity and therapeutic benefit began during the 1980s (Peele, 1989). Professionals like Dara (TP), clinical director of addiction services in a residential addiction treatment centre, who was originally critical of the 12-step model changed his mind and became positively disposed to the 12-step concept:

*I would have been quite hostile . . . naively hostile to AA and NA when I first got into the business. I just didn't believe in the disease model . . . but the more I trained and the more I learned the more I realised that it works for a hell of a lot of people . . . and there is something in the spiritual aspect of life which is the basis for the 12-step programme . . . so that can't be denied . . . I might not like the labelling and the lifelong recovery aspect of it personally, but certainly it works for people and helps people. I would encourage people to attend* (TP 4, page 13).

The established recognition of the disease model of addiction created a readiness to accept the concept of sexual addiction as a framework to explain out-of-control sexual behaviour. Individuals like Tom (SA), a twenty-eight-year-old gay sexual addict, described the many benefits from the 12-step programme for sexual addicts:

*Talking to other people who could understand the struggles . . . people who can support me but also keep me accountable for my actions . . . I think that's a big part of it . . . going to meetings and hearing other people share their stories and their experience and the regression of their disease and then their recovery and everything . . . it's quite inspirational* (SA 20, page 12).

In addition to the development of self-help support, professional interest began to grow in the concept of sexual addiction which eventually became a significant force in advancing the concept clinically and ideologically. Having spent time working as a social worker in the United States during the 1980s Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, observed how the gradual acceptance of the concept generated sexual addiction ‘experts’ as part of a growing sexual addiction industry.
I haven't participated in the addiction industry stuff, but I'm aware that people are going around saying they are experts in sexual addiction . . . and also in the States [USA] when I was there, there were 12-step movements around sexual addiction and they became very popular and then they kind of fell back . . . as in people weren't going . . . it was kind of like the sexy topic . . . do you know . . . the sexy addiction in some way (TP 32, page 19).

Expertise in sexual addiction was typically based on the completion of some form of specialised professional training in sexual addiction, which is perceived as another lucrative component of the addiction industry (Ley, 2012). The training is intended to provide a therapeutic competence to professionals in order that they can provide specific treatment to individuals who claim they have a sexual addiction. The growth of professional interest led to the development of treatment and theoretical frameworks to conceptualise sexual addiction. Some of the treatment providers in this study, typically the psychotherapist, have received specialised training for sexual addiction counselling. The training was based on the disease model of addiction and generally views out-of-control sexuality as a diagnostic classification. Sexual addicts who sought professional help for their out-of-control sexual behaviours were usually introduced to the disease model of sexual addiction and to the 12-step philosophy. A growing sexual addiction industry has developed in Ireland offering various therapeutic options. Brian (SA), a thirty-four-year-old sexual addict, recovering from sexual addiction, described the number of supports that he used:

Well first I was in a treatment centre . . . through a treatment centre I have gone to see a therapist . . . I see a therapist once a month and through the 12-step fellowships and then the friends that I have met through that I am able to talk about it (SA 2, page 21).

As the sexual addiction industry developed, the validity of the concept of sexual addiction is increasingly debated even among professionals who deal with sexuality. Despite increasing usage of the term sexual addiction, some professionals chose not to use addictive style labels with individuals who seek help with out-of-control sexual behaviour as Fergal (TP), a social worker and psychotherapist, who specialises in gay-positive therapy, explained:

I'm reluctant to use labels . . . I'll talk addiction language with the clients . . . I'll talk about the meaning behind what they're doing, the purpose it serves and explore the reasons why it came about but I wouldn't tick boxes saying 'oh you're addicted' (TP 32, page 5).

6.12.4 Inconsistencies Regarding Terminology, Criteria and Concept

The concept of sexual addiction was further confused by the lack of consensus regarding an agreed definition or established criteria, which was a significant clinical difficulty for treatment providers.
Many research subjects were unsure about the true nature of out-of-control sexual behaviour and called for increased clarity. Some said that there was no scientific basis for using the term ‘sexual addiction’ while others said that the overuse of the term ‘addiction’ undermines the concept of addiction in general. The use of the term ‘sexual addiction’ was also criticised as it may undermine the individual’s capacity to take responsibility for their own behaviour. Others described out-of-control sexuality by using the term ‘compulsive’ sexual behaviour, claiming that it was a more accurate description than sexual addiction. Seamus (TP), director of counselling in an addiction treatment centre, uses the term ‘compulsion’ because the term ‘addiction’ was perceived as a pejorative term which stigmatises the individual:

> When we’re talking to a client about it, we try to get them to look at it as a compulsive behaviour so as to remove the shame that’s often attached to sex addiction ... there’s a huge degree of shame that comes with the term and often times it’s a barrier to people looking at their compulsive behaviour (TP 19, page 2).

Advocates of the concept of sexual addiction believed that the contemporary concept of sexual addiction was weakened by the lack of scientific and professional recognition. Professional recognition of this concept was often viewed in terms of its inclusion or not in the DSM which in itself remains a publication of controversy (Genova 2003). Michael (TP), an addiction therapist, specialising in sexual addiction, explained how the concept is not as recognised among the more established disciplines such as psychiatry, as it is in psychotherapy:

> Part of the difficulty among professionals is that there’s some justified theoretical disagreement as to whether there is such a thing as sexual addiction ... that’s more of an issue for what might be called our mainstream professionals ... I mean psychotherapy is a relatively mainstream profession and becoming more so but you know ... you could say that social work and psychiatry and even psychology are more main stream ... and within those professions ... I think part of the difficulty is that sexual addiction might be seen as a fairly woolly concept that’s not in the DSM and therefore not an official condition (TP, 39 page 3-4).

The disease model was not always perceived as an accurate model to explain out-of-control sexual behaviour. Arron (SA), a thirty-eight-year-old sexual addict who experienced sexual abuse and depression, and who sought help from the medical profession for his out-of-control sexual behaviour articulates some key issues:

> The people in the medical profession are angry at this being called a disease because it’s not a disease ... it’s a behaviour ... a disease is like malaria and cholera to me ... whereas a disease of the mind opens up all the doors to almost anything ... if you can classify it as that (SA 1, page 43).
6.13 Conclusion

The treatment providers interviewed for this research gave a definite, albeit qualified, support for the concept of sexual addiction. While they were aware of academic criticisms of the concept of sexual addiction, in pragmatic terms they viewed it as helpful for clients who had failed to control problematic sexual behaviour by their own efforts. Many treatment providers had caveats about the use of labelling, but tended to see that, at least in the short term, such labels could be helpful for clients by giving them an explanation of what they were experiencing and reassuring them that they were not unique in their experience. In the longer term, treatment providers used and recommended a variety of strategies to assist with the creation and maintenance of change—these included both community-based and residential counselling programmes, individual counselling, group therapy, peer support groups and psychoeducational approaches. Nevertheless, there were inconsistencies and ambiguities amongst treatment providers in relation to the way in which sexual addiction was defined in the professional literature and in diagnostic systems. Some believed that the failure to provide clear definitions and clear diagnostic criteria for sexual addiction was problematic, while others were opposed to such activity seeing it as morally and scientifically dubious and as incompatible with traditional psychotherapy. Of particular interest, was the use of 12-step peer support fellowships by those self-defined sex addicts who were in need of ongoing, accessible and financially affordable support in their attempts to maintain the process of recovery initiated in professionally-delivered treatment systems. While both addicts and treatment providers were generally positive about such 12-step activity, specific difficulties arose in relation to the way in which one of these ‘fellowships’—Sexaholics Anonymous (SA)—attempted to define sexual addiction in a way which clearly reflected a particular values position: privileging procreational and relational sex (in monogamous heterosexual relationships) while labelling masturbation, homosexual sex and multiple partnerships as symptomatic of addiction. This value-based definition of sexual addiction proved controversial and, not surprisingly, was criticised by some research subjects, and is in sharp contrast to the loosely-constructed approach of AA which has avoided all definitions of alcoholism in its determination to avoid controversy.

The majority of the self-defined sexual addicts interviewed for this research were, by definition, those who had failed to self-correct in their efforts to change what they came to see as problematic sexual behaviours. This, from a methodological perspective, is a limitation of this study, and it is not contended here that self-change is unusual or exceptional. However, those self-defined sexual addicts who were research subjects for this study were, in the main, positive about the validity and practical utility of the concept of sexual addiction, and with some criticisms of specific treatment providers or treatment modalities reported that the concept was helpful, at least in the early stages of recovery from this experience. The completion of the findings’ chapters provide the opportunity to initiate an analysis of the major issues which have emerged. The analysis is the central focus of the next chapter.
Chapter 7

Discussion and Conclusion

7.1 Introduction

This study has investigated the concept of sexual addiction in an Irish context from the perspective of self-identified sexual addicts and treatment professionals dealing with this issue in clinical practice. This final chapter attempts to bring together the central issues which have emerged. The chapter opens with a summary of the aims and objectives of the overall study. The major issues which have emerged from the research are then discussed in terms of the literature and the chapter concludes with a final comment on the significance of the main findings.

The aim of this research was to gather detailed data on how two different sets of actors (those who self-identify as sexual addicts and those involved in treating sexual addiction) conceptualise the phenomenon of sexual addiction in an Irish setting. The first objective was to investigate how the research subjects understood the aetiology of sexual addiction. This included an exploration of the research subjects perception of the development of sexual addiction and the characteristics associated with it. The second objective was to investigate what the research subjects perceived the main symptoms and lifestyle elements of this alleged condition to be. The third and final objective was to investigate how the research subjects view recovery and the role played by formal treatment or rehabilitation systems in the recovery process.

7.2 Conflicting Perspectives

From a theoretical perspective, this research was conducted against the background of two conflicting views of sexual addiction. One such view, a positivistic view, is that the concept of sexual addiction and its associated therapeutic practices reflect objective scientific progress in the understanding and management of problematic or out-of-control sexual behaviour. A more critical sociological view is that the concept of sexual addiction is a social construct, which extends an
already spurious addiction model from its base in the area of psychoactive drug use to an area of human behaviour marked by ongoing contention about what is normative and what is deviant; in instrumental terms, such critics are not persuaded that ‘treatment’ of sexual addiction confers identifiable therapeutic benefits on its client group, and tend to see the creation of sexual addiction services as another example of expansion within an already rampant addiction treatment ‘industry’.

In Ireland the concept of sexual addiction has followed a similar developmental pattern to what previously happened in the USA. While some treatment providers suggest that sexual addition is increasing in clinical practice in Ireland others argue that it lacks scientific validity as reflected elsewhere (Irvine 1995, Levine & Troiden 1988). At a policy level there is currently no national sexual health strategy in Ireland despite continuous calls to develop a strategy that will coordinate policy and service provision regarding sexuality (Layte et al. 2006). In the absence of any sexual health strategy many professionals, mainly psychotherapists, offer support for sexual addiction within the context of individual psychotherapy in private practice and as part of the services provided within traditional substance use treatment centres. However, the data suggest that there remains a lack of knowledge and no agreement as to how such behaviour should be understood. Even though many of the research subjects are not convinced of the validity of this concept, they are content to use the concept of sexual addiction as a meaningful framework to understand out-of-control sexual behaviour. Carnes’s (1983) model of sexual addiction proved beneficial for many of them because it identified common characteristics and consequences associated with this behaviour. Additionally it provided a set of useful suggestions regarding how to manage the behaviour and a framework of therapeutic support.

The literature reviewed in chapter two suggested that the concept of out-of-control sexual behaviour, which has been referred to by many terms such as hypersexuality and sexual compulsivity, is a highly contested notion. Over the past thirty years out-of-control sexual behaviour has been described in terms of an addiction and labelled popularly as a sexual addiction. This view is exemplified by the writings of American psychologist Patrick Carnes (1983) who represents the positivistic perspective and who presents sexual addiction as a real disease entity which, to a large extent, he claims to have discovered. Essentially Carnes’s (1983) concept of sexual addiction is based upon many of the diagnostic criteria associated with drug and alcohol addiction. For instance, it emphasises characteristics such as mental obsession, compulsivity and persistence with the behaviour regardless of the recurrent negative consequences for the individuals life. Despite the fact that there is no equivalent to the process of physiological withdrawal symptoms associated with addiction to psychoactive drugs, it is suggested that some equivalent cravings are experienced by individuals who have developed addictive patterns of sexual behaviour. Carnes (1983) views sexual addiction as a disease and as a result actively promotes the development and expansion of sexual addiction treatment systems. The concept of sexual addiction has grown over recent years
and is observed in terms of the increasing interest among treatment professionals and academics in a range of disciplines who discuss the concept. The popularity of the concept of sexual addiction is further observed in terms of the growing number of professionals, especially psychotherapists, who have trained in sexual addiction counselling and currently present as sexual addiction experts. Consequently, specialised psychotherapeutic treatment for sexual addiction is now readily available. This concept has been further popularised in the media, particularly by the number of high profile celebrities who are allegedly addicted to sex. While the label of addiction is suggested by some, mainly those who are associated with the treatment movement, as a classification for out-of-control sexual behaviour, the concept of sexual addiction remains a highly controversial issue. Ongoing debates regarding the validity and use of the concept of sexual addiction have been more observed in the United States of America but are also happening more recently in Ireland.

In contrast to Carnes’s (1983) realist perspective, the literature also contains an increasing body of material which criticises the notion of conceptualising problematic sexual behaviour as an addiction. Levine & Troiden (1988), reflecting much of the social science literature, argue strongly against the concept of sexual addiction. Instead they view it in terms of a social construction rather than an objectively valid, scientific entity. Levine & Troiden (1988) and DeLamater (1981) highlight the existence of the prevailing sexual “scripts” which govern sexuality in Western society: namely the procreative, relational and the recreational. These scripts influence what is considered ‘normal’ and ‘deviant’ or, in this case, sexually addictive. During the 1970s and 1980s the rejection of the recreational sexual script in Western society was seen as a negative reaction to the permissiveness associated with the sexual revolution of the 1960s. This led to the sex-negative period of the 1980s during which, Levine and Troiden (1988) argue, the concept of sexual addiction emerged. To its critics, therefore, the concept of sexual addiction is a ‘pseudoscientific codification’, representing a negative attitude towards sexuality (Levine and Troiden, 1988: 349). The concept pathologises recreational sexual behaviours which were previously deemed as acceptable but which became socially unacceptable and were reframed as a sexual addiction.

Expanding Levine and Troiden’s (1988) argument, Irvine (1995: 429) states that the sexual addict ‘is a historical character constructed from the ambivalences of a particular era’. The ambivalences are associated with the significant change occurring in Western society regarding sexual attitudes and behaviours during the post-sexual revolution period of the 1960s (Irvine, 1995). During the sexual revolution a rejection of traditional values resulted in social and moral anxiety. This anxiety culminated in the AIDS crisis of the 1980s which changed the sexual landscape significantly. The recreational script of sexuality became associated with disease, death and moral decline. This anxiety led to the rejection of recreational sex and a reinstatement of the procreative and relational scripts. In this new climate the reclamation of ethically-appropriate sexuality was deemed a priority by some, and was expressed in terms of right-wing political, social and moral movements. It was within this socio-historic climate that the concept of sexual addiction gained
credibility. The concept offered a sought after 'explanation' for out-of-control sexuality and presented multiple treatments which were welcomed by a society which had witnessed the reinvention of 'perversion' under the new guise of sexual addiction (Irvine, 1995). In addition to sexual diseasen and social anxiety, the concept of sexual addiction was further developed by the expanding medicalisation of sexuality. This was associated with such influential factors as a resurgent 12-step movement, the growth of psychotherapy generally and specifically of an 'addiction treatment industry' - all of which added to the promotion of the concept of sexual addiction. The concept is viewed, by its critics, therefore, as an indication of social and moral conservatism associated with a specific historical period and one which has resulted in the infringement of sexual and human rights (Levine and Troiden, 1988). The concept has been criticised from many perspectives, therefore, and generally seen as lacking sufficient scientific evidence and ignoring the psychological and physiological factors associated with sexual dysregulation among others. The literature highlights the difficulties of defining or identifying pathological sexual behaviour in a world where sexual norms are continually shifting and uncertain.

In addition, Peele (1989), a long-term critic of the 'diseasing' process associated with the psychoactive drug addiction treatment industry, rejects the concept of sexual addiction as a valid independent entity. Peele (1999) also points to the fact that sexual addiction is a culture-bound concept, primarily associated with the USA and influenced by a combination of a 12-step mentality and the treatment industry. Peele (1999) is critical of individuals such as Carnes (1983) and Goodman (1998) who advocate sexual addiction, who promote 'treatment' as the primary solution, and who ignore the vast literature documenting the case for natural remission from compulsive behaviours. Peele (1999)'s dismissal of the concept of sexual addiction also highlights the issue of what sexual behaviour is perceived as acceptable or non-acceptable from a cultural perspective, which changes over time.

The controversy regarding the concept of sexual addiction has also been viewed in terms of its inclusion and exclusion in the controversial DSM (Kafka, 2010). Over the years, proponents of the concept have submitted proposals, under a variety of terms, to include the concept of sexual addiction in the DSM. Eventually the term 'sexual addiction' was formally included for the first time in the DSM-III-R in 1987 (APA, 1987). It was later removed in subsequent editions due to the lack of empirical data and the lack of consensus regarding the validity of the concept. As discussed in the literature review, the most recent attempt to have sexual addiction included in the 2013 edition of the DSM-5, under the category of Hypersexual Disorder, was rejected (Samenow, 2013). Some proponents of the concept would have hoped that the inclusion of the concept of sexual addiction in the DSM would have brought clarity to the ongoing debate surrounding the concept. Others would have perceived that the inclusion of the concept of sexual addiction in the DSM was a semi-official endorsement which would lead to greater acceptability of the concept. Contrary to the belief that the inclusion of the concept in the DSM would increase its recognition and improve
7.2. CONFLICTING PERSPECTIVES

consensus on the issue, many social scientists have been and remain highly critical of the alleged scientific objectivity of the DSM in particular regarding drug and alcohol categories. It is argued that the DSM is 'culture bound' (Room, 2011: 881) and frequently based on moral perspectives rather than on science. It is also argued that the DSM constructs the concept of addiction, by its subjective use of criteria such as lifestyle and behaviour (Keane, Moore & Fraser 2011). Sexual addiction, therefore, is perceived by many social scientists as the construction of an alleged reality, influenced by a number of sociocultural and moral influences rather than by objective scientific findings.

Whatever the validity of these critical views of the concept of sexual addiction, it should be emphasised that the research reported here was carried out with research subjects who were primarily concerned with the practicalities of the difficulties related to sexual behaviours which were perceived to be what Orford (2001) refers to as 'excessive'. Both the treatment providers and the sexual addicts, therefore, were more likely to be concerned with practical strategies for resolving such problems than with a relatively abstract debate about models of addiction. And, of course it may be argued that there are positive outcomes which may flow from the application of imperfect, models - just as there may be little practical advantage at times to the application of a valid model.

The data in the three findings chapters contains a range of experiences and opinion regarding sexual addiction. These data must be understood in terms of the sample participating in this study. The data are based on the experiences and opinions of a very specific population namely self-identified sexual addicts and treatment providers who work in the area of treating sexual addiction. A majority of the self-identified sexual addicts have undergone some type of treatment experience, mainly psychotherapy or a 12 step fellowship, to assist them in the management of their sexual behaviour sometimes in conjunction with a more conventional addiction to psychoactive substances. As a result, their opinions were influenced by the treatment philosophy which many of them positively subscribed to. Moreover, many of the treatment providers in this study were involved in the provision and promotion of therapeutic services and support which is heavily influenced by the treatment ideology. Therefore, their opinions and experiences generally contained a bias towards the treatment philosophy. Consequently, the data reveal a positive perception of the concept of sexual addiction in general and many of the research subjects were committed to the concept of sexual addiction reflecting Carnes's (1983) model of sexual addiction. Some treatment providers were totally convinced that the concept of sexual addiction was real and therefore believed that the only solution was to undergo expert treatment. Many of the treatment providers, particularly psychotherapists, have undergone specialised training in the area of sexual addiction. In contrast, the findings also contained a cohort of self-identified sexual addicts and treatment providers who presented counter arguments reflecting the tone and opinion represented by Levine and Troiden (1988) and others who oppose the concept. Among this cohort many
research subjects were sceptical and critical of the concept of sexual addiction. Others remained less than convinced about the validity of sexual addiction as an independent scientific entity but were happy to use the concept for its practical utility and view it as a metaphor which offers meaning to some individuals and provides a guiding framework to understand sexual addiction behaviour. In addition to those who reflected the polar attitudes of Carnes (1983) and Levine and Troiden (1988), others in this study argued that the concept of sexual addictive behaviour was best understood as symptomatic of a separate underlying issue such as a medical or a psychological condition among others. These issues were among the main themes which emerged in the findings chapters and which are now discussed in three sections. Section one discusses the origins, and development of sexual addiction. Section two discusses the lived experience, and section three discusses the implications of the treatment of sexual addiction.

7.3 The Origins and Development of Sexual Addiction

The data presented in chapter four focused primarily on the origin, development and continuation of compulsive and out-of-control sexual behaviour. The aetiology of sexual addictive behaviour was discussed by the research subjects in terms of trying to understand and explain such behaviour. Its origin was commonly associated with a range of psychosocial and physiological factors.

The primary causal explanations associated with the origin of sexual addiction were psychosocial. They included factors such as dysfunction in the individuals family of origin, sexual trauma, poor parental attachment and childhood sexualisation. Sexual orientation, education and religion were also discussed as possible influences which contribute to the development of sexual addiction. It was claimed that as a result of a range of negative childhood experiences at a formative age, which often involved their relationships and their sexual and emotional life, children developed a set of ‘core beliefs’ - an inner belief system, which predisposed them to developing sexual addictive behaviours. The core beliefs result in such individuals believing that they are inadequate, undeserving and incapable of intimate relationships. As a result of experiences such as broken trust or sexual trauma, some sexual addicts believe that all relationships are unreliable or potentially abusive. Others believe that sexual relationships will satisfy unmet childhood needs and provide psychological validation. The data report that an accumulation of such beliefs frequently results in the development of mistaken core beliefs pertaining to sexuality and leaving sexual addicts with defective or erroneous notions of sexuality. Many research subjects, especially the self-defined sexual addicts, claim that as a result of such negative experiences they are more susceptible to developing sexual addictive behaviours than others who did not have traumatic childhood experiences. It was argued by many of the research subjects that this type of process was the origin of sexual addiction.

The data, which corresponds with the literature, suggest that the origin of sexual addiction is
also associated with a number of physiological conditions which may result in out-of-control sexuality. The main physiological conditions reported were depression, particularly bipolar, invasive surgery and head injury. These conditions, it is argued, can affect sexuality in several ways, but particularly by increasing sexual drive while simultaneously lowering impulse control capacities. Such views about the origins of problematic sexuality correspond with previous studies (Finlayson et al., 2001; Chughtai et al., 2010; Samenow, 2010) as discussed in the literature review. The data focused particularly on the relationship between sexuality and mental health. Research subjects claimed that sexual addiction can be both a cause of, and a consequence of, depression, which has been reported elsewhere (Reid, 2010; Samenow, 2010; Kafka, 2010). Samenow, (2010) argues that when such underlying mental health disorders are accurately identified and treated appropriately, the associated compulsive sexual behaviour ceases. This suggests that out-of-control or compulsive sexual behaviour which contains some of the typical characteristics of Carnes's (1983) model of sexual addiction needs to be accurately investigated in order to determine exactly the precise nature and cause of such behaviour. In contrast to the literature, the physiological conditions associated with dysregulated sexuality were discussed by a minority of the research subjects only, and in some instances there seemed to be a lack of knowledge or clarity about how such physiological conditions impact sexuality.

In general, the sexual addicts, who tend to be more personal and emotional in their explanations, believe that their sexual addictive behaviour is a maladaptive response to childhood trauma. Such explanations reflect the causal factors advocated in Carnes's (1983) model of sexual addiction. It should be emphasised that such causal explanations must be interpreted with caution, since they represent the concept of 'effort after meaning' (Garro 2007). In such instances individuals seek to explain their out-of-control behaviour as a consequence of their past trauma. Given that the process of understanding and objectively measuring an individuals past trauma is a highly complex undertaking (McFarlane 1995), it is equally contentious to conclude that past traumas necessarily create a sexual addiction. Clearly, most people who have experienced childhood trauma do not develop out-of-control sexual behaviour in adult life, so there are obvious limits to such explanations.

In most cases the research subjects account of the origin of sexual addiction contains personalised explanations which were very meaningful for the individuals who reported them. However, the explanations contained an extensive range of complex variables which make it impossible to accurately conclude that these alleged influences are absolute determinants in the creation of sexual addiction. Many of the explanations purported are also experiences that other individuals encounter in everyday life and which are successfully negotiated without developing a sexual addiction. For example, in this study, 19 (41%) sexual addicts who experienced sexual abuse associated their sexual abuse with the development of sexually addictive behaviour. In contrast to the argument of 'cause and effect' which implies that sexual abuse is the primary cause of sexual addiction,
27 (59%) sexual addicts in this study did not experience child sexual abuse. The data also suggest that out-of-control sexual behaviour experienced by sexual abuse survivors may serve a number of functions. In this study, the excessive sexual behaviour was used, by those who experienced sexual abuse, as a method to lessen the psychological pain of sexual abuse and was often a behavioural re-enactment of the individuals sexual abuse symbolising their search for meaning. Despite the alleged association between sexual abuse and sexual addiction experts in this area warn against overstating the consequences of child sexual abuse (Browne & Finkelhor 1986). Furthermore, contrary to common belief, Rind & Tromovitch (1997) suggest that many individuals who experience child sexual abuse manage to make appropriate psychological and behavioural adjustments in adult life. So the question remains; how can any of these experiences such as sexual abuse or childhood trauma, become the catalyst for the development of alleged sexual addiction for one individual and not for another individual?

Finally, the research subjects in this study were eager to understand as part of their clinical treatment the origin of out-of-control sexual behaviours which they had personally experienced. Many of the research subjects, particularly the sexual addicts, found Carnes's (1983) model of sexual addiction beneficial in order to understand what they perceived as sexually addictive behaviour. Carnes's (1983) model was appealing because it offered a framework which they could identify with in terms of understanding the origin and development of their sexual addictive behaviour. Some research subjects were convinced that such an entity exists while others who do not see this concept in terms of an absolute entity were simply content to use Carnes’s (1983) model as a conceptual framework. Reflecting the arguments of Levine and Troiden (1988) some research subjects strongly opposed Carnes's (1983) model and contested the validity and usefulness of the concept and perceived it as negative labelling. Some research subjects viewed the origin of the concept as a social construct which emerged within the socio-historical context of the HIV/AIDS era of the 1980s. The concept and model of sexual addiction was seen by some as a negative reaction to sexuality and a concept which was associated with those who were concerned with the moral control of sexuality. A further reservation about using the concept of sexual addiction, observed more so among treatment providers, was based on the fear that such a concept may present a premature diagnosis if not an inaccurate description of an individuals sexual behaviour. The use of this concept may mask a deeper underlying condition or ignore other socio-cultural realities which may be overlooked to the detriment of the individual.

In pragmatic terms, the causal explanations offered in this study make sense to those who have been struggling to cope with what they see as out-of-control sexual behaviour and, from a counselling perspective, they deserve to be treated with respect; this is not to say that they should be automatically accepted as having scientific validity. The causal explanations offered are perhaps best described as non-specific risk factors which may leave individuals more susceptible to developing a maladaptive response to managing the difficulties which they encounter. Such
maladaptive responses are not particular to sexual behaviour but can be observed in some peoples
response to alcohol or psychoactive drugs. None of the sexual addicts presented their sexual
behaviour as a way to excuse or lessen their personal responsibility but they admitted that their
choices regarding their sexual behaviour were unhealthy and created negative consequences for
them and others.

7.4 The Lived Experience of Sexual Addiction

The data presented in chapter five provided an account of the 'lived experience' of sexual addiction
from the perspectives of the self-defined sexual addicts and the treatment professionals who work
with these addicts. The findings in chapter five were generally presented in terms of the key
features of the addiction process which correspond with the diagnostic criteria and general clinical
accounts of what constitutes addiction to psychoactive substances, as discussed in the literature
review.

As noted previously, the data contained in chapter five, in terms of the research subjects un­
derstanding of the concept of sexual addiction, is influenced by their personal and professional
experiences. The treatment providers views on sexual addiction were shaped by their professional
education and training and in particular by the application of models of addiction which have
largely been developed in relation to the ingestion of psychoactive drugs. The self-defined sexual
addicts in this study generally constitute a 'treatment population', that is people, who are (or have
been in the past) exposed to treatment processes. As a result of their experience of treatment of
one kind or another many of the self-defined sexual addicts demonstrate a certain willingness to
accept health system labelling of this kind. The uncritical acceptance of such labelling may indicate
their exposure to the treatment philosophy, to which many of them positively subscribe. In con­
trast, a minority of research subjects argued that the labelling of any forms of sexual behaviour as
pathological or symptomatic of disease is questionable, particularly given the lack of cultural con­
sensus as to what constitutes 'normal' sexuality. The lack of consensus regarding what is 'normal'
sexuality is reflected in DeLamaters (1981) framework, which identifies three main perspectives
(procreational, relational and recreational) on human sexuality. DeLamater (1981) suggests that
what constitutes pathological forms of sexuality is likely to be relativistic and culture-bound rather
than based upon objective medical scientific criteria. As a result all accounts of sexual addiction
presented as pathology in chapter five must therefore be seen as reflecting shifting and often con­
tentious cultural norms rather than scientific consensus about disease states. The contested nature
of the construction of sexual addiction was particularly noticeable in relation to the 'lived experi­
ence' of sexual addiction amongst homosexual or gay men. Radically different views were presented
as to what constitutes a normal sex culture for gay men. In some instances the very essence of gay
sexuality emphasised recreational sex, which revolved around clubs and bath houses and involved
multiple partners and a general hedonism. On the other hand, other research subjects viewed gay sexuality in terms of monogamous relationships and believed that such hedonism or promiscuity was abnormal or pathological and perceived it as an addiction. These contrasting views on gay sexuality obviously reflect conflicting value judgements and draw attention to the fact that there is no scientific basis for deciding what constitutes 'normal' gay sexuality. Opponents of the concept of sexual addiction, in terms of the gay community, strongly argue that such a concept is a stigmatising and moralistic label which seeks to impose the sexual practices of the dominant heterosexual culture on to sexual minorities. The data, and in particular the views of treatment providers reported in chapter five, highlight the subtlety and sensitivity required to work clinically with gay clients in the absence of cultural consensus or absolute clinical guidelines.

The lived experience of sexual addiction was discussed in terms of a multiplicity of specific behaviours. These behaviours, according to many of the research subjects, demonstrated the classic traits associated with Carnes's (1983) model of sexual addiction. Nevertheless, it was also argued that many of the behavioural expressions of sexual addiction presented in the data were behaviours that are regularly used by people in pursuit of enjoyment and pleasure in their sexual lives, but who do not become sexually addicted. In some instances non-committed or casual sexual relationships may be perceived as sexual addictive behaviour by one individual whereas another individual may perceive it as a legitimate means to pursue sexual enjoyment. The range of behaviours presented in the data in chapter five, as expressions of sexual addictive behaviour, highlights the difficulty that exists in terms of what constitutes sexual addiction. Factors such as individuals value systems, their sexual preferences and cultural norms are some of the many influences that determine our perception of what constitutes sexual addiction or not, reflecting the argument that sexual addiction is subjective and often used inaccurately (Levine, 2010). However, Goodman (1998), an advocate of the concept of sexual addiction, argues that sexual addiction is not determined by the type of sexual behaviour but rather by the impact it has on the individuals life. And, in practical terms, what may be most important is that some people perceive that they have lost control over certain sexual behaviours which are at variance with their personal value systems and which they would wish either to reduce or completely eliminate. The fact that there are no objective ethical criteria by which such behaviours may be judged, or that these behaviours may be regarded as ethically normative forms of sexual activity to many others, is largely immaterial to those who, in subjective terms, are unhappy with the perceived loss of control over them.

Research subjects, while reporting the lived experience of sexual addiction, identified a number of specific functions which were served through sexual addictive behaviour. It was primarily used to meet a range of psychological needs such as managing difficult emotions, coping with sexual abuse, human loneliness, among others, and it was not invariably associated with sexual pleasure. It was also noted that the sexual addictive behaviours were typically underpinned by issues such
as the sexual addicts inability to develop or sustain intimacy.

In discussing the lived experience of sexual addiction, research subjects drew attention to the complex relationships which seem to exist between sexual addictive behaviours and other addictions. Of sexual addicts in this study claimed that they also experienced other addictions. Drugs like heroin and alcohol were commonly viewed as 'gateway' drugs that triggered sexual addictive behaviour while it was sometimes reported that such substances inhibited sexual behaviour as well. Comparisons were made between the characteristics of sexual addiction and those of other addictions. Similarities were identified between sexual addiction and addiction to psychoactive drugs which added credibility to the concept of sexual addiction from the perspective of the proponents of the concept. As mentioned previously, it must be noted that many of the research subjects views of the concepts of addiction and sexual addiction have been influenced by their experience of the treatment process either as recovering addicts who have received addiction treatment or professionals who have been influenced by their education and training in the treatment philosophy. It was also suggested that some addicts who stopped taking psychoactive drugs 'switched' their addiction and simply compensated by using sex which over time became addictive. In contrast to such theories, the high incidence of out-of control sexuality, reported among those recovering from psychoactive drug use may indicate a dysfunctional reawakening of their sexual appetite or their need to re-establish a relationship life which may have been curtailed due to drug use. The data report that complex relationships exist between problem psychoactive drug use and problem sexuality.

Research subjects also discussed the lived experience of sexual addiction in terms of negative consequences which resulted from the behaviour. These were often compared with the negative consequences associated with addiction to psychoactive drugs. The consequences were often viewed as an indication of the presence of a sexual addiction, as reflected in Carnes's (1983) model of sexual addiction. Nonetheless, it was also argued that the understanding of what is a negative consequence is subjective and value-laden. The presence of negative consequences is not viewed as being objective or reliable scientific criterion upon which to determine the presence of a sexual addiction.

Overall, chapter five contained the descriptive accounts of the lived experience of sexual addiction. These experiences usually contained the catalyst for the sexual addict to develop practical strategies which helped them to manage their addictive tendencies. These experiences, even though controversies persist as to whether they are symptomatic of an objective disease state, deserve to be viewed respectfully as a legitimate experience which has meaning particularly for the self-defined sexual addicts who participated in this study. The concept of sexual addiction remains, therefore, a phenomenon which is subjectively meaningful to some self-defined addicts and their clinicians, despite the fact that it is frequently viewed by academic critics as a culture-bound social construction. Moser (2013), a critic of the concept, argues that some people seek help because they perceive
their sexuality as being out-of-control but it is not clear if this perception is accurate. Referring to
the rejection of the concept of sexual addiction in the DSM-5, he claims that the field of psychiatry
has a long history of 'moralistic pronouncements masquerading as scientifically validated entities'
(Moser 2013).

### 7.5 Treatment and Recovery from Sexual Addiction

Treatment and recovery from sexual addiction was the central focus of chapter six. Once again, the
question of what constitutes normal or abnormal sexual behaviours emerged as being important
in the context of treatment and recovery. Understandably, the research subjects understanding of
the concept of sexual addiction influenced their view of the notion of treatment and recovery from
sexual addiction. The notion of treatment and recovery from sexual addiction was also influenced
by the research subjects personal and professional knowledge and experience of the treatment
philosophy to which many of them positively subscribe.

The data reveal that there were a number of views expressed regarding the notion of treat­
ment and recovery. Among those who generally accepted the legitimacy of the concept of sexual
addiction, treatment and recovery processes were viewed in terms analogous to those involved in
treatment and recovery from psychoactive drugs. Generally, research subjects believed that treat­
ment was beneficial and would assist sexual addicts to desist from their addictive behaviours. The
range of treatments reported in chapter six were similar to those used in the treatment of addiction
to psychoactive drugs. Other research subjects, who were somewhat more ambivalent about the
validity of the sexual addiction concept, were still prepared to concede that there was merit in
the provision of formal treatment systems which offered practical support to those who experi­
enced difficulties with their sexuality. Another group of research subjects, who understood sexual
addictive behaviours as indicative of an underlying physiological or psychological issue, viewed
treatment in terms of treating the underlying issue with the intention that once it was treated
the sexual addictive behaviour would regularise itself. Some critics of the concept of sex addiction
questioned the logic of seeking to provide treatment for a condition for which there were no agreed
diagnostic criteria. While such reservations are understandable, it should be acknowledged that
debates and controversies still exist in relation to the diagnosis of addiction to psychoactive drugs
(Kor et al. 2013).

The major treatments described in chapter six included psychotherapy, residential treatment,
and 12-step fellowships. Alternative treatments discussed included medial, psycho-educational and
family support. Psychotherapy which was used by almost half of the sexual addicts was experi­
enced either on a one-to-one basis or as group psychotherapy. While there were some difficulties
encountered the majority of the research subjects perceived this as a beneficial treatment. The no­
tion of residential treatment for sexual addiction, which is popular in the USA, is a relatively new
idea in Ireland and one that is not commonly available. As the data reports, in Ireland it is more common for self-defined sexual addicts to access therapeutic help for their sexual addiction within a residential treatment centre for substance abuse. Some claimed that within such a context, which was primarily focused on substance addiction, it was difficult to address the sensitivities regarding sexuality. There was also a suggestion that such centres lacked the expertise to deal sufficiently with sexual addiction. While there seemed to be a general agreement that these residential treatment centres were helpful, there was a lack of clarity or assurance about how effective they actually were in helping individuals stop their addictive sexual behaviours.

The 12-step sexual fellowships were another common form of treatment reported by research subjects. These are based on the fellowship groups which originated in Alcoholics Anonymous (AA). The fellowships were generally deemed to be a supportive mechanism which was affordable and practically useful to those who experienced difficulties with sexual addiction. In contrast, one significant difficulty was noted by research subjects regarding the definition of sexual addiction in the Sexaholics Anonymous (SA) fellowship. This definition favoured procreational and relational sex in monogamous heterosexual relationships and labelled homosexuality and masturbation as symptomatic of sexual addiction. This value-based definition is seen by opponents of the concept of sexual addiction as evidence to undermine the credibility of the concept as a legitimate objective entity. It is also noteworthy that in generating controversy of this kind SA has deviated significantly from the administrative culture of Alcoholics Anonymous which, through its Twelve Traditions, scrupulously avoids becoming embroiled in either scientific or moral controversy. Furthermore, it is worth remembering that the definition of sexual addiction in Sex and Love Addicts Anonymous (SLAA) is distinctly different to that of SA. In SLAA it is the responsibility of the individuals who attend to determine for themselves the sexual behaviours that are addictive and the behaviours that they wish to abstain from.

The treatment of sexual addiction was also discussed in terms of seeking medical assistance from a GP, a psychologist, psychiatrist or from a sexual health clinician. A lack of awareness or acceptance of the legitimacy of the concept of sexual addiction by some medical professionals was noted by a minority of research subjects. The lack of diagnostic criteria was identified as a possible obstacle which inhibited awareness and knowledge of the concept. Medical professionals were generally deemed as being supportive in helping individuals access help for the consequences of sexual addiction in areas such as sexual disease, depression and psychotherapy.

Overall, the treatments reported for sexual addiction were perceived as beneficial. Despite the practical help that such treatments may provide for individuals who genuinely struggle with addictive tendencies, there was an underlying criticism, among a minority of research subjects, about the concept of sexual addiction. Such criticisms mirror the scepticism contained in the literature review which perceive the concept of sexual addiction as a social construction which emerged in the aftermath of the sexual revolution of the 1960s during a sex-negative period. The concept
of sexual addiction developed within a cultural and moral context which, in DeLamater’s (1981) terms, favoured a sexuality which was procreative and relationship orientated. The establishment of the concept of sexual addiction has, in turn, created the necessity of the ‘treatment’ of what is perceived by some as excessive sexual behaviour. Peele (1989) argued that ‘treatment’ of sexual addiction was a cynical ploy manufactured by a self-serving multi-million dollar addiction industry which is prepared to add sexual addiction to its menu of available treatments, just as individual psychotherapists see this new condition as a business opportunity. Such sentiments found limited support among research subjects in the present study. In contrast to the formal treatment such as psychotherapy or 12-step fellowships, a minority of research subjects experienced recovery without any such intervention. This corresponds with the view that self-change is possible if not in fact the norm and that most people who develop addictions to psychoactive substances resolve their problems without any formal treatment (Klingemann & Carter-Sobell 2010).

7.6 Conclusion

This study presents a range of insights into the experience of the concept of sexual addiction which was specifically examined from the perspective of self-identified sexual addicts and treatment professionals dealing with this issue in clinical practice and examined in an Irish context.

It was difficult to determine exactly how many research subjects believed with total conviction that the concept of sexual addiction existed. The data suggest that over half of the self-defined sexual addicts and over one quarter of the treatment providers appeared strongly convinced that sexual addiction exists as an independent entity. These were content to accept Carnes’s (1983) model of sexual addiction as accurate. Nevertheless, for the majority of research subjects there remained a considerable deficit of knowledge, a lack of clarity and no agreement as to how out-of-control sexual behaviour should be conceptualised. Despite the lack of clarity a number of significant patterns emerged. The major pattern demonstrated that a majority of the research subjects acknowledged that a range of out-of-control sexual behaviour can be experienced by some individuals. Regardless of the contested nature of this behaviour it was commonly considered in terms of a behavioural addiction and was popularly labelled as a sexual addiction. The traits, consequences and prescribed treatment suggested for sexual addiction were very similar to those associated with substance addiction. The concept of sexual addiction offered a meaningful framework against which many research subjects can understand out-of-control sexual behaviour. Even though many were not convinced of the validity of this concept, it was still used pragmatically by many in clinical practice and for personal use to explore and understand out-of-control sexual behaviour. The model of sexual addiction proved valuable for a range of reasons. It provided a definitive set of signs and symptoms thought to characterise sexual addiction. Additionally the common characteristics and consequences of sexual addiction were clearly identified. Moreover,
this model offered a therapeutic framework of suggestions regarding how to stop the sexual addiction and how to regain control over one's sexual life. The proposed treatments associated with this model provided sexual addicts with the opportunity to speak with a professional and with other self-identified sexual addicts about their lived experience. Many self-identified sexual addicts in this study argued that this type of therapeutic experience was effective for them and frequently provided meaning, help and support.

Despite what seemed a straightforward model of sexual addiction that is beneficial for some it is also a model which contains many underlying and subtle complexities. The entire concept of addiction upon which this model is founded remains highly contested. There is a continuous claim that the proposal to conceptualise some patterns of sexual behaviour as an addiction does not have sufficient evidence to support it as a valid scientific disorder. Furthermore, it is strongly argued that the concept is merely a social construct which serves to support the dominant social and sexual structures of society. The concept of sexual addiction is also perceived as a psychological mask for a moral crusade against the excesses of the sexual revolution of the 1960s. The model of sexual addiction is vulnerable to being influenced by a very moralistic if not fundamentalist perception of sexuality. This has the potential to result in a reductionist view of sexuality and also to endanger human and sexual rights. Moreover there are significant concerns raised about the model of sexual addiction due to the inherent dangers of its association with the treatment industry. The multi-million dollar industry is poised to make considerable financial gain if the concept of sexual addiction is formally accepted as a diagnostic classification. The treatment industry is therefore very interested in creating a new addiction in need of a treatment which they can convincingly sell as a cure for a much maligned disease. This mentality ignores the fact that there is no consensus on what constitutes 'normal' sexuality.

It is observed that a sole reliance on a model of addiction to understand out-of-control sexuality may limit one's understanding and obscure the range of possible underlying issues in need of attention. It is recognised that a more comprehensive perspective is required to understand the continuum of sexualities. A broader perspective helps us to understand the arbitrary nature of concepts such as 'normal' and 'addiction' and offers insights into how these concepts change from century to century and from culture to culture. The use of an expansive perspective provides the opportunity to value the complexity of sexuality and avoid the temptation to limit sexuality to diagnostic categories or disease classifications. It is useful to compare sex addiction, with all of its contradictions and controversies, with addiction to alcohol. Just as we have no cultural consensus as to what constitutes 'normal sex', so too do we lack a cultural consensus on what constitutes 'normal drinking'. Although the drinks industry, cynically perhaps, promotes 'responsible drinking', public health professionals simply look for lower consumption and religious temperance advocates argue that alcohol is inherently evil and should be prohibited. The idea of a comprehensive assessment of clients with out-of-control sexual behaviour, with a view to determining whether such
behaviour is a true addiction or merely symptomatic of a more profound underlying psychological disorder, also may be compared with how professionals assess those with alcohol problems. In the alcohol sphere professionals, while not entirely dismissive of the influence of underlying disorders which may have played a causal role in the aetiology of an alcohol problem, tend to see the alcohol problem as an independent issue in its own right and do not assume that if the underlying problem is resolved, the alcohol problem will automatically be resolved also. If anything, alcohol treatment professionals tend to the view that by giving up alcohol clients are enabled to deal with a host of other psychological issues which they would have been unable to tackle had they continued to drink.

The research findings contain the potential to inform a broad debate regarding sexuality within the Irish context. It is hoped that the findings will provide the basis for a positive contribution to the creation of policy and health provision regarding sexuality in particular to the long-awaited national sexual health policy. Continuous calls have been made to develop a strategy that will coordinate policy and service provision regarding sexuality (Layte et al. 2006). The primary focus of policy and provision pertaining to sexuality is generally concentrated in two main areas, namely sexual health and sexual education and these are respectively coordinated by the Department of Health, the Health Service Executive (HSE) and the Department of Education and Skills. The concept of sexual addiction, while not officially recognised, is primarily addressed by non-statutory bodies, typically within the area of psychotherapy. Information regarding sexuality is compiled from the growing archive of Irish research material by agencies such as The Health Service Executive (HSE) Crises Pregnancy Programme, the Royal College of Surgeons of Ireland (RCSI) and the Department of Health. As a result significant studies such as The Irish Study of Sexual Health and Relationships (IRSSHR), Layte et al. (2006) have been published. Furthermore, other agencies such as the Health Protection Surveillance Centre (HPSC), which is affiliated to the HSE, collects data on infectious disease, including sexual disease which informs strategic planning and treatment provision. A number of other statutory and non-statutory bodies such as The National AIDS Strategy Committee (NASC), Dublin AIDS Alliance (DAA) and Gay and Lesbian Equality Network (GLEN) among others contribute in the collection of data, which cumulatively provides a growing database of information on sexuality in Ireland. The findings in this research may be useful to further the work that is undertaken by these bodies and help to develop research and clinical practice regarding sexual health, education, sexual behaviours and attitudes to sexuality within a very complex Irish context. At a therapeutic level these findings will be of interest to treatment providers and those who experience out-of-control sexual behaviour and will increase awareness and knowledge regarding the common traits and treatment options. However, given that research policy on psychoactive drugs is only marginally and obliquely influenced by research findings, it might be foolish to assume that the still sensitive topic of sexuality and sexual health will automatically be open to any research findings which might be controversial.
In conclusion, the concept of sexual addiction as a mental health disorder continues to be contentious. Arguments that it is a social construction, partially motivated by the seeming necessity to impose order on what is a culturally ambiguous area of human life, and partially by the self-interest of treatment providers, have obvious validity. On the other hand there is no doubt that in practical terms such a construction is helpful to those who seek help with compulsive sexual behaviours. Social scientists have consistently argued that the more traditional conceptions of addiction or dependence involving psychoactive substances are also socially constructed; therefore, whether constructions of sexual addiction are more or less scientifically dubious is a moot point.
Appendix A

Glossary of Terms & Abbreviations

A.1 Terminology Describing ‘Sexual Addiction’

A range of terms are used to describe out of control or excessive sexual behaviour such as, Compulsive Sexual Behaviour (CSB) (Coleman 1992), Problematic Hypersexuality (Finlayson, Sealy & Martin 2001), Hypersexual Disorder, (Kafka 2010)), and Sexual Addiction (Carnes 1983). For the purposes of this thesis the term ‘sexual addiction’ is generally used as it is the term that the research subjects generally use and is reflected in the literature. Despite the ongoing debate regarding terminology the descriptions have more similar traits than differences (Raymond, Coleman & Miner 2003).

A.2 Research Subjects

There are two main groups of research subjects in this study, namely the sexual addicts and the treatment providers and a number of terms are used to describe them.

Sexual Addict: The term ‘sexual addict’ is primarily used to describe those who have self-identified with the concept of sexual addiction. This term is used because it is the term with which this group of research subjects identify. At other times the sexual addicts may be referred to as clients, patients or service users, in situations where it helps to explain a specific context. The abbreviated term of SA is used to identify a quotation from a sexual addict.

Treatment Provider: The term ‘treatment provider’ is primarily used to describe participants who deal with the concept of sexually addictive behaviour in clinical practice. In some instances other terms including clinician, clinical staff, psychotherapist or physician may be used in
order to give a fuller understanding of a specific situation. The abbreviated term of TP is used to identify a quotation from a provider.

Participant: The term ‘participant’ refers to the entire group of individuals who were interviewed for this research. They include ‘sexual addicts’ and treatment providers.

Pseudonyms

Pseudonyms were assigned to each research subject and were used to protect the participants’ anonymity. The pseudonym also indicated the research subjects’ gender.

Quotations

The quotations in this study are taken from the transcripts of the sexual addicts and the treatment providers and are used throughout the text to illustrate specific issues. A code is used before and after each quotation.

Before the Quote: A Christian pseudonym name is given indicating the individual’s gender and the term SA or TP is used to indicate if the quote is from a sexual addict (SA) or a treatment provider (TP). There is usually a description of the individual’s situation which contextualizes their experience.

After the Quote: A code appears after each quote in brackets ( ) and it indicates the source of the quote. The code includes the term SA or TP, a number and a page number. The term SA or TP indicates if the quote is from a sexual addict (SA) or a treatment provider (TP). The number refers to the research subject. Sexual addicts are numbered from 1 to 46 and treatment providers are numbered from 1 to 55. The numbers were assigned in chronological order in terms of when the interview occurred. The page number refers to the page in the individual’s transcript from where the quotation appears. Example: (TP 10, page 1) refers to treatment provider 10 and the quote is from Page 1 of their transcript.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The DSM, published by the American Psychiatric Association (APA) contains the criteria for the classification of mental disorders. This manual is used by healthcare professionals, researchers and others particularly in the United States of America (USA) and internationally. There are many references to the DSM in this study mainly because the majority of the research literature on this topic is American based and uses the DSM classifications. The current edition is DSM-IV (APA, 2000).
A.2. RESEARCH SUBJECTS

The International Classification of Diseases (ICD)

The ICD is a similar manual to the DSM above and is published by the World Health Organization (WHO). It is more frequently used outside of the USA. The current edition is ICD-10 (WHO, 1992).

Cruising

Cruising is a term referring to an individual pursuing a sexual engagement. It typically involves the pursuit of a casual, anonymous sexual encounter often sought out in locations like public parks and more recently by individuals pursuing sex on the internet.

Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Expansion</th>
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</thead>
<tbody>
<tr>
<td>AA</td>
<td>Alcoholic Anonymous</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>APPA</td>
<td>Association Against Prohibition Amendment</td>
</tr>
<tr>
<td>ASL</td>
<td>Anti-Saloon League</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
</tr>
<tr>
<td>CTAS</td>
<td>Cork Total Abstinence Association</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner / Medical Doctor</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HPSC</td>
<td>Health Protection Surveillance Centre</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>ICCP</td>
<td>The Irish Contraception and Crisis Pregnancy</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>INCA</td>
<td>Irish National Council of Alcoholism</td>
</tr>
<tr>
<td>IPA</td>
<td>Interpretative Phenomenology Analysis</td>
</tr>
<tr>
<td>ISSHR</td>
<td>Irish Study of Sexual Health and Relationships</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual and transgendered Community</td>
</tr>
<tr>
<td>MI</td>
<td>Motivational Interviewing</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NA</td>
<td>Narcotics Anonymous</td>
</tr>
<tr>
<td>NCA</td>
<td>National Council for Alcoholism</td>
</tr>
<tr>
<td>PTAA</td>
<td>Pioneer Total Abstinence Association</td>
</tr>
<tr>
<td>RCPI</td>
<td>Royal College of Physicians of Ireland</td>
</tr>
<tr>
<td>RSE</td>
<td>Relationships and Sexuality Education</td>
</tr>
<tr>
<td>SA</td>
<td>Sexaholics Anonymous</td>
</tr>
<tr>
<td>SLAA</td>
<td>Sex and Love Addicts Anonymous</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitors</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TA</td>
<td>Thematic Analysis</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
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</table>
Appendix B

Information Leaflet for Treatment Providers

The School of School Work and Social Policy
Trinity College Dublin

Treatment Providers Required for Unique Study

Study Aim:

The purpose of this research is to explore the concept of sexually addictive / sexually compulsive behaviour and to obtain a clear description and understanding of addictive sexual behaviour from those who work with this phenomenon within clinical practice.

Eligibility:

The study requires participants who are working in any capacity, as treatment providers with individuals who report dealing with sexually addictive behaviour. This may be in the area of counselling, treatment, medicine, education or any related area.

Requirement:

Participation requires being available for one interview to document your professional experience of this issue and the completion of one questionnaire.
Confidentiality:

An understanding has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003 (Data Protection Act 2003). Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. All material will be stored in locked files and on completion of the project, the material will be destroyed.

Contribution:

Your involvement provides the opportunity to develop an understanding of this under-researched topic. Your experience and your insights into this behaviour are very valuable and will make a significant contribution to this research.

Contact:

For more information, please email ResearchTCD@gmail.com or Phone No: 086 2037 538
Appendix C

Information Leaflet for Sexual Addicts

The School of School Work and Social Policy

Trinity College Dublin

Research Participants Required for Unique Study

Study Aim:

The purpose of this study is to explore the concept of sexual addiction and to obtain a clear description and understanding of addictive sexual behaviour from those who experience this phenomenon.

Eligibility:

The study requires participants who report dealing with sexually addictive behaviour. It would be beneficial that the participant would have an interest in seeking help or be in recovery from this behaviour. It is essential that all participants are 18 years and older.

Requirement:

Participants are asked to complete one questionnaire alone and one interview (spoken or written) which can be completed with the researcher, a therapist or alone.
Confidentiality:

Your Contribution is Anonymous and Confidential. An undertaking has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003. Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. All material will be stored in locked files and on completion of the project, the material will be destroyed. Child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

Contribution:

Your involvement provides the opportunity to develop an understanding of this under-researched topic. Your experience and your insights into this behaviour are very valuable and will make a significant contribution to this research.

Contact:

For more information, please email
ResearchTCD@gmail.com
Phone 00 353 86 2037 538
Appendix D

Profile of Research Subjects

The individual profile contains a short description of each research subjects professional or personal context capturing an overall view of the range of individuals and issues associated with this research. Essential issues are highlighted which may help to understand the individuals professional and personal context and to interpret their contributions. The names used below are pseudonyms which were assigned to each research subject. The pseudonyms protect the participants anonymity and indicate the gender of the research subject. The numbers used below refer to the research subjects. Treatment providers are numbered from 1 to 55 and sexual addicts are numbered from 1 to 46. The numbers were assigned in chronological order as the interviews took place.

Table D.1: Profile of Research Subjects - Treatment providers (TPs)

<table>
<thead>
<tr>
<th>No</th>
<th>Pseudo ID</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agnes</td>
<td>Addiction therapist specialising in sexual addiction counselling</td>
</tr>
<tr>
<td>2</td>
<td>Brid</td>
<td>Cognitive behavioural therapist specialising in sexual addiction counselling</td>
</tr>
<tr>
<td>3</td>
<td>Carl</td>
<td>Addiction counsellor specialising in sexual addiction counselling</td>
</tr>
<tr>
<td>4</td>
<td>Dara</td>
<td>Clinical director of addiction services in a residential addiction treatment centre</td>
</tr>
<tr>
<td>5</td>
<td>Erik</td>
<td>Social worker specialising in addiction and who works with sexual addicts</td>
</tr>
<tr>
<td>6</td>
<td>Frank</td>
<td>Treatment specialist working with sexual offenders some of whom are sexual addicts</td>
</tr>
<tr>
<td>7</td>
<td>Gerry</td>
<td>Clinical psychologist specialising in child sexual abuse</td>
</tr>
<tr>
<td>8</td>
<td>Hanna</td>
<td>Psychotherapist with sexual addiction training</td>
</tr>
<tr>
<td>9</td>
<td>Iris</td>
<td>Nurse and sexual trauma specialist working with survivors of sexual abuse, some of whom are sexual addicts</td>
</tr>
<tr>
<td>10</td>
<td>Jim</td>
<td>Psychotherapist, trained in sexual addiction counselling</td>
</tr>
<tr>
<td>11</td>
<td>Kate</td>
<td>Psychosexual therapist specialising in sexual addiction</td>
</tr>
<tr>
<td>12</td>
<td>Leanne</td>
<td>Nurse and sexual abuse specialist working with sexual addicts, some of whom are survivors of sexual abuse</td>
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### Table D.2: Profile of Research Subjects - Treatment Providers (TPs) continued

<table>
<thead>
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<th>No</th>
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<td>13</td>
<td>Martin</td>
<td>Social worker and addictions services co-ordinator in a treatment centre</td>
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<td>14</td>
<td>Noeleen</td>
<td>Psychotherapist working with substance users in recovery, some of whom are sexual addicts</td>
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<td>15</td>
<td>Orla</td>
<td>Project worker working with female substance users, some of whom experienced sexual addiction</td>
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<tr>
<td>16</td>
<td>Pauline</td>
<td>Psychotherapist specialising in addiction; working with female sexual addicts, some of whom have experienced sexual abuse</td>
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<tr>
<td>17</td>
<td>Queena</td>
<td>Addiction therapist specialising in sexual abuse</td>
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<tr>
<td>18</td>
<td>Roisin</td>
<td>Project worker in an addiction treatment centre</td>
</tr>
<tr>
<td>19</td>
<td>Seamus</td>
<td>Director of counselling in an addiction treatment centre</td>
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<tr>
<td>20</td>
<td>Ted</td>
<td>Psychotherapist and solicitor, specialising in sexual addiction counselling</td>
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<tr>
<td>21</td>
<td>Ultan</td>
<td>Forensic psychologist specialising in addictive and sexual behaviour</td>
</tr>
<tr>
<td>22</td>
<td>Val</td>
<td>Genitourinary physician specialising in sexually transmitted infections</td>
</tr>
<tr>
<td>23</td>
<td>Warren</td>
<td>Genitourinary physician working in sexual health and addiction</td>
</tr>
<tr>
<td>24</td>
<td>Xena</td>
<td>Addiction therapist specialising in addiction and sexual behaviour</td>
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<tr>
<td>25</td>
<td>Yvonne</td>
<td>Clinical psychologist specialising in sexual behaviour, with experience of working with gay and lesbian individuals</td>
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<td>Zara</td>
<td>Social worker in the lesbian community, who worked in the USA and the UK</td>
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<tr>
<td>27</td>
<td>Ann</td>
<td>Social worker, working with prostitutes some of whom are substance users</td>
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<td>28</td>
<td>Brendan</td>
<td>Trauma therapist working with sexual addicts</td>
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<td>29</td>
<td>Celine</td>
<td>Clinical psychologist specialising in sexual offenders support</td>
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<td>30</td>
<td>Deirdre</td>
<td>Social worker specialising in sexual health offering support to females in prostitution and addiction</td>
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<td>Eileen</td>
<td>Social worker working in sexual health and addiction</td>
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<td>32</td>
<td>Fergal</td>
<td>Social worker and psychotherapist specialising in gay-positive therapy</td>
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<tr>
<td>33</td>
<td>Geraldine</td>
<td>Psychosexual therapist working in relationship counselling</td>
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<td>34</td>
<td>Henry</td>
<td>Psychotherapist specialising in couple counselling</td>
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<tr>
<td>35</td>
<td>Irene</td>
<td>Psychotherapist specialising in relationship counselling</td>
</tr>
<tr>
<td>36</td>
<td>Jackie</td>
<td>Psychotherapist specialising in relationship counselling</td>
</tr>
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<td>37</td>
<td>Kamila</td>
<td>Psychosexual therapist working in relationship counselling</td>
</tr>
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<td>38</td>
<td>Louise</td>
<td>Nurse and psychotherapist specialising in sexual health counselling</td>
</tr>
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<td>39</td>
<td>Michael</td>
<td>Addiction therapist, specialising in sexual addiction counselling</td>
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<tr>
<td>40</td>
<td>Niall</td>
<td>Psychotherapist with sexual addiction training</td>
</tr>
<tr>
<td>41</td>
<td>Oisin</td>
<td>Addiction therapist, specialising in sexual addiction counselling</td>
</tr>
<tr>
<td>42</td>
<td>Patricia</td>
<td>Nurse and psychotherapist, specialising in addiction and sexual health counselling</td>
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<tr>
<td>43</td>
<td>Quigley</td>
<td>Psychotherapist specialising in sexual addiction counselling</td>
</tr>
<tr>
<td>44</td>
<td>Rory</td>
<td>Psychotherapist specializing in sexual addiction counselling</td>
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<td>45</td>
<td>Simon</td>
<td>Psychotherapist with sexual addiction training and working with gay sexual addicts</td>
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<td>46</td>
<td>Terry</td>
<td>Medical doctor specialising in infectious diseases and sexual health</td>
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<td>47</td>
<td>Ulrik</td>
<td>Social worker and practice manager specialising in mens sexual health</td>
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<tr>
<td>48</td>
<td>Vera</td>
<td>Nurse specialising in sexual health</td>
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<tr>
<td>49</td>
<td>Wendy</td>
<td>Psychotherapist specialising in sexual abuse</td>
</tr>
<tr>
<td>50</td>
<td>Xiomar</td>
<td>Psychotherapist specialising in sexual abuse</td>
</tr>
<tr>
<td>51</td>
<td>Yale</td>
<td>Medical researcher specialising in sexual health and HIV</td>
</tr>
<tr>
<td>52</td>
<td>Zac</td>
<td>Project manager of sexual health service</td>
</tr>
<tr>
<td>53</td>
<td>Alice</td>
<td>Policy advisor in a statutory service specialising in child protection and counselling</td>
</tr>
<tr>
<td>54</td>
<td>Bernie</td>
<td>Policy officer and solicitor working in a statutory service specialising in child protection</td>
</tr>
<tr>
<td>55</td>
<td>Catherine</td>
<td>Researcher and policy officer specialising in Internet usage</td>
</tr>
<tr>
<td>No</td>
<td>Pseudo ID</td>
<td>Experience</td>
</tr>
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</tr>
<tr>
<td>1</td>
<td>Arron</td>
<td>38-year-old male who experienced sexual abuse and depression</td>
</tr>
<tr>
<td>2</td>
<td>Brian</td>
<td>34-year-old male who is bisexual and recovering from substance use</td>
</tr>
<tr>
<td>3</td>
<td>Collette</td>
<td>40-year-old single female</td>
</tr>
<tr>
<td>4</td>
<td>Darren</td>
<td>51-year-old male recently divorced</td>
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<td>5</td>
<td>Edward</td>
<td>31-year-old male who is addicted to gambling</td>
</tr>
<tr>
<td>6</td>
<td>Finbar</td>
<td>52-year-old single gay male</td>
</tr>
<tr>
<td>7</td>
<td>Gary</td>
<td>42-year-old gay male recovering from substance use</td>
</tr>
<tr>
<td>8</td>
<td>Harry</td>
<td>63-year-old married male who has bipolar disorder</td>
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<tr>
<td>9</td>
<td>Ivan</td>
<td>26-year-old gay sex and food addict</td>
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<td>10</td>
<td>Jane</td>
<td>39-year-old gay female recovering from substance use</td>
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<tr>
<td>11</td>
<td>Karen</td>
<td>32-year-old single female who experienced child sexual abuse</td>
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<tr>
<td>12</td>
<td>Liam</td>
<td>45-year-old married man who is primarily addicted to prostitution</td>
</tr>
<tr>
<td>13</td>
<td>Matt</td>
<td>45-year-old married man</td>
</tr>
<tr>
<td>14</td>
<td>Noel</td>
<td>51-year-old male who is divorced and recovering from alcohol addiction</td>
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<tr>
<td>15</td>
<td>Oliver</td>
<td>56-year-old male who is in recovery from alcohol addiction</td>
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<tr>
<td>16</td>
<td>Peter</td>
<td>49-year-old male who was sexually abused and who is divorced</td>
</tr>
<tr>
<td>17</td>
<td>Quintan</td>
<td>Middle-aged gay male recovering from substance use</td>
</tr>
<tr>
<td>18</td>
<td>Rose</td>
<td>39-year-old single female</td>
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<tr>
<td>19</td>
<td>Sarah</td>
<td>21-year-old female who is recovering from substance use</td>
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<tr>
<td>20</td>
<td>Tom</td>
<td>28-year-old gay male</td>
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<tr>
<td>21</td>
<td>Ursula</td>
<td>22-year-old female recovering from substance use</td>
</tr>
<tr>
<td>22</td>
<td>Vincent</td>
<td>28-year-old male who is recovering from childhood trauma and substance use</td>
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<tr>
<td>23</td>
<td>William</td>
<td>28-year-old male with a history of drug addiction and child trauma</td>
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<td>24</td>
<td>Xavier</td>
<td>A male who experienced sexual abuse, substance use and depression</td>
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<tr>
<td>25</td>
<td>York</td>
<td>A male who is separated from his wife and recovering from substance use</td>
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<td>Zabriia</td>
<td>38-year-old male with a history of sexual abuse</td>
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<td>27</td>
<td>Adam</td>
<td>46-year-old married man primarily addicted to prostitution</td>
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<tr>
<td>28</td>
<td>Vincent</td>
<td>28-year-old gay male who is recovering from childhood trauma and substance use</td>
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<td>Ciaran</td>
<td>45-year-old gay male who is recovering from sexual abuse and substance use</td>
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<td>Derek</td>
<td>Middle-aged male who withdrew from the research study</td>
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<td>Eamonn</td>
<td>A male who is primarily addicted to prostitution &amp; Internet sex and who is</td>
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<tr>
<td></td>
<td></td>
<td>recovering from sexual abuse and substance use</td>
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<tr>
<td>32</td>
<td>Fred</td>
<td>44-year-old gay male</td>
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<tr>
<td>33</td>
<td>Garvan</td>
<td>59-year-old gay male who was dismissed from his employment due to his sexual behavior</td>
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<td>34</td>
<td>Hugh</td>
<td>58-year-old gay male who is addicted to anonymous sex and who experiences clinical depression</td>
</tr>
<tr>
<td>35</td>
<td>Ian</td>
<td>A male who is primarily addicted to prostitution and Internet sex and who received residential treatment for sex addiction</td>
</tr>
<tr>
<td>36</td>
<td>Jim</td>
<td>A gay male who is primarily addicted to Internet sex and who experienced child sexual abuse</td>
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<tr>
<td>37</td>
<td>Kevin</td>
<td>A middle-aged single heterosexual male who suffers from depression</td>
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<td>Laura</td>
<td>A homosexual female in a committed relationship</td>
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<td>39</td>
<td>Maura</td>
<td>A middle-aged married woman</td>
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<td>35-year-old homosexual female</td>
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<td>Oran</td>
<td>Single male who suffers from clinical depression</td>
</tr>
<tr>
<td>42</td>
<td>Philip</td>
<td>A male who is addicted to prostitution and Internet sex and who experienced child sexual abuse</td>
</tr>
<tr>
<td>43</td>
<td>Quinn</td>
<td>45-year-old single gay male who is addicted to Internet sex</td>
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<td>Raymond</td>
<td>34-year-old gay male who is HIV positive</td>
</tr>
<tr>
<td>45</td>
<td>Steven</td>
<td>A gay male who is HIV positive and who has clinical depression</td>
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<tr>
<td>46</td>
<td>Trevor</td>
<td>60-year-old gay male divorced as a result of his sexual addiction</td>
</tr>
</tbody>
</table>
Appendix E

Information Pack for Treatment Providers

PhD Research

Working Title:
A Qualitative study of individuals who experience ‘Sexual Addiction’ and of Treatment Providers who work in this area

The School of School Work and Social Policy
Trinity College Dublin
Dear Participant,

The purpose of this research is to explore the concept of 'sexually addictive' / sexually compulsive behaviour and to obtain a clear description and understanding of addictive sexual behaviour from those who work with this phenomenon within clinical practice.

The study requires participants who are working in any capacity, as treatment providers with individuals who report dealing with sexually addictive behaviour. This may be in the area of counselling, treatment, medicine, education or any related area.

Participation requires being available for one interview to document your professional experience of this issue and the completion of one questionnaire.

Confidentiality

An understanding has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003 (Data Protection Act 2003). Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. All material will be stored in locked files and on completion of the project, the material will be destroyed.

Ethics

In order to assure you that this research project meets the accepted standards of ethical practice, this project has been presented to the Ethics Committee of the University and has received approval. Following Trinity College guidelines, I enclose for your attention:

1. The researchers' contact details
2. University authorization
3. Principles of Ethical Research
4. Consent form

Child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

Thank you for your co-operation in this project.

Yours sincerely,

Ben Hughes, M.Sc.
Researcher
Contact Details

As you participate in this research project, please contact me if there are any outstanding issues that need further clarification. You may reach me at:

Ben Hughes, M.Sc.,
Postgraduate Researcher,
School of Social Work and Social Policy,
Trinity College Dublin,
IRELAND
Tel: 086 2037 538
E-mail: ResearchTCD@gmail.com

If you require additional information please contact the research supervisor,

Dr. Marguerite Woods,
School of Social Work and Social Policy,
Trinity College Dublin,
Dublin,
IRELAND
Tel: (01) 8962001 or E-mail: woodsma@tcd.ie
Re: Ben Hughes
PhD Candidate
School of Social Work & Social Policy
Trinity College Dublin

TO WHOM IT MAY CONCERN

I am writing to confirm that Ben Hughes is a registered PhD student in this school. He is currently in his second year of full-time study. His PhD research is a qualitative study of the experiences and views of individuals who have experienced sex addiction and of treatment providers in this field.

If further information is required, please do not hesitate to contact me at the School of Social Work & Social Policy.

Yours sincerely

[Signature]

Dr. Marguerite Woods
Postgraduate Research Supervisor

Course Coordinator
Diploma in Addiction Studies/
Lecturer in Social Studies
Principles of Ethical Research

Issued by The Social Research Association

1. Obligations to Society

If social research is to remain of benefit to society and the groups and individuals within it, then social researchers must conduct their work responsibly and in light of the moral and legal order of the society in which they practice.

They have a responsibility to maintain high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings.

2. Obligations to Funders and Employer

Researchers relationship with and commitments to funders and/or employers should be clear and balanced. These should not compromise a commitment to morality and to the law and to the maintenance of standards commensurate with professional integrity.

3. Obligations to Colleagues

Social research depends upon the maintenance of standards and of appropriate professional behaviour that is shared amongst the professional research community.

Without compromising obligations to funders/employers, subjects or society at large, this requires methods, procedures and findings to be open to collegial review. It also requires concern for the safety and security of colleagues when conducting field research.

4. Obligations to Subjects

Social researchers must strive to protect subjects from undue harm arising as a consequence of their participation in research. This requires that subjects participation should be voluntary and as fully informed as possible and no group should be disadvantaged by routinely being excluded from consideration.
Consent form

Title: A Qualitative study of individuals who experience Sexual Addiction and of Treatment Providers who work in this area

Researcher:
Ben Hughes, M.Sc.,
School of Social Work and Social Policy,
Trinity College Dublin.

The purpose of this work and the procedure involved in the research has been clearly explained to me. I am assured that my responses will be treated as anonymous and that confidentiality will be maintained.

Confidentiality

Your Contribution is Anonymous and Confidential. An undertaking has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003. Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. The interview is audio taped to accurately capture your experience. All tapes and written material will be stored in locked files and on completion of the project the material will be destroyed so that the ideas and opinions discussed are completely anonymous. I agree to the use of this information by the researcher for educational purposes and for research publication as long as anonymity is strictly observed. Furthermore, child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

My participation is entirely voluntary and I understand that I may terminate my participation at any time.

.................................................................
Signature of research participant

.................................................................
Witnessed by

Record No. . . . . . . . . . . . . Date . . . . . . .
Appendix F

Information Pack for Sexual Addict Participants

PhD Research

Working Title:
A Qualitative study of individuals who experience ‘Sexual Addiction’ and of Treatment Providers who work in this area

The School of School Work and Social Policy
Trinity College Dublin
Dear Participant,

The purpose of this research is to explore the concept of sexually addictive / sexually compulsive behaviour and to obtain a clear description and understanding of addictive sexual behaviour from those who work with this phenomenon within clinical practice.

The study requires participants who are working in any capacity, as treatment providers with individuals who report dealing with sexually addictive behaviour. This may be in the area of counselling, treatment, medicine, education or any related area.

Participation requires being available for one interview to document your professional experience of this issue and the completion of one questionnaire.

Confidentiality

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Ethics

In order to assure you that this research project meets the accepted standards of ethical practice, this project has been presented to the Ethics Committee of the University and has received approval. Following Trinity College guidelines, I enclose for your attention:

1. The researchers contact details
2. University authorization
3. Principles of Ethical Research
4. Consent form

Child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

Thank you for your co-operation in this project.

Yours sincerely,

Ben Hughes, M.Sc.

Researcher
Contact Details

As you participate in this research project, please contact me if there are any outstanding issues that need further clarification. You may reach me at:

Ben Hughes, M.Sc.,
Postgraduate Researcher,
School of Social Work and Social Policy,
Trinity College Dublin,
IRELAND
Tel: 086 2037 538
E-mail: ResearchTCD@gmail.com

If you require additional information please contact the research supervisor,

Dr. Marguerite Woods,
School of Social Work and Social Policy,
Trinity College Dublin,
Dublin.
IRELAND
Tel: (01) 8962001 or E-mail: woodsma@tcd.ie
Re: Ben Hughes  
PhD Candidate  
School of Social Work & Social Policy  
Trinity College Dublin  

TO WHOM IT MAY CONCERN  

I am writing to confirm that Ben Hughes is a registered PhD student in this school. He is currently in his second year of full-time study. His PhD research is a qualitative study of the experiences and views of individuals who have experienced sex addiction and treatment providers in this field.

If further information is required, please do not hesitate to contact me at the School of Social Work & Social Policy.

Yours sincerely  

[Signature]  

Dr. Marguerite Woods  
Postgraduate Research Supervisor  
Course Coordinator  
Diploma in Addiction Studies/  
Lecturer in Social Studies
Principles of Ethical Research

Issued by The Social Research Association

1. Obligations to Society

If social research is to remain of benefit to society and the groups and individuals within it, then social researchers must conduct their work responsibly and in light of the moral and legal order of the society in which they practice.

They have a responsibility to maintain high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings.

2. Obligations to Funders and Employer

Researchers relationship with and commitments to funders and/or employers should be clear and balanced. These should not compromise a commitment to morality and to the law and to the maintenance of standards commensurate with professional integrity.

3. Obligations to Colleagues

Social research depends upon the maintenance of standards and of appropriate professional behaviour that is shared amongst the professional research community.

Without compromising obligations to funders/employers, subjects or society at large, this requires methods, procedures and findings to be open to collegial review. It also requires concern for the safety and security of colleagues when conducting field research.

4. Obligations to Subjects

Social researchers must strive to protect subjects from undue harm arising as a consequence of their participation in research. This requires that subjects participation should be voluntary and as fully informed as possible and no group should be disadvantaged by routinely being excluded from consideration.
Consent form

Title: A Qualitative study of individuals who experience Sexual Addiction and of Treatment Providers who work in this area

Researcher:
Ben Hughes, M.Sc.,
School of Social Work and Social Policy,
Trinity College Dublin.

The purpose of this work and the procedure involved in the research has been clearly explained to me. I am assured that my responses will be treated as anonymous and that confidentiality will be maintained.

Confidentiality

Your Contribution is Anonymous and Confidential. An undertaking has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003. Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. The interview is audio taped to accurately capture your experience. All tapes and written material will be stored in locked files and on completion of the project the material will be destroyed so that the ideas and opinions discussed are completely anonymous. I agree to the use of this information by the researcher for educational purposes and for research publication as long as anonymity is strictly observed. Furthermore, child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

My participation is entirely voluntary and I understand that I may terminate my participation at any time.

.......................................................... ..........................................................
Signature of research participant

.......................................................... ..........................................................
Witnessed by

Record No. ........ Date ...........
Appendix G

Focus Group Information Leaflet - Treatment Providers

The School of School Work and Social Policy

Trinity College Dublin

Research Participants Required

for Unique Focus Group Study

Study Aim:

The purpose of this focus group is to explore the concept of sexual addiction and to obtain a clear description and understanding of addictive sexual behaviour from those who work with this phenomenon within clinical practice.

Eligibility:

The study requires participants who are working in any capacity, as treatment providers with individuals who report dealing with sexually addictive behaviour. This may be in the area of counselling, treatment, medicine, education or any related area. It is essential that the participant would have a working knowledge of the concept of addiction /sexual addiction and have experience of therapeutically engaging with individuals who have sought help with sexual addiction.
Requirement:
Participation requires attending one focus group meeting which will involve questionnaires and group discussion.

Contribution:
The focus group provides the opportunity to develop an understanding of this under-researched topic. Your experience and your insights into this behaviour are very valuable and will make a significant contribution to this work.

Contact: For more information, please email ResearchTCD@gmail.com or Phone 00 353 86 2037 538
Appendix H

Focus Group Information Leaflet - Sexual Addicts

The School of School Work and Social Policy

Trinity College Dublin

Research Participants Required

for Unique Focus Group Study

Study Aim:

The purpose of this focus group is to explore the concept of sexual addiction and to obtain a clear description and understanding of addictive sexual behaviour from those who experience this phenomenon.

Eligibility:

The study requires participants who are working in any capacity, as treatment providers with individuals who report dealing with sexually addictive behaviour. This may be in the area of counselling, treatment, medicine, education or any related area. It is essential that the participant would have a working knowledge of the concept of addiction / sexual addiction and have experience of therapeutically engaging with individuals who have sought help with sexual addiction.
Requirement:

Participation requires attending one focus group meeting which will involve questionnaires and group discussion.

Contribution:

The focus group provides the opportunity to develop an understanding of this under-researched topic. Your experience and your insights into this behaviour are very valuable and will make a significant contribution to this work.

Contact: For more information, please email
ResearchTCD@gmail.com or Phone 00353 86 2037 538
Appendix I

Information Pack for Focus Groups - Treatment Providers

PhD Research

Research Title:
A Qualitative study of individuals who experience ‘Sexual Addiction’ and of Treatment Providers who work in this area

The School of School Work and Social Policy
Trinity College Dublin
Dear Participant,

The purpose of this focus group study is to identify key issues pertaining to sexual addiction and to prioritise areas of significance for individual interviews with sex addicts and treatment providers (which will take place later on in the process).

Due to the nature of your experience, your insights into this behaviour are very valuable and will make a significant contribution to this work. As well as developing an understanding of this under-researched topic, your input will benefit other individuals and your participation in this study is appreciated.

The following issues are central to this study.

**Confidentiality**

In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. All material will be stored in locked files and on completion of the project, the material will be destroyed.

**Protection**

Given the sensitive nature of this area of research, your choice to decline from answering specific questions, or to terminate your involvement at any time, will be respected.

**Ethics**

In order to assure you that this research project meets the accepted standards of ethical practice, this project has been presented to the Ethics Committee of the University and has received approval. Following Trinity College guidelines, I enclose for your attention:

1. The researchers contact details
2. Principles of Ethical Research
3. Record of focus group details (*Private and Confidential*)
4. A consent form (to be signed)
5. Research questions and worksheets

Thank you for your co-operation in this project.

Yours sincerely,

Ben Hughes, M.Sc.
Researcher
Contact Details

As you participate in this research project, please contact me if there are any outstanding issues that need further clarification. You may reach me at:

Ben Hughes, M.Sc.,
Postgraduate Researcher,
School of Social Work and Social Policy,
Trinity College Dublin,
IRELAND
Tel: 086 2037 538
E-mail: ResearchTCD@gmail.com

If you require additional information please contact the research supervisor,

Dr. Marguerite Woods,
School of Social Work and Social Policy,
Trinity College Dublin,
Dublin,
IRELAND
Tel: (01) 8962001 or E-mail: woodsma@tcd.ie
TO WHOM IT MAY CONCERN

I am writing to confirm that Ben Hughes is a registered PhD student in this school. He is currently in his second year of full-time study. His PhD research is a qualitative study of the experiences and views of individuals who have experienced sex addiction and of treatment providers in this field.

If further information is required, please do not hesitate to contact me at the School of Social Work & Social Policy.

Yours sincerely

Dr. Marguerite Woods
Postgraduate Research Supervisor

Course Coordinator
Diploma in Addiction Studies/
Lecturer in Social Studies
Principles of Ethical Research

Issued by The Social Research Association

1. Obligations to Society

If social research is to remain of benefit to society and the groups and individuals within it, then social researchers must conduct their work responsibly and in light of the moral and legal order of the society in which they practice.

They have a responsibility to maintain high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings.

2. Obligations to Funders and Employer

Researchers relationship with and commitments to funders and/or employers should be clear and balanced. These should not compromise a commitment to morality and to the law and to the maintenance of standards commensurate with professional integrity.

3. Obligations to Colleagues

Social research depends upon the maintenance of standards and of appropriate professional behaviour that is shared amongst the professional research community.

Without compromising obligations to funders/employers, subjects or society at large, this requires methods, procedures and findings to be open to collegial review. It also requires concern for the safety and security of colleagues when conducting field research.

4. Obligations to Subjects

Social researchers must strive to protect subjects from undue harm arising as a consequence of their participation in research. This requires that subjects participation should be voluntary and as fully informed as possible and no group should be disadvantaged by routinely being excluded from consideration.
Record of Focus Group Details for Treatment Providers

Date ......................................................................................................................................................

Time ...................................................................................................................................................

Location ..........................................................................................................................................

Participants record No ........................................................................................................

Participants pseudonym ..................................................................................................

Age: 18-25 / 26-40 / 41-50 / 51-60 / Over 60 ...........................................

Gender (tick as appropriate) Male □  Female □

Occupation ......................................................................................................................................

What area of treatment provision are you involved in? .............

How long have you worked in this area? ..........................
Consent form

Title: A Qualitative study of individuals who experience 'Sexual Addiction' and of Treatment Providers who work in this area

Researcher:
Ben Hughes, M.Sc.,
School of Social Work and Social Policy,
Trinity College Dublin.

The purpose of this work and the procedure involved in the research has been clearly explained to me. I am assured that my responses will be treated as anonymous and that confidentiality will be maintained.

Confidentiality

Your Contribution is Anonymous and Confidential. An undertaking has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003. Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. The interview is audio taped to accurately capture your experience. All tapes and written material will be stored in locked files and on completion of the project the material will be destroyed so that the ideas and opinions discussed are completely anonymous. I agree to the use of this information by the researcher for educational purposes and for research publication as long as anonymity is strictly observed. Furthermore, child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

My participation is entirely voluntary and I understand that I may terminate my participation at any time.

.................................................................
Signature of research participant

.................................................................
Witnessed by

Record No . . . . . . Date . . . . . . . . . .
Worksheet One

Record No ......

Q. 1. What are the main issues that you think are important in the entire area of sexual addiction?

In answering this question participants begin the process by working alone.
Q. 2. Out of all the issues that have emerged from question 1, choose the three priority areas that you think should be addressed? and explain Why?

In answering this question participants begin the process by working alone.

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<table>
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<th>Reasons</th>
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<table>
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<th>Priority</th>
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Group exercise

After completing worksheet 2, individuals are given three pieces of paper and a marker.

Each person is asked to write out their three priority areas on three separate pieces of paper.

When everyone has finished, the group reassembles.

Participants are asked to place their three pieces of paper on the floor in a circle for everyone to see.

After everybody has viewed the responses, the group are invited to select a set of three priority areas.

This process of refinement will be limited to 15 minutes due to time constraints.
Q. 3. Please write down as best you can the key questions that you think should be asked of a sex addict during a one to one interview.

Please be as concise as you can. There is no limit to the number of questions that you may write. It is not necessary to confine your questions to the areas that were previously discussed.
Worksheet Four

Record No . . . .

Q. 4. Please write down as best you can the key questions that you think should be asked of a treatment provider during a one to one interview.

Please be as concise as you can. There is no limit to the number of questions that you may write. It is not necessary to confine your questions to the areas that were previously discussed.

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Q. 5. What do you think would be the best way to collect information on sexual addiction that would yield the most information or the greatest range of opinion?
Worksheet Six

Record No ......

Q. 6. What are the other issues that you think are important for this research?

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Priority Issue One
Priority Issue Two
Priority Issue Three
Appendix J

Information Pack for Focus Groups - Sexual Addicts

PhD Research

Research Title:
A Qualitative study of individuals who experience 'Sexual Addiction' and of Treatment Providers who work in this area

The School of School Work and Social Policy
Trinity College Dublin
Dear Participant,

The purpose of this focus group study is to identify key issues pertaining to sexual addiction and to prioritise areas of significance for individual interviews with sex addicts and treatment providers (which will take place later on in the process).

Due to the nature of your experience, your insights into this behaviour are very valuable and will make a significant contribution to this work. As well as developing an understanding of this under-researched topic, your input will benefit other individuals and your participation in this study is appreciated.

The following issues are central to this study.

Confidentiality

In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. All material will be stored in locked files and on completion of the project, the material will be destroyed.

Protection

Given the sensitive nature of this area of research, your choice to decline from answering specific questions, or to terminate your involvement at any time, will be respected.

Ethics

In order to assure you that this research project meets the accepted standards of ethical practice, this project has been presented to the Ethics Committee of the University and has received approval. Following Trinity College guidelines, I enclose for your attention:

1. The researchers contact details
2. Principles of Ethical Research
3. Record of focus group details (Private and Confidential)
4. A consent form (to be signed)
5. Research questions and worksheets

Thank you for your co-operation in this project.

Yours sincerely,

Ben Hughes, M.Sc.
Researcher
**Contact Details**

As you participate in this research project, please contact me if there are any outstanding issues that need further clarification. You may reach me at:

Ben Hughes, M.Sc.,
Postgraduate Researcher,
School of Social Work and Social Policy,
Trinity College Dublin,
IRELAND
   Tel: 086 2037 538
E-mail: ResearchTCD@gmail.com

If you require additional information please contact the research supervisor,

Dr. Marguerite Woods,
School of Social Work and Social Policy,
Trinity College Dublin,
Dublin.
IRELAND
   Tel: (01) 8962001 or E-mail: woodsma@tcd.ie
Re: Ben Hughes
PhD Candidate
School of Social Work & Social Policy
Trinity College Dublin

TO WHOM IT MAY CONCERN

I am writing to confirm that Ben Hughes is a registered PhD student in this school. He is currently in his second year of full-time study. His PhD research is a qualitative study of the experiences and views of individuals who have experienced sex addiction and of treatment providers in this field.

If further information is required, please do not hesitate to contact me at the School of Social Work & Social Policy.

Yours sincerely

Dr. Marguerite Woods
Postgraduate Research Supervisor
Course Coordinator
Diploma in Addiction Studies/
Lecturer in Social Studies
Principles of Ethical Research

Issued by The Social Research Association

1. Obligations to Society

If social research is to remain of benefit to society and the groups and individuals within it, then social researchers must conduct their work responsibly and in light of the moral and legal order of the society in which they practice.

They have a responsibility to maintain high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings.

2. Obligations to Funders and Employer

Researchers relationship with and commitments to funders and/or employers should be clear and balanced. These should not compromise a commitment to morality and to the law and to the maintenance of standards commensurate with professional integrity.

3. Obligations to Colleagues

Social research depends upon the maintenance of standards and of appropriate professional behaviour that is shared amongst the professional research community.

Without compromising obligations to funders/employers, subjects or society at large, this requires methods, procedures and findings to be open to collegial review. It also requires concern for the safety and security of colleagues when conducting field research.

4. Obligations to Subjects

Social researchers must strive to protect subjects from undue harm arising as a consequence of their participation in research. This requires that subjects participation should be voluntary and as fully informed as possible and no group should be disadvantaged by routinely being excluded from consideration.
Record of Focus Group Details for Treatment Providers

Date .................................................................
Time ..................................................................
Location .........................................................
Participants record No ........................................
Participants pseudonym ....................................
Age: 18-25 / 26-40 / 41-50 / 51-60 / Over 60 ..........
Gender (tick as appropriate) Male □ Female □
Describe your sexual orientation: Lesbian / Gay / Bisexual / Other ....
If “Other”, please specify: ....................................
Occupation ........................................................
How much school have you completed?
Primary □ Secondary □ Third Level □
Martial Status: single, married, divorced, widowed, living with partner or other.
If “Other”, please specify: ....................................
Do you attend a twelve step programme for sexual addiction? ........
If yes, which one(s)? ........................................
Do you attend any other twelve step programme? .............
If yes which one(s)? ........................................
Consent form

Title: A Qualitative study of individuals who experience Sexual Addiction and of Treatment Providers who work in this area

Researcher:
Ben Hughes, M.Sc.,
School of Social Work and Social Policy,
Trinity College Dublin.

The purpose of this work and the procedure involved in the research has been clearly explained to me. I am assured that my responses will be treated as anonymous and that confidentiality will be maintained.

Confidentiality

Your Contribution is Anonymous and Confidential. An undertaking has been given with respect to participant confidentiality to this research in strict adherence to Trinity College policy and the Data protection Acts of 1988 and 2003. Quotations or examples of individual cases given in this research will be generic and represent typical cases that might occur. In order to ensure confidentiality, each participant will be given an individual identification number and a pseudonym. This is how your contribution will be referred to in the research, ensuring that your own personal details will not appear in any data. The interview is audio taped to accurately capture your experience. All tapes and written material will be stored in locked files and on completion of the project the material will be destroyed so that the ideas and opinions discussed are completely anonymous. I agree to the use of this information by the researcher for educational purposes and for research publication as long as anonymity is strictly observed. Furthermore, child protection and the protection of vulnerable group guidelines and procedures will be adhered to throughout the study.

My participation is entirely voluntary and I understand that I may terminate my participation at any time.

.................................................................
Signature of research participant

.................................................................
Witnessed by

Record No . . . . . Date . . . . . . .
Worksheet One

Record No ........

Q. 1. What are the main issues that you think are important in the entire area of sexual addiction?

In answering this question participants begin the process by working alone. After a period of time, individuals return for group discussion. This is NOT intended as a time for reading the entire list but rather a time to discuss the issues that have emerged.
Q. 2. Out of all the issues that have emerged from question 1, choose the three priority areas that you think should be addressed? and explain Why?

In answering this question participants begin the process by working alone.

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<th>Priority</th>
<th>Reasons</th>
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Priority

Reasons
Group exercise

After completing worksheet 2, individuals are given three pieces of paper and a marker.

Each person is asked to write out their three priority areas on three separate pieces of paper.

When everyone has finished, the group reassembles.

Participants are asked to place their three pieces of paper on the floor in a circle for everyone to see.

After everybody has viewed the responses, the group are invited to select a set of three priority areas.

This process of refinement will be limited to 15 minutes due to time constraints.
Worksheet Three

Record No . . . .

Q. 3. Please write down as best you can the key questions that you think should be asked of a sex addict during a one to one interview.

Please be as concise as you can. There is no limit to the number of questions that you may write. It is not necessary to confine your questions to the areas that were previously discussed.

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Worksheet Four

Record No .......

Q. 4. What do you think would be the best way to collect information on sexual addiction that would yield the most information or the greatest range of opinion?
Q. 5. What are the other issues that you think are important for this research?
Priority Issue One
Priority Issue Two
Priority Issue Three
Appendix K

Interview Questions - Treatment Providers

Start time: .......... End Time: ............ Date: ............ Record # ......

1. The Lived Experience

1. Can you describe sexual addiction as you experience it in clinical practice?
   2. What predisposes an individual to sexual addiction?
   2a. Describe how sexual addiction develops over time.
   3. What terminology is used to describe sexual addiction in your profession?
   4. How do you distinguish between normal sexual behaviour and sexual addiction?
   5. How do individuals typically recognise that their sexual behaviour is addictive?
   6. Do sexual addicts try to cut down, control or stop their sexual behaviour?
   6a. Can you describe what cutting down or stopping is like for the addict?
   7. What is the longest period of time that you have seen the addict stop their sexual addictive behaviour?
   8. What purpose does the addiction serve for the addict?
   9. What triggers the addict to engage in sexually addictive behaviour?
  10. Does drink, or drugs, play any role in sexual addiction?
  11. How is sexual addiction similar to any other addictions?
  12. How is sexual addiction different from other addictions?

2. Impact

13. How does sexual addiction impact upon the individuals life?
   14. How does sexual addiction affect how the addict sees themselves?
15. How does sexual addiction affect the lives of those around the sexual addict?

3. The Recovery Experience

16. What help/support is available for the sexual addict?
17. When does the addict normally first seek help for their sexual behaviour?
18. How long do you expect the addict to maintain therapeutic support?
19. Why does the sex addict seek help?
20. What helps the sexual addict recover from sexual addiction?
20a. How does it help?
21. When the addict has started recovery, describe their experience of leaving the addiction behind.
21a. As the sexual addict begins recovery what does he/she find difficult?
22. What helps the addict to stay in recovery?
23. Why does a sex addict stay in recovery?
24. Where does the process of recovery lead to?
25. What dreams or hopes does the sexual addict have regarding their sexual life?
26. What suggestions would you give to those who experience sexual addiction?

4. Professional Issues

27. How could support for the sexual addict be improved?
28. What suggestions would you give to the caring professionals about this issue?
29. As a professional what issues are the most challenging to deal with?
29a. Are there any areas that you are uncomfortable with?
30. Is there any area on which you like more information or training?
31. Are there any special issues re the relationship between the sex addict and the treatment provider?
32. Some commentators suggest that sexual addiction is a myth or a creation of the addiction industry?
33. In what situation would you refer someone to another agency? Who would you refer them to?
34. As we conclude have you any other comments or suggestions that have not been mentioned?
35. Are there other individuals that you think may be knowledgeable about this issue?

Thank you for completing this interview
Appendix L

Interview Questions - Sexual Addicts

Start time: ................ End Time: ............. Date: ................ Record # .........

1. The Lived Experience

1. When did your addictive sexual behaviour begin? Describe how it developed over time.
   2. How do you see yourself as being sexually addicted? (Why do you call yourself a sexual addict?)
   3. At what point did you recognise that your sexual behaviour was a problem? How did you know it was a problem?
   4. Have you tried to cut down, control or stop your addictive sexual behaviour? Describe what that experience has been like.
   5. What is the longest period of time that you have stopped the sexual addictive behaviour?
   6. What purpose did your addiction serve? (or What did your sexual addiction do for you?)
   7. What triggers you to engage in your sexually addictive behaviour?
   8. Have drink or drugs played any role in your sexual addiction?
   9. How is your sexual addiction similar to any other addictions you may have?
  10. How is your sexual addiction different from other addictions?

2. Impact

11. How has your sexual behaviour impacted upon your life?
   12. How has sexual addiction affected how you see yourself?
   13. As far as you know, how has sexual addiction affected the lives of those around you?
3. The Recovery Experience

14. When did you first seek help for your sexual behaviour?

15. Why did you seek help at that particular time?

16. What has helped you recover from your sexual addiction? How did it help you?

17. Now that you have started recovery, describe the experience of leaving the addiction behind. What have you found difficult?

18. What has helped you to stay in recovery?

19. Why have you stayed in recovery?

20. Where do you see the process of recovery leading to?

21. What are your dreams or hopes regarding your sexual life?

22. What advice would you give to others who experience this addiction?

4. Conclusions

23. How could support for the sex addict be improved?

24. What advice would you give to the caring professionals about this issue?

25. As we draw to a close have you any other comments or suggestions regarding the topic that we have not yet mentioned?

26. Is there anybody else that you would suggest that I speak to regarding this topic?

Thank you for completing this interview
Appendix M

Interview Questions for Sexual Addicts - Non-Recorded

Start time: ............ End Time: ............ Date: ............ Record # ....

1. The Lived Experience

1. When did your addictive sexual behaviour begin? Describe how it developed over time.

2. How do you see yourself as being sexually addicted? (Why do you call yourself a sexual addict?)

3. At what point did you recognise that your sexual behaviour was a problem? How do you know it was a problem?

4. Have you tried to cut down, control or stop your sexual behaviour? Describe what that experience has been like.

5. What is the longest period of time that you have stopped the sexual addictive behaviour?
6. What purpose did your addiction serve? (or What did your sexual addiction do for you?)

7. What triggers your sexual addiction?

8. Have drink or drugs played any part in your sexual addiction?

9. How is your sexual addiction similar to any other addictions you may have?

10. How is your sexual addiction different from other addictions?

2. Impact

11. How has your sexual behaviour impacted upon your life?

12. How has sexual addiction affected how you see yourself?

13. As far as you know, how has sexual addiction affected the lives of those around you?
3. Your Experience of Recovery

14. When did you first seek help for your sexual behaviour?

15. Why did you seek help at that particular time? (Turning point experience)

16. What has helped you recover from your sexual addiction? How did it help you?

17. Now that you have started recovery, describe the experience of leaving the addiction behind. What have you found difficult?

18. What has helped you to stay in recovery?

19. Why have you stayed in recovery?

20. Where do you see the process of recovery leading to?

21. What are your dreams or hopes regarding your sexual life?

22. What advice would you give to others who experience this addiction?
23. How could support for the sex addict be improved?

24. What advice would you give to the caring professionals about this issue?

25. Have you any other comments or suggestions regarding the topic that we have not yet mentioned?

Thank you for completing this interview
Appendix N

Written Questionnaire for Sexual Addicts

Record No . . .

This information is strictly PRIVATE AND CONFIDENTIAL. Some Questions are personal and sensitive. Please take your time and ask for help if you need it. Being as honest and as concise as possible will help. Tick all the boxes that are appropriate.

FAMILY-OF-ORIGIN

1. In your family were you the Oldest □ Youngest □ Place order (i.e. 2nd/3rd) . . . .

2. How many brothers and/or sisters do you have? Brothers . . . . . . . . Sistetrs . . . . . .

3. Did you live more or less continuously with both of your parents at home until you were 16?
   Yes □ No □
   If No, was that because of Divorce / separation □ Death □
   Or, your parents never lived together □ Or, you are adopted □
   If there is another reason please explain briefly: ..............................................................
   .................................................................................................................................

4. Please state below if either of your parent(s) or your sibling(s) have died:

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<tr>
<th>Cause of death</th>
<th>Mother</th>
<th>Father</th>
<th>Sibling 1</th>
<th>Sibling 2</th>
<th>Sibling 3</th>
<th>Sibling 4</th>
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<tbody>
<tr>
<td>Your Age when they died</td>
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5. If you experienced a family death at a young age how did it affect you? ..................
6. If your parents separated/divorced, what age were you when that occurred? ... 
What impact did this have on your life? .................................................................

7. If you were adopted, how old were you when you were placed in your adopted home? ... 
How has adoption impacted your life? .................................................................

8. Describe the home environment in which you were reared? (e.g., chaotic; loving; unsafe) ...

9. What was the socio-economic status of your family of origin?
Working □  Middle □  Upper □  class

10. Please list any major family events/ issues or family secrets that might be significant in your family: .................................................................

11. Were/are any of your immediate family members addicted to: 
Alcohol □  Drugs □  (please state) ... 
Gambling □  Food □  Nicotine □  Sex □  Other (describe) ......................... 
Briefly explain your answer(s)........................................................................

12. Describe the relationship you had with your mother when you were young: ........

13. Describe the relationship you had with your father when you were young: ........

CHILDHOOD/ SEXUALITY

14. Did you witness or experience any kind of domestic violence as a child? 
Yes □  No □
If Yes please explain briefly: ..............................................................................

15. How has this affected you? .................................................................

16. Do you feel you were emotionally neglected as a child? 
Yes □  No □
17. How has this affected you?

18. Were you ever sexually abused? Yes □  No □
If 'Yes', did it involve an individual from:
Within the family □  Outside the family □  A combination of both □
Other (please describe) ..............................................
Briefly explain your answer(s): ...........................................

19. How has this affected you?

20. Was the abuser(s)?
Male only □  Female only □  Male and female □

21. Did the abuse involve?
Physical contact (non-genital) □  Physical contact (genital) □
Penetration □  Abuse with violence □
Non physical-contact □ (e.g. exposure to inappropriate sexuality)
Other (describe) .............................................. Briefly explain your answer(s): ...........................................

22. What age were you when the sexual abuse began? ..................

23. What age were you when the sexual abuse stopped? .............

24. Has your experience of domestic violence / emotional neglect / sexual abuse affected your sexuality?

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<th>Domestic Violence</th>
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<td>Emotional Neglect</td>
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<tr>
<td>Sexual Abuse</td>
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Briefly explain your answer(s) ...........................................

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25. Is there a relationship between your domestic violence / emotional neglect / sexual abuse and your sexual addiction?

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<th>Yes</th>
<th>No</th>
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<td>Domestic Violence</td>
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<td>Emotional Neglect</td>
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<td>Sexual Abuse</td>
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Briefly explain your answer(s).

26. What other childhood experiences may have affected your sexual development?

27. How were you affected?

28. Describe how you felt about yourself or what you thought about yourself when you were growing up.

SEXUAL EDUCATION AND DEVELOPMENT

29. Where did you receive your sexual education?

Home □ School □ Peers □ Media □ Other (describe) □

Briefly explain your answer(s):

30. How did you feel about your sexual education?

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<th>Very Satisfied</th>
<th>Satisfied /Nor Dissatisfied</th>
<th>Dissatisfied</th>
<th>Very Dissatisfied</th>
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31. What were the attitudes towards sexuality at that time?

32. How did these attitudes affect you?
APPENDIX N. WRITTEN QUESTIONNAIRE FOR SEXUAL ADDICTS

ADDICTIVE SEXUAL BEHAVIOUR

33. What age were you when you recognised your sexual addiction? ..............

34. What types of sexually addictive behaviours did you engage in?

 Paid for sex □  Internet sex □  Phone sex □  Anonymous sex □
 Pornography □  Exhibitionism □  Voyeurism □  Fantasy □
 Other (please describe) .............. Briefly explain your answer(s): ..............

35. How often did you engage in these behaviours? (please tick)

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<th>Behaviour</th>
<th>Times / day</th>
<th>Times / week</th>
<th>Times / Month</th>
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<tbody>
<tr>
<td>Paid for sex</td>
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<td>Internet sex</td>
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<td>Phone sex</td>
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<td>Anonymous sex</td>
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<td>Pornography</td>
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<td>Exhibitionism</td>
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<td>Voyeurism</td>
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<td>Fantasy</td>
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<td>Other</td>
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36. How much time did you spend on this addiction in a week? (please tick)

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<th>5-9 Hours</th>
<th>10-20 Hours</th>
<th>21-40 Hours</th>
<th>&gt; 40 Hours</th>
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<td>Pornography</td>
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<td>Other</td>
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</table>
37. How much money did you spend on your addiction in a week? (please tick in Euros)

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<thead>
<tr>
<th>Behaviour</th>
<th>&lt; 20 €</th>
<th>20 - 40€</th>
<th>41- 60€</th>
<th>61-100€</th>
<th>101-200€</th>
<th>&gt; 201€</th>
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<tr>
<td>Paid for sex</td>
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</table>

YOUR CURRENT SEXUAL BEHAVIOUR

38. Do you continue to engage in sexually addictive behaviour? Yes □ No □

If 'Yes’ please explain briefly .................................................................................................................................

39. How often do you engage in these behaviours?

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Times / day</th>
<th>Times / week</th>
<th>Times / Month</th>
</tr>
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<td>Other</td>
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40. How much time do you spend on this addiction per week? (in Hours)

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<thead>
<tr>
<th>Behaviour</th>
<th>&lt; 1 Hour</th>
<th>1-4 Hours</th>
<th>5-9 Hours</th>
<th>10-20 Hours</th>
<th>21-40 Hours</th>
<th>&gt; 40 Hours</th>
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<td>Paid for sex</td>
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41. Do you currently spend money on your addiction?

Yes □ No □
If ‘Yes’ how much money do you spend in a week? (in Euros)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>&lt; 20 €</th>
<th>20 - 40€</th>
<th>41- 60€</th>
<th>61-100€</th>
<th>101-200€</th>
<th>&gt; 201€</th>
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42. Do you currently experience other difficulties with your sexual life and behaviour?
   Yes □  No □
   If ‘Yes’ please explain briefly .............................................................

EMOTIONAL/MENTAL HEALTH

43. Have you ever suffered from depression or any other mental health issue?
   Yes □  No □
   If ‘Yes’ please explain briefly .............................................................

44. What age were you when it began? ...........

45. Has your sexual addiction affected your mental health?
   Yes □  No □
   If ‘Yes’, in what way(s)? .................................................................

46. How do you feel before you sexually act out? ...........................................

47. How do you feel during the sexual encounter? ...........................................

48. How do you feel after you are finished the sexual encounter? ....................

49. Are you, or have you been, on any medication?
   Yes □  No □
   If Yes, please name the medication(s) .....................................................
THERAPEUTIC SUPPORT

50. Describe your progress of recovery from sexual addiction.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
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</table>

Briefly explain your answer(s): .................................................................

51. Have you sought help from any of the following because of sexual addiction? GP □
   Sexual health clinic □ Psychiatrist or psychologist □
   Therapist □ Minister of Religion □ 12-step Fellowship □
   Helpline □ Treatment centre □
   Other (describe) .....................

Briefly explain your answer(s): .................................................................

52. Do you currently attend a 12-step fellowship for sexual addiction?
   Yes □ No □

53. If ‘Yes’, which fellowship(s) SLAA □ SA □
   Other ................................. (Please describe)

54. How many meetings do you usually attend each week? .......................

55. How long have you been attending these meetings? (in months/ years)
   1 - 6 months □ 6-12 months □ 1-3 years □ 3-5 years □
   6-10 years □ >10 years □

56. Have you participated in online meetings?
   Yes □ No □
   If ‘Yes’, how often? .............

57. Describe your experience of the 12-step fellowship regarding sexual addiction:

.................................................................................................................

58. In what ways has this 12-step fellowship helped you?

.................................................................................................................

59. What has not been helpful in the 12-step fellowship?

.................................................................................................................

60. Have you participated in counselling because of your sexual addiction?
   Yes □ No □
61. If ‘Yes’, indicate what type of counselling:
   Individual □  Couple □  Group □  Combination □
   Briefly explain your answer(s): .................................................................

62. How long did you attend counselling?
   1 - 6 months □  6-12 months □  1-3 years □  3-5 years □
   6-10 years □  > 10 years □

63. How was counselling helpful? .................................................................

64. In what ways was it not helpful? ..............................................................

OTHER ADDICTIONS

65. Have you engaged in other addictive behaviours?
   Yes □  No □

66. If ‘Yes’ mark all that apply:
   Alcohol □  Drugs □  (please state) .........................................................
   Gambling □  Food □  Nicotine □  Sex □  Other (describe) ............
   Briefly explain your answer(s): .................................................................

67. Do you still engage in any of these addictions?
   Yes □  No □

68. If ‘Yes’ mark all that apply:
   Alcohol □  Drugs □  (please state) .........................................................
   Gambling □  Food □  Nicotine □  Sex □  Other (describe) ............
   Briefly explain your answer(s): .................................................................

69. In your experience, are these addictions related to sexual addiction?
   Yes □  No □  Don’t No □
   If ‘Yes’ please explain briefly .................................................................
SPIRITUALITY / RELIGIOUS BELIEF

70. Name your family's religious tradition .................................................................

71. Did this impact on your sexual life? Yes □ No □

72. If 'Yes' please explain briefly ................................................................................

73. Do you now belong to a particular religious tradition? Yes □ No □
   If 'Yes' which one? ......................................................................................................

74. How important is religion and religious beliefs to you at present?

<table>
<thead>
<tr>
<th>Very Important</th>
<th>Important</th>
<th>Neither Important /Nor Unimportant</th>
<th>Unimportant</th>
<th>Very Unimportant</th>
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<td>□</td>
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75. In your experience has spirituality played a role in your addiction recovery?
Yes □ No □
Briefly explain your answer: .................................................................................

Participant information:

76. Age ............... 

77. Gender (tick as appropriate) Male □ Female □

78. Occupation ...........................................................

79. Where did you grow up? City □ Provincial town □ Countryside □

80. How would describe your sexual orientation?
Heterosexual □ Homosexual □ Bisexual □ Other (describe) . . .

81. Are you currently
Married □ Separated □ Divorced □ Widowed □ Single □

82. Are you currently in a committed relationship?
Yes □ No □

83. How long is your current relationship? ...........................................................

84. How many times have you been married or lived with someone as a couple? . . .

85. Do you have children? Yes □ No □
   If 'Yes', how many do you have: ...........................................................

86. If the relationship(s) ended please explain briefly ............................................

87. How much school have you completed?
Primary □ Secondary □ Third Level □
APPENDIX N. WRITTEN QUESTIONNAIRE FOR SEXUAL ADDICTS

88. Please write down the highest qualification that you achieved.

89. Was your primary school
   a mixed school for boys and girls □  Single sex school □

90. Was your secondary school
   a mixed school for boys and girls □  Single sex school □

91. Describe how you feel about yourself, or what you think about yourself, at this stage of
   your life:

CONCLUSION:
Thank you for completing this questionnaire.

Administration Detail
Date ................................................ Time .......................................... Location ...........

Participants record No ..............
Appendix O

Written Questionnaire for Treatment Providers

Record No …

This information is PRIVATE AND CONFIDENTIAL

1. Describe any significant patterns within the sexual addict’s family of origin

2. Are there any typical childhood experiences in the sexual addict’s life?

3. Describe what you know about the sexual addict’s sexual education

4. Describe the sexual addict’s emotional / mental health?

5. Describe the individual who typically uses your service, (age, gender, work)

6. How long does the addict use your service?

7. What role if any did religion / spirituality play in the ‘addict’s life?’

8. What role if any does religion / spirituality play in the ‘addict’s’ life NOW?
# Appendix P

## Ethical Approval

**Office Use Only:**

Decision of the School of Social Work and Social Policy Ethical Approval Committee:

<table>
<thead>
<tr>
<th>REFERENCE NUMBER</th>
<th>077</th>
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<tbody>
<tr>
<td>Title of Project</td>
<td>A qualitative study of individuals who experience 'sexual addiction' and treatment providers who work with these individuals</td>
</tr>
<tr>
<td>Research Ethics Meeting Date</td>
<td>7th April 2008</td>
</tr>
<tr>
<td>Approved</td>
<td>Yes*</td>
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<tr>
<td>To be resubmitted</td>
<td>No</td>
</tr>
<tr>
<td>Reasons for resubmission</td>
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</tr>
<tr>
<td>Date</td>
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</table>

*The Committee suggested that the Participant Information Form should be shortened.*
Appendix Q

Summary of Data Analysis of Individual Interviews

A five-phase process of analysis was undertaken where the interview transcripts belonging to the sexual addicts and treatment providers (TPs) were analysed separately. In the fifth and final phase of analysis the results for both groups were combined and resulted in the production of twenty-five major themes representing the entire research population in this study.

Phase One

Aim: to establish an initial coding system
Method: each transcript is read
Significant words highlighted in the transcript using floresent pens
Researchers thoughts were written on the left hand side of the transcript
Quotable extracts were marked in the script by using the letter Q
An Excel file is created for each research subject
Written memos, highlighted phrases are refined, extracted & transferred to an Excel file
Extractions were listed chronologically and numbered
Result: the creation of Preliminary Themes specific to each research subject
Process of analysis and reduction: accumulated themes were refined, merged and collapsed
Result: Clustered Themes emerge for each research subject

Phase Two

Aim: to engage in Cross-Case Analysis
Method: the Clustered Themes of each research subject is totalled
Result: 406 themes for sexual addicts and 416 themes for TPs
Process of analysis and reduction: accumulated themes were refined, merged and collapsed
Result: Cumulative Themes emerge: 22 for sexual addicts & 19 for TPs

Phase Three
Aim: to engage in frequency analysis
Result: determines the cumulative frequency distribution of themes within each group
Method: collate the total of Clustered Themes discussed in phase two above
Result: total of Clustered Themes; 406 for sexual addicts and 416 for TPs
Method: Clustered Themes alphabetically sorted & analysed for frequency distribution
Process of analysis and reduction: accumulated themes were refined, merged and collapsed
The themes were counted and ranked from the most frequently used to the least
Result: Most Frequently Used Themes emerge: 36 for sexual addicts and 54 for TPs

Phase Four
Aim: to create Key Themes for the Sexual Addicts and the TPs separately
Method: combine the Cumulative Themes and the Most Frequently Used Themes
Process of analysis and reduction: accumulated themes were refined, merged and collapsed
Result: Key Themes emerge: 19 for the sexual addicts and 14 for the TPs

Phase Five
Aim: to create one set of Major Themes for all the research subjects
Method: combine the Key Themes for the sexual addicts and the TPs
Result: a combined group of thirty-three themes
Process of analysis and reduction: accumulated themes were refined, merged and collapsed
Result: twenty five Major Themes emerge and become the thematic guide for the entire study

A Quotation Archive
of relevant material is created to support the analysis
Significant quotes identified, extracted & saved
Quotes labelled - individual reference number, transcript page number & synopsis of content
Quotes are saved chronologically in terms of the research subject
Appendix R

Major Themes for the Entire Study

Below are the twenty five Major Themes which resulted from phase five of the data analysis process. The themes emerged as a result of combining the collective Key Themes of both the sexual addicts and the treatment providers. After a process of analysis and reduction, the themes were refined and merged. They became the definitive thematic guide for the entire study. The themes are presented alphabetically.

1. Beginnings
2. Behaviours
3. Challenges
4. Childhood
5. Clients
6. Consequences
7. Controversy
8. Depression
9. Gay issues
10. Help /support
11. Ireland & sexuality
12. Other addictions
13. Purpose
14. Recognized as an issue
15. Recommendations
16. Recovery
17. Sex abuse
18. Sex addict
19. Sex addiction
20. Therapeutic issues
21. Therapist
22. Therapy
23. Triggers
24. Turning points
25. Underlying issues
Appendix S

Associated Publications

S.1 Book Chapter


S.2 Journal Articles


URL: http://www.sciencedirect.com/science/article/pii/S1877042810015843

S.3 Peer Reviewed Published Conference Proceedings


URL: http://www.biomedcentral.com/1753-6561/6/S4/P33

**URL:** http://library.iated.org/view/HUGHES2012SEX


**URL:** http://library.iated.org/view/HUGHES2012EAR


**URL:** http://library.iated.org/view/HUGHES2011SEX
S.4 Conference Presentations

Hughes, B. 2013. ‘Sexual Compulsive Behaviour and Mental Health’. In 14th Healthcare Interdisciplinary Research Conference. Health, Wellbeing and Innovation: Recent advances in research, practice and education. 5th - 7th November 2013, School of Nursing and Midwifery, Trinity College Dublin, Ireland.

Hughes, B. 2012a. ‘Childhood Abuse and Sexual Behaviour’. In International Conference on Global Issues of Early Childhood Education and Children’s Rights. 27 - 29 April 2012, University of Zirve, Gaziantep, Turkey.


URL: http://www.youtube.com/watch?v=3kyQXRjpdnI


Hughes, B. 2010a. Behavioural Interventions and Sexual Health: A Therapeutic Review. In 11th Annual Interdisciplinary Research Conference - Transforming Healthcare through Research & Education. 4-5th November 2010, School of Nursing and Midwifery, Trinity College Dublin, Ireland.
Hughes, B. 2010b. Diagnosis and Management of the Phenomenon of ‘Sexual Addiction’. In Society for the Study of Sexually Transmitted Diseases in Ireland, (SSSTD) Annual Scientific Conference. 25th October 2010, Dublin, Ireland.

Hughes, B. 2010c. ‘Behavioural Addiction’? Clinical Presentations and Treatment Approaches. In The Irish College of General Practitioners (ICGP) Summer School & Research Conference. 18th June 2010, Kilkenny, Ireland.

Hughes, B. 2010d. Contentious and Ethical Considerations in Sensitive Research. In 2nd Doctoral Colloquium for Nursing, Midwifery, Health Sciences and the Social Sciences. 27th May, School of Nursing and Midwifery, Trinity College Dublin, Ireland.

Hughes, B. 2009a. A qualitative study of adults who self-identify as ‘sexual addicts’ and of the experience of treatment providers who work in this area. In 10th Annual Interdisciplinary Research Conference - Transforming Healthcare through Research & Education. 4th - 5th November, School of Nursing and Midwifery, Trinity College Dublin, Ireland.

Hughes, B. 2009b. ‘Sexual Addiction’: Perspectives of the ‘Sexual Addict’ and the Treatment Provider. In Medical Humanities Conference. 3rd December, Medical School, Trinity College Dublin, Ireland.


URL: http://books.google.ie/books?id=bI-Jau14aLAC

URL: http://books.google.ie/books?id=Ov0cuAAACAAJ

URL: http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=44189899&site=ehost-live

URL: http://dx.doi.org/10.1007/BF02109781
**URL:** [http://books.google.ie/books?id=2E3uAAAAMAAJ](http://books.google.ie/books?id=2E3uAAAAMAAJ)


**URL:** [http://books.google.es/books?id=SiCe-ZfOnTIC](http://books.google.es/books?id=SiCe-ZfOnTIC)


**URL:** [http://books.google.ie/books?id=IC8bAAAAAAYAAJ](http://books.google.ie/books?id=IC8bAAAAAAYAAJ)


**URL:** [http://books.google.ie/books?id=usBrAAAAAMAAJ](http://books.google.ie/books?id=usBrAAAAAMAAJ)

Butler, Shane. 2002. *Alcohol, Drugs and Health Promotion in Modern Ireland*. Dublin: Institute of Public Administration.


**URL:** http://dx.doi.org/10.1007/s10508-013-0085-1


**URL:** http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=52120747&site=ehost-live


**URL:** http://books.google.ie/books?id=Doo6SYKhw-cC


**URL:** http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=3979670&site=ehost-live


**URL:** http://books.google.ie/books?id=PSvHAy7NndEC


Cooper, A. 1998. “Sexuality and the internet: surfing into the new millennium.” *Cyberpsychology and*


URL: http://books.google.ie/books?id=biLZAAAAAMAAJ


URL: http://dx.doi.org/10.1046/j.1360-0443.95.11s3.5.x


URL: http://www.jstor.org/stable/2946031


URL: http://books.google.ie/books?id=M9zZIw6EK54C


URL: http://books.google.ie/books?id=glqhh84DGToC


URL: http://www.ingentaconnect.com/content/routledg/usac/2005/00000012/00000004/art00002 http://dx.doi.org/10.1080/10720160500362306


URL: http://sti.bmj.com/content/84/4/324.abstract


URL: http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=37607257&site=ehost-live


URL: http://www.informaworld.com/10.1080/10720160802035600


URL: http://sti.bmj.com/content/87/5/370.short


**URL:** http://dx.doi.org/10.1007/s10508-009-9483-9


URL: http://dx.doi.org/10.1007/s10508-009-9574-7


URL: http://dx.doi.org/10.1023/A:1020007004436


Kor, Ariel, Yehuda A. Fogel, Rory C. Reid & Marc N. Potenza. 2013. “Should hypersexual disorder be

URL: http://www.tandfonline.com/doi/abs/10.1080/10720162.2013.768132


URL: http://www.jstor.org/stable/1870344


URL: http://dx.doi.org/10.1080/00224490903151374


Greenwood Press.


URL: http://dx.doi.org/10.1002/jhbs.20103


URL: http://www.jstor.org/stable/3786692


URL: http://www.tandfonline.com/doi/abs/10.1080/10720162.2013.775631


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