UNDERSTANDING CYBERSEX IN 2010

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For many clinicians, sex addiction has appeared as a peripheral and perhaps questionable diagnosis. Recent media hype and the portrayal of sex addicts in treatment add to that perception. However, realization grows that sex addiction is a viable designation and a treatable illness. Many therapists now have patients and families who describe hopelessness around compulsive sexual behavior on the Internet. In fact, over seventy percent of sex addicts report cybersex as the beginning or as a catalyst to their sexual acting out.

When clinicians research the topic, they discover sex addicts with compulsive sexual behavior described in mainstream professional mental health (Carnes in Saddock & Saddock, 2005), addiction (American Society of Addiction Medicine), and family therapy publications such as the *Journal of Marital and Family Therapy*. Further, they discover a growing body of clinical and research literature spurred on by twenty years of a dedicated medical journal (*Sex Addiction and Compulsivity, The Journal of Treatment and Prevention*) and an active professional society (Society for the Advancement of Sexual Health). A working knowledge of the problem and its treatment is important given its emerging status as a public health issue. Perhaps more important from a family and marriage perspective is how cybersex reveals tectonic sexual shifts occurring in the substrates of our culture.

Researchers in all addictions report the key variable in addiction etiology is availability. With gambling, more casinos results in more problem gamblers. Similarly, obesity and compulsive eating issues occur in a society in which food is abundant. Cocaine and heroin problems fluctuate because of access. In sex, cybersex provides many venues for sexual access that are easy, affordable, and anonymous. One can find affair partners, pictures, media clips, and alternative universes to live out fantasies. A person within minutes can schedule a meeting with a prostitute in any major airport in this country. Texting and sending pictures by cell phone brings innovative exhibitionism and invasion. Sex has been the number one "product" of the internet since 2003 outselling both computers and software. However, the porn industry has been decimated with the advent of flash media and webcams. So much free media is available no real need exists to purchase it. If availability and ease of access is core to addictive use, we have many measures of having reached that threshold.

The Internet also brings a wealth of sexual awareness. One can find appropriate partners, information about sexual issues, and forums for expanding sexual information. But when courtship goes awry so that behavior is no longer a choice, then like food, abundance can become a problem. Here are some clinical scenarios:

- A bank system president was caught using Internet porn at work. He reported spending one to two hours a day at work seeking porn and upwards of three hours every night. Upon seeking therapy he promised to stop. His wife discovered him accessing porn and girlfriends from his phone which prompted their therapist to insist on inpatient treatment.
- A priest went to treatment for his alcoholism and lied about his sexual behavior. An audit eventually revealed his embezzlement of funds from his diocese for women he met on the Internet.
- A female attorney meets violent men online for anonymous "rough" sex. She meets them in their cars on the street. She is beaten and left for dead. Her husband and young children are stunned. She learns in treatment about how the violent sexual abuse by her stepfather affected her arousal patterns and compulsive cycles.
- A physician spends endless hours online orchestrating threesomes with his affair partner he then watches. All this comes to light when he is arrested for offering on Craigslist to trade oxycotin for sex partners. There is also a problem involving nurses who were affair partners and worked under his supervision in the hospital emergency room.
- A grandmother of five is the picture of suburban, upscale, family values. A pillar of the church, she has a drinking problem augmented by a prescription drug problem. However, she is unable to stay sober despite treatment. One of her grandchildren discovers her internet porn collection. This in turn leads to her daily meetings with escorts with whom she pays to have unprotected sex.
- A married grandfather in his seventies discovers Internet porn which leads to many sexual relationships with women in foreign countries. At the time of discovery, he supported three of them financially which in total exceeded five-thousand dollars a month. He was literally burning through retirement money needed for cost of living for him and his spouse. He chatted with each every day, sent checks every week,

and had "business" trips to each twice a year.

- A college student flunked out of school because of his cybersex obsession. He was online from "morning until night" never making it to class. He started at the age of ten looking at "MILF" sites which portrayed mothers as sex partners. He never dated but had unusually close relationships with older women including family members.

All ages, orientations and genders are vulnerable. The usual signs of addiction are there: inability to stop, life problems as a result, extreme time lost, and obsession compromising values and ability to function. The question to ask is how it happens.

Neuroscience provides a window to addictive processes. Critical to an addiction are the reward centers of the brain. Critical neurotransmitters are activated by neurochemicals such as dopamine. Sexual activities are recognized by the brain in both men and women 20 percent faster than any other stimulation presented to it (Anokhin et al., 2006). Sex, like food, is differentiated from other addictions because sex is wired for survival and it is wired to be activated by the senses. A cocaine addict, for example, does not care how cocaine is "presented," but with food and sex, visual cues are critical. A further significant catalyst is fear, whether it comes from earlier traumatic history, adolescent risk taking, or the breaking of cultural taboos. Fear becomes the chief chemist of the brain, releasing hormones which further enhance the reward centers. In all addictions, fear plays some role, but in sex so many exist to access fear as an accelerator of reward.

Patients with the problem report a level of stimulation that is difficult to replicate in real life and real time with real people. This phenomenon is really a "machine enhanced sexual arousal (Carnes, 2008)." No spouse or partner can compete with the Internet. Two decades ago, specialists in human sexuality would have said that arousal patterns are fairly fixed by age eleven. It is common to hear patients describe obsessive preoccupation about behaviors that they did not know existed until they were well into their sixties. The brain has extraordinary ability to rewire the synapses for intense pleasure and keep repeating the self administration. The digital production of multiple stimulations apparently intensifies that adaptation implicit in synaptic rewiring. Patients report feeling intensively sexual all the time to a level they did not know prior to using digital media.

In earlier years, most sex addicts consistently reported a discernable pattern. They tended to come from rigid disengaged families, were victims of childhood abuse, had other addictions,

AVAILABILITY & ADDICTION

Gambling	"Our report represents the first published longitudinal study to empirically evaluate the impact of the establishment of a casino on gambling habits, using a paired-subject design and a control group. The results confirm the hypothesis that an increase in the availability of gambling activities, even within as short a period as 1 year (Jacques, Ladouceur, & Ferland, 2000)."
Alcohol	"Research has shown a direct relationship between alcohol availability (measured by the number of bars, restaurants, and stores selling alcohol in a specific geographical area, such as a city block) and alcohol-related problems, such as violence (Alaniz, 1998)."
Methamphetamine & Cocaine	"Increased availability of these drugs [methamphetamine and cocaine] at & reduced prices has led to a parallel rise in local [Mexico, especially Ciudad Juarez and Tijuana] drug consumption (Brouwer, et al, 2006)."
Internet	"…increased availability of the Internet has led some researchers to examine the effects excessive usage has on an individual's social, emotional, cognitive, and physical development (Watson, 2005)."
Internet	"The interactive features and availability online can be addictive. Then, the stock trading and ebay auctions attract people and can be addictive too (Young, 2009)."
Online Pornography & Cybersex	"Given the widespread availability of sexually explicit materials online, Internet sex addiction is the most common form of problem online behavior among users (Young, 2008)."

had problems with attachment, and had other family members who were also addicts (Carnes, 1991). Roughly, two thirds of sex addicts still represent that pattern. However, a substantial group has emerged which does not fit that well documented etiology. Usually their behavior started with cybersex and maintained an Internet focus. Often these Internet behaviors combine with other addictions including drugs, alcohol, compulsive gambling, and compulsive eating. In fact, clinicians will discern a weaving of these themes in the patient's history. The resulting profile, however, shares common characteristics.

Assessment: Who is a Sex Addict?

Just because someone uses Internet pornography does not make that person a sex addict. Consider this quote from authors Jennifer Schneider and Robert Weiss (2006): "Pornography abuse or addiction are not of concern to most people, anymore than drinking, eating or gambling are problematic for everyone who drinks alcohol, eats, or gambles. But as long as substances and behaviors can bring people pleasure and distraction, a small percentage of people will abuse those very pleasures, only to find themselves eventually hooked and broken by them. Porn and sexuality are no different." It is important for the clinician to be able to discern who is a sex addict and also who is not a sex addict. There are many useful tools to assist therapists in making this distinction, such as the Sexual Addiction Screening Test (SAST). Clients can take the SAST for free and receive their score at www.sexhelp.com. There is also the Internet Sexual Screening Test (ISST, available on www.sexhelp.com; Delmonico & Miller, 2003). If a client meets more than three of the ten criteria listed below, they need further evaluation for compulsive sexual behavior.

Diagnostic Criteria for Sexual Addiction Patients.

Three or more of the following symptoms:

1. Recurrent failure to resist impulses to engage in specific sexual behavior
2. Frequent engaging in sexual behaviors to a greater extent or over a longer period of time than intended
3. Persistent desire or unsuccessful efforts to stop, reduce, or control sexual behaviors
4. Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experience
5. Preoccupation with sexual behavior or preparatory activities
6. Frequent engaging in sexual behavior when expected to fulfill occupational, academic, domestic, or social obligations
7. Continuation of sexual behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior
8. Need to increase the intensity, frequency, number, or risk of sexual behaviors to achieve the desired effect, or diminished effect with continued sexual behaviors at the same level of intensity, frequency, number, or risk
9. Giving up or limiting social, occupational, or recreational activities because of sexual behavior
10. Distress, anxiety, restlessness, or irritability if unable to engage in sexual behavior

A good and apparently reliable set of criteria for office use is based on the acronym PATHOS, the term the Greeks used for "suffering." This short

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assessment was inspired by the successful use of the CAGE criteria (four items) in assessing for alcoholism and can be used as a quick mnemonic. PATHOS uses six items derived from large samples of both inpatient and outpatient clients. PATHOS stands for:

PATHOS Questionnaire Items

1. Do you often find yourself preoccupied with sexual thoughts? (Preoccupied)
2. Do you hide some of your sexual behavior from others? (Ashamed)
3. Have you ever sought help for sexual behavior you did not like? (Treatment)
4. Has anyone been hurt emotionally because of your sexual behavior? (Hurt others)
5. Do you feel controlled by your sexual desire? (Out of control)
6. When you have sex, do you feel depressed afterwards? (Sad)

Additionally, during the assessment process, a therapist needs to rule out all other possible diagnoses that may be complicating the clinical presentation. Common ones include: anti-social personality disorder, narcissistic personality disorder, bi-polar disorder, delusional disorder (erotomanic subtype), cognitive disorders (e.g., brain injury, etc.,) paraphilias, and impulse control disorders. Common co-morbid conditions include substance dependence, eating disorders and ADHD. As with any case, some clients will present with a dual diagnosis which may make treatment more challenging.

Relationship and Intimacy Impairment

Findings from several research studies suggest that there is a relationship between Internet pornography usage and an impaired ability to develop and maintain intimate relationships. For example, Yoder, Virden, and Amin (2005) discovered a significant relationship between Internet pornography usage and loneliness. Boies, Cooper and Osborn (2004) found that those young adults who are "relying on the Internet and the affiliations it provides appear at risk of decreased social integration." Also, those students who were "seeking sexual information and masturbating online were the two activities most strongly associated with dissatisfaction with people's offline lives." Schneider (2003) writes, "cybersex addiction was a major contributing factor to separation and divorce of couples in this survey: 22.3 percent of the respondents were separated or divorced, and several others were seriously contemplating leaving. Among 68 percent of the couples, one or both had lost interest in relational sex: 52.1 percent of addicts had decreased interest in sex with their spouse, as did 34 percent of partners." Given the fact that Internet pornography addicts spend inordinate amounts of time and money on the pursuit of pornography, it stands to reason that their relationships and intimate sex would be impaired.

The Partner's Plight

Sex addiction is steeped in secrecy and shame. Sex addicts will go to great lengths to cover up their sexual behaviors, creating a world of confusion, doubt and pain for the partner. It is common for the enraged or hurt partner to be the catalyst for treatment. Partners of sex addicts fall into two groups: those who knew about the sexual behaviors and those who were completely in the dark. The partners who knew about the behaviors typically didn't know the extent of the behaviors, and sometimes may have minimized or rationalized the behavior (e.g., all men use porn). The partner typically discovers the full scale of the addiction through a painful, staggered disclosure process. This process usually begins with a discovery by the partner (e.g., he or she finds pornography on the computer) and then the addict will engage in a five-step process:

1) Deny everything
2) Disclose what what he or she thinks he or she can get away with
3) Disclose more
4) Get confronted as more information is discovered
5) Disclose all

Research has shown that the majority of addicts (70 percent) and their partners (80 percent) report that there has been more than one major disclosure process (Schneider & Corley, 2002). And for many couples, compulsive pornography use can escalate into other types of sexual behaviors such as escorts, affairs, anonymous sex, fetishes etc., which can cause immense pain for the partner. This disclosure process can unfold over years and be repeated, which can be very damaging to the trust in the relationship. This disclosure process can be traumatic for partners and research has shown that some partners actually experience trauma symptoms (Steffens & Rennie, 2006). Partners typically need to see honesty and accountability from the addict so that they can be empowered with the truth and to have enough hope to continue in the relationship.

This disclosure process is very painful for the partners and they frequently exhibit emotional turmoil. Some will be too ashamed to reach out for support, and others may ruminate on the addict's behaviors and his or her recovery. Some partners will feel pressure to accommodate the addict's sexuality and may engage in sex or behaviors that they may be uncomfortable doing. Some couples will find their sexuality

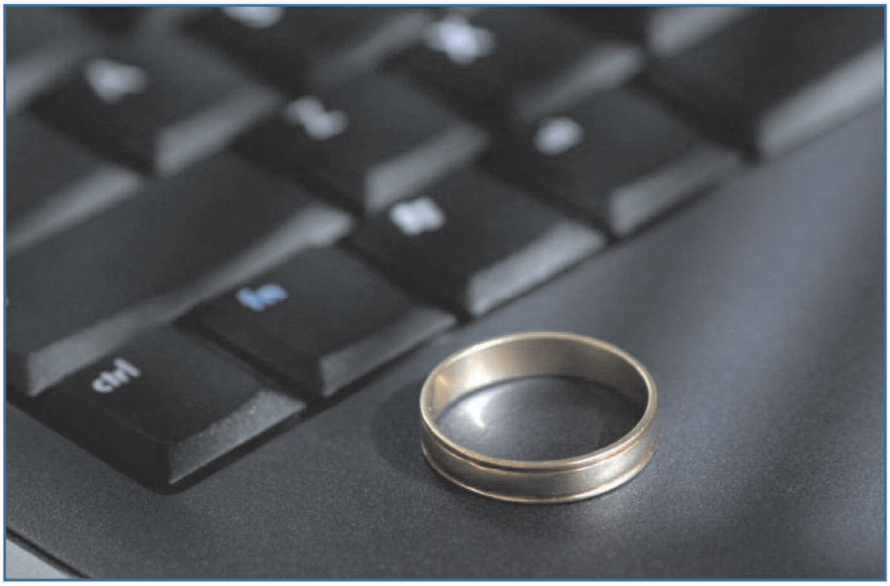
and intimacy becomes impaired as the partner wonders how they can compete with the hundreds of images the addict has seen on the Internet. In most cases, when the partner feels pain and betrayal, long-term couples therapy will be indicated.

Addiction therapy is a process which takes up to four to five years. Factors which contribute to the length of treatment are: 1) time to establish abstinence from dysfunctional behaviors and learn healthy sexual focus, 2) the stimulation of new synaptic growth incorporating new sexual knowledge, relapse prevention, and 12-step participation, 3) extensive therapy around intimacy, affect management, and trauma history, and 4) working through consequences and complications resulting from the behavior (including legal, occupational, and relational). Core to this process is family and marital therapy to resolve grief, trauma, and differentiation issues. However, certain classic errors do emerge as part of family therapy.

Roadblocks in Couples Therapy

One common clinical mistake occurs when a therapist advances with couple's therapy when the addict is not in recovery. Lack of progress can undermine the confidence in therapy for both family members and addicts. New episodes of discovery and disclosure can generate hopelessness with the coupleship. If unable to sustain an agreed upon abstinence, the patient may need a more structured setting such as intensive inpatient or outpatient programs. Just as in substance abuse, it is important to treat the addiction first. If not, the couples work is often riddled with secrecy, repetitive dysfunctional dynamics and no progress.

A second mistake that therapists might make is to keep secrets for the addict. For a review of the ethical problems therapists face when harboring infidelity secrets please see the article written by Butler, Seedall, and Harper (2008). Many therapists find themselves in the dilemma of needing to facilitate a therapeutic disclosure process, where the addict discloses information about his



or her sexual behaviors to the partner. These can be emotional and difficult sessions to facilitate (for further training on facilitating disclosure sessions visit www.iitap.com). Many therapists will make the mistake of assuming it is better to let the information emerge over time in the therapy process, with the concern that receiving all the information all at once might be too overwhelming for the partner. This replicates the staggered disclosure process and only prolongs the agony for both parties.

The Children Suffer

Children can be the unfortunate recipients of many of the negative consequences of cybersex use. As mentioned earlier, the addict may become withdrawn and struggle with maintaining intimate relationships. Tension between the parents may become evident and children may get triangulated into marital conflict. It is not uncommon for children to discover the pornography on the computer, and either be forced to keep a secret or disclose painful information to the partner. Additionally, children's developing sexuality may be impacted by early exposure to pornography. Therapists can be faced with difficult clinical situations, such as a 9-year-old who discovers child pornography on the computer, or parents struggling with how to explain this problem to their children.

Sometimes the problem is the children themselves. Most clinicians active with this population have cases in which the clients report already having trouble by the fifth or sixth grade. Consider a 25-year-old client who started looking at child pornography when he was ten. He was arrested for child porn when in the eighth grade. He never dated because he was still adsorbed in children. Because of his inability to hold a job due to his constant immersion in the Internet, his family insisted he go to inpatient treatment. As a patient he was stunned to realize that society would consider him a sex offender. In another case, an 18-year-old's school failure was directly due to his preoccupation with sex on the Internet. Unfortunately he now has three felonies in different states for texting a nude picture of himself to 14- and 15-year-old girls.

A recent study, (Sabina, Wolak, & Finkelhor, 2008) was able to identify that the majority of adolescents in a large scale study looked at pornography while doing homework. Thirty-four percent now were "at risk" for sexually compulsive behavior. In addiction medicine, early intense exposure leads to adult chronic problems (alcohol, drugs, gambling, nicotine, and food). Certainly that appears to be true for sex as well. Given Internet availability and dramatically shifting behavior patterns for adolescents, many parents will feel lost at sea. For sure, family therapists will be facilitating discussions with parents and children about online behavior

that is appropriate and that which has risk. Plus, there is always the problem addiction specialists face in simply parsing adolescent behavior from that which is addictive. Yet those of us who work in this field are now witnessing a trajectory which suggests that a tsunami of behavioral problems are coming in the next generation.

Cultural and Clinical Reflections

We are probably a full hundred years away from understanding the full impact of what is happening sexually in our culture at the moment. Even the events of the last 18 months have been staggering. In December of 2009, the whole Playboy enterprise was outsourced in an effort to salvage the brand which has endured from the early fifties. The organization simply cannot compete with free material posted on the Internet. Porn stars who averaged $150,000 of income in 2007, were lucky to net $8,000 in 2008 (Fritz, 2009). A further problem is that use of webcams and posting sites by adolescents make it hard to distinguish between adult and underage pictures. Plus, there is a whole net of sites featuring child modeling, family nudism, ex-girlfriends, simulated incest, and barely legal pictures which open portals to a darker side of the net. There are now many who have a problem with sexually compulsive and/or sex offending behavior that would never have gotten there had it not been for the Internet. Actual arrest rates for sex offenses have gone down with the advent of online sexual behavior. Voyeurism, exhibitionism, anonymous sex, and prostitution now can be done with much less risk on the Internet.

All of this creates new territories for the therapist to tread which can be intimidating. It is quite understandable why some are reluctant to engage these issues in therapy. Yet the number one complaint of patients is that they had to see a number of therapists before they got help. The common refrain is, "I wish my earlier therapists had been able to help." Part of this might be naïveté and inexperience. More significant is the number of therapists who fail to see sex addiction as a problem. They dismiss it as episodic, symptomatic, or a problem of culture and attitude.

Yet, all the criteria for addiction are accessible. Note in the PATHOS short assessment described earlier, that out of the thousands of patients involved in the evolution of the criteria, that one of the assessment guidelines has been an effort to seek help from therapists in the past. It is a testimony to our professional reluctance to see the problem for what it is. Most of us got involved because of a client who needed help and we learned from them. We believe that is the invitation to all of us. ■

Resource Guide

Co-Dependents of Sex Addicts (COSA)
www.cosa-recovery.org

Society for the Advancement of Sexual Health
www.sash.net

S-Anon
www.sanon.org

Sex and Love Addicts Anonymous
www.slaafws.org

Sex Addicts Anonymous
www.sexaa.org

Sexual Addiction Resources/ Dr. Patrick Carnes
www.sexhelp.com

Sexual Compulsives Anonymous
www.sca-recovery.org

Sexaholics Anonymous
www.sa.org

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