Context Statement

Developing Contemporary Models for Understanding and Treating Sex Addiction in the Digital Age

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Submission Date: 14th December 2020

Word count: 18,708

Abstract

Sex addiction has been a highly contentious and controversial label since its conception in the early 80's and debates continue between academics, therapists and sexologists. This context statement is a reflexive audit of the conception and evolution of public works that have been influenced by, and address these arguments. These public works, on which I base my doctoral claim, have broadened the understanding and treatment of sex and porn addiction for the counselling and therapeutic communities, other health professionals and the general public.

A critical reflection of the development and evolution of five pan-theoretical models is presented that conceptualise, assess and treat sex and porn addiction. The rationale and background research for each of these models is described along with how each can be used in clinical practice. A reflective critique of my personal and professional development is also provided to explain the context to this work and my role within it.

A significant contribution of the public works is that they bridge the divide between psychodynamic, psychosexual and addiction disciplines and provide new ways to understand and treat, what is still, a relatively new problem. They also encapsulate the complexity of case formulation and treatment and encourage a sex positive approach that addresses relapse prevention and concurrent psychological and relational issues. This doctoral claim is supported by an evidence section that details how the models have been shared with both professionals and the general public through extensive writing, including four books published by Routledge, teaching and public speaking and the development of the CPCAB level 5 accredited diploma in sex addiction counselling.

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Introduction

My doctoral claim is based on public works that have broadened the understanding and treatment of sex and porn addiction for the counselling and therapeutic communities, other health professionals and the general public. In particular, the models I have created bridge the gap between the addiction and sexology fields and have incorporated an understanding of modern technology and changing sexual behaviours. These models have been presented through writing books, articles and professional papers; public and professional speaking; training programme design and delivery and development of a range of therapeutic services.

This statement begins by providing a background context to the issues of sex and porn addiction as well as an introduction to myself as a psychotherapist. The controversies surrounding sex and pornography addiction are then presented along with an explanation of how they motivated me to specialise in this field. The models are then explained including how they were researched, conceptualised and evolved. This is followed by detailing how they've been applied in clinical practice, including how they have led to the growth of the Laurel Centre and our groupwork programmes. The final section of this statement describes how the models have been shared with others through writing, professional training and public speaking. Details of the impact on both clients and professionals is shared in an additional 'evidence' document.

The background

Before talking about the controversy of sex and pornography addiction, it's important to frame the context of these controversies, and my work, within the eternal moral minefield that is human sexuality. Ever since Adam and Eve, the act that enables us to create human life has been both feared and revered. Perhaps it's unavoidable that societies would strive to control human sexuality when it can have such significant social consequences. Hence whilst sex may be an intimate act, it is also a political one that has played a profound role in the belief systems of most of the world's cultures throughout the ages and in all major religions. Sexual mores change over time, as do the ways in which sex is controlled, with responsibility moving between the individual, the family, the church and the government.

Like sex, pornography seems to have been around almost since the dawn of time with erotic cave drawings dating back as early as 2,000 BC. The advent of the printing press in the 15th

century allowed images and words to be widely distributed for two hundred years until obscenity laws were gradually introduced to protect the public from corruption. As societies have evolved, so too have our definitions of obscenity and pornography. From ancient fertility symbols with exaggerated genitalia, to Michelangelo's David and renaissance nudes, to Page 3 glamour models, to hentai and avatars - the evolution, the desire and the outcries continue. Whether an image is art, or erotica, or education, or pornography depends on the eye of the beholder and the way it is used. And whether it is moral depends on the outcome of that usage and on how it is produced.

An ongoing frustration of mine is how easily the subject of sex and pornography addiction is hijacked by the ethics of porn and the discussion becomes about morality rather than mental health. But perhaps that's inevitable when sex itself is such a political and moral issue. I'm often asked if my motivation for working in this field is a moral objection to pornography, or if I've become morally averse as a consequence of working in this field. The answer to both questions is no. I believe that pornography can be ethically produced and ethically enjoyed, but like everyone, my definition of pornography and ethical is not unanimous. The controversies of sex and porn addiction sit within the larger landscape of the constant ebb and flow of cultural mores, sexual regulation and society's latest view of pornography.

The first time I heard the term 'sex addiction' was at a sex therapy conference in 2002 and the cycle of addiction that the speaker described resonated with a client I'd been struggling with in private practice for many months. My client loathed his sexual behaviours, but felt powerless to stop them. We had explored the genesis of these behaviours in ruptured attachments and early trauma and whilst he had gained considerably greater insight, his unwanted behaviours continued. Unaware at the time of the controversy surrounding sex addiction I decided to investigate further training to help me work with a growing number of clients presenting with similar issues. I had no intention of specialising in sex addiction, nor indeed becoming an 'expert', but a combination of the controversy, and the complexity, got me hooked.

On reflection, my preparation for the field of sex addiction began long before I became a therapist. At age three, I was adopted into an evangelical Christian family where there was right or wrong, good or bad and the method of discipline was shame. Any questions I had pertaining to the imposed belief system was viewed as a sin; my older brother and I were both silenced and hence we became close confidants, which indeed we still are today. When I hit puberty,

aged 11, it was met with embarrassment and dire warnings not to get pregnant, even though I had never been told how pregnancy occurred, and my brother, now aged 17, received comparable warnings about his burgeoning sexuality. If anything smutty was revealed on the television it would immediately be turned off and hence I was taught that sex, and sexuality, was shameful and something to be kept hidden – much like the clients I would go on to work with. As my brother and I went through adolescence it became increasingly common for him to confide in me about his sexual trials and tribulations and subsequently I learned how it felt to be a sexual man whilst developing into a sexual woman myself. I learned to listen and to empathise and to maintain confidentiality. Meanwhile my schooling, a rough comprehensive school, was teaching me that to survive, you had to fit in or learn to stand alone. Like many adoptees, I had a legacy of 'not fitting in' and the trauma I'd experienced during my first three years, equipped me with hypervigilance to danger and quick access to my fight and flight defences. And so, to survive, I became fiercely independent and increasingly rebellious. By the age of 13 I was smoking, drinking, truanting and questioning everything, regardless of the consequences. At 15, much to my parents' outrage, or perhaps to provoke it, I left school with little education. In my father's words, I had become 'contrary', a word which shares the same Latin root as controversial, 'contra', meaning, to turn against.

I have no doubt that my decision to begin training as a psychosexual therapist with Relate twenty years later was borne from the experiences described above, accompanied by a semi-conscious need to continue to redress the negative messages about sex and sexuality that I'd absorbed. During my training I was particularly fascinated by the connections and tensions between spirituality and sexuality and my extracurricular reading strengthened my opinion that in the west it was the Church, rather than God, that wanted to control sex and there was much we could learn from eastern spirituality. When I saw clients struggling with secrecy and shame around their sexual compulsivity, it resonated with my own personal experiences and I felt a deep sense of compassion and empathy. And as I became increasingly aware of the controversy around the nomenclature and conceptualisation of the problem, and heard how this increased their feelings of shame and isolation, I felt a profound desire to defend and protect them; to be someone who was in their corner, to fill the place that no-one had filled for me.

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The controversy

One of the reasons sex addiction is controversial is because it's complex, both in causation and consequence and in presentation. I have always enjoyed solving a puzzle, whether that's finding the leak in the garden pond or helping clients understand why they behave the way they do. Whilst my parents had their faults, they also had many strengths and one of those was that they encouraged and praised curiosity, especially in the world around. This has resulted in me being someone who bores easily and quickly becomes restless if I'm not doing something new. It could be that I have ADHD and/or that my inherent restlessness derives from trauma. Either way, it is a characteristic I value and one that motivated me to get to the root of the controversies and try to resolve them.

Following the conference in 2002, I began researching sex addiction. At that time there was no training available in the UK and therefore I relied on reading and found what limited research and literature there was originated in the US. The first book I bought was Out of the Shadows by Patrick Carnes (Carnes 1992). Whilst it was an eloquently written and fascinating read, I found myself questioning much of what I read. In particular, he defined compulsive sexual behaviours as SAFE. The SAFE formula asserts that if the behaviour is Secret, Abusive (harmful to self or others), used to avoid painful Feelings and Empty (outside a caring, committed relationship), then it is probably a sign of addiction. I struggled to conceptualise sex addiction in this way because it raised too many ethical issues, and indeed, it was not my experience. There are many people who enjoy casual sex but may choose to keep it secret due to fear of judgement. Furthermore, there are many who use sex for self-soothing, be that alone or with a partner, and I struggled to see why that meant it was compulsive. I was working at the time as a couple psychotherapist as well as a psychosexual therapist and I worked with many clients from the LGBT communities – if healthy sexuality was defined by monogamy, as Carnes posited, then anyone from a poly or open non-monogamous relationship would be deemed addicted. Thanks to google, I wasn't limited to books and soon found an article by an American sexologist called Marty Klein titled, Sex Addiction – A Dangerous Clinical Concept (Klein 2002). In the article he communicated his concerns about the pathologising descriptions of healthy sexuality in Carnes' work and encouraged a sex-positive and culturally sensitive approach. Another key author at the time was Eli Coleman who proposed an obsessive-compulsive model as an alternative to the addiction model (Coleman 1991). He was also critical of Carnes' pathologising position on sexuality and proposed viewing the behaviours as a compulsive attempt to soothe other underlying issues. I agreed with Klein and Coleman, but my experience of working with clients

was that defining ‘healthy’ sexuality and identifying and addressing underlying causes was not helping them to stop the unwanted behaviours. Furthermore, the experience my clients described resonated too loudly with the clients I’d seen when working briefly in drug addiction. They desperately wanted to stop something they desperately wanted to do, and felt crazy, and ashamed, that they couldn’t just ‘get a grip’.

Whilst I was continuing my academic research on sex addiction, there was growing interest within the media. Michael Douglas, Charlie Sheen, Ulrika Jonsson and Tiger Woods were just a few of the celebrities revealing, or being exposed, as ‘sex addicts’. Sex addiction became tabloid news and ‘experts’ were called upon for their opinion. Those who believed in sex addiction cited these famous cases as evidence that the condition existed, whilst others claimed sex addiction was a myth, an excuse, an invented pop-psychology phenomenon, an irresponsible diagnosis, a forewarning that the addict was untrustworthy in every area of life. Unsurprisingly the impact of these opinions on clients was that their shame increased along with feelings of isolation, anxiety, depression and despair. A prominent antagonist of sex addiction was David Ley, a US Sexologist who a few years later in 2014 launched his book, The Myth of Sex Addiction (Ley 2014). Ley became a prominent antagonist of the sex addiction label within the media and took particular exception to the idea that pornography could be addictive, seeing this assertion as being linked to America’s puritanical and conservative attitudes towards sexuality and erotica. As someone who had direct experience of evangelical communities, I found myself agreeing with much of what he said.

In November 2009, I attended Module 1 of Patrick Carnes’ CSAT (Certified Sex Addiction Therapist) training and was troubled by what I perceived as a sex-negative, prescriptive approach. He proposed a biological, disease model of addiction which required treatment with his 30-task model and attendance at 12-step meetings. According to the training this was the only effective approach. My questions about research, efficacy, working with diversity and/or trauma, alternative modalities, went unanswered. I was told that I had to trust the experience of my trainers and follow the handbook. I was told that people with addiction need to be ‘told’ what to do and as therapists, our role is to be directive and set firm boundaries. When I asked what to do if a particular exercise didn’t work for a client, or they didn’t want to do it, I was told that meant the client was still in denial and I should stop therapy until they were ready to ‘do the work’. Perhaps because of my experience of being brought up in a dictatorial home, or perhaps because of differences in UK and US therapy styles, I knew this was not how I wanted to work. I

have always taken a collaborative approach with my clients and I was not willing to change that. I was thrust back to my adolescent self, desperate for explanations but feeling ashamed for asking. I rebelled and did not attend the rest of the training. My experience of CSAT training, (which I'm told has been considerably revised and updated since I attended) helped me to understand the objections to the sex addiction label, particularly the ones cited by Ley, but as I saw more and more clients who self-defined as sex addicts, I could not ignore their experiences. Their behaviours felt out of control and they felt powerless to stop, in spite of the harmful consequences it was having on their lives. I began to cherry-pick some of Carnes' tools, anglicised and adapted them, then tentatively introduced them to clients and began to see not just psychological, but behavioural change.

Throughout this period, the neuroscientists had been hard at work publishing new research on the impact of addiction on the brain. There was growing evidence that the reward centres of the brain are changed and so are the decision-making areas (Bechara and Damasio 2002, Goldstein et al 2001). Research was also showing that these same changes occur with behavioural internet addictions (Kuss and Griffiths 2012). Whilst this could be seen as evidence that supported the biological disease model, 'change' does not necessarily mean 'disease'. I was greatly influenced by the work of Marc Lewis (Lewis 2011) a former addict and developmental neuroscientist. He used all the language of addiction, without pathology, and whilst he respected the 12-step approach, he wasn't limited by it. Working as a psychosexual therapist meant that a biopsychosocial approach was not new to me, for example, whilst erectile dysfunction is biological, you can't dismiss the psychological impact of performance anxiety or the social messages around masculinity. If I viewed sex addiction through a biopsychosocial lens, that explained why I agreed, at least in part, with Carnes, Coleman and Klein. I began to believe that I could provide an alternative model for sex addiction that could break through the controversy and hence protect clients from the shaming opinions and confusing viewpoints.

My interest and growing caseload with sex addiction clients was gaining recognition. I had been working as part of the Relate media team for many years, appearing on radio and television and speaking to the press, and I began to be approached to speak about sex addiction. Doing media work meant that I already had some experience of receiving criticism from professional colleagues, particularly those who don't understand how the media works. I was fortunate to be part of a supportive and experienced media team, but beyond that, I think my adolescent experience of coping alone gave me the resilience I needed. And like many adoptees, I was

used to feeling different, and being seen as different, when/if people found out I was adopted, so being ‘outside’ and being looked at is common for me. However, I was not prepared for the vehemence I received when I spoke about sex addiction. I was accused of pathologising healthy sexuality, of moralising pornography use and of jumping on an unethical, money making American bandwagon. I was shocked, but as far as I was concerned, I was speaking to the press so that people like my clients, and those who cared about them, could hear a more empathic and understanding voice and their needs were more important than the biased views of a few. But one criticism was valid, and that related to accurate diagnosis. I could answer challenges around nomenclature and conceptualisation, but diagnosis was still problematic.

The most common assessment tool at the time, and one that is still widely used in the US today, was the SAST (Sex Addiction Screening Test) (Carnes et al, 2010). I had undertaken this test personally and according to its scoring, I was a sex addict. I was not surprised by this result as the questions focussed predominantly on experiences of sexual shame, which, given my background, meant I would inevitably score highly. The growing body of writing on sex addiction (Schneider and Weiss 2006, Maltz and Maltz 2010, Collins and Adleman 2011) much of which was influenced by Carnes’ early works, cited shame and despair as key characteristics of a sex addict. But I knew that those emotions could be misplaced from childhood or socio-cultural messages, rather than due to the addiction. Furthermore, whilst many of my clients did describe shame, it was not necessarily about the behaviour, but more often about deceiving someone they loved. And whilst a few experienced despair, others were irritated or frustrated or simply annoyed that they were wasting time or money and wanted to stop. It seemed that the higher you scored on shame in the SAST, the greater the chance of being an addict. Another difficulty was that the result was either ‘yes’, or ‘no’ – nothing in between. Beyond my professional experience, I had personal experience of addiction. I was myself a smoker, who would sometimes smoke regularly for weeks on end and then quit for months at a time, before returning to recreational use and then greater dependency. My husband, or ex-husband as he was then, struggled with alcohol. He had been a drinker since his university years, but like me and smoking, he could have months, or even years, of controlled drinking, or total abstinence, before lapsing again into dependency. My experience was that addiction is not binary, it’s a continuum. A common quotation from the 12-steps is that saying you’re ‘a little bit addicted’ is like saying you’re ‘a little bit pregnant’, which I understand if you follow a pure disease model, but a range of severity of addiction is possible with a biopsychosocial model. I trawled the internet for other assessment tools and began to reflect on a model that explored the severity of

addiction, rather than a binary yes/no conclusion. I also began to question how Carnes' cycle of addiction could work if you removed despair. For me, these issues went beyond assessment, because if you removed shame and despair as defining factors, then the conceptualisation would be less influenced by a client's moral judgement of themselves, and more rooted in clinical observation.

The controversy around sex addiction continues (Reay 2013, Reid 2014, Grubbs et al 2015, Prause 2016, Ley 2018, Grubbs and Perry 2019). The World Health Organisation has accepted CSBD (compulsive sexual behaviour disorder) into ICD11 (World Health Organisation, 2019), as an impulse control disorder, rather than an addictive disorder. They have stated that they are taking a conservative approach whilst research continues and it may be moved to addictive disorders at a future date, as happened with compulsive gambling (Kraus et al 2018). Whilst this is a huge step forward, there are still many who equate the word addiction with pathologising normative sexuality. I chose to use the term addiction, and continue to do so, because we are a client-facing organisation and the terms sex addiction and porn addiction are the ones most widely recognised and used. In writing I often interchange the terms addiction and compulsion because the felt experience of so many clients is that addictive behaviours feel compulsive, and vice-versa. Ultimately, I believe the conceptualisation and treatment approach is far more important than the nomenclature, and I will always use the term that the client prefers.

Whilst writing this statement, a colleague publicly accused 'sex addiction therapists' of working in a way that is akin to conversion therapy by trying to stop sexual behaviours that are part of a client's innate erotic template (Kort 2020, Neves 2020). The accusation assumes that if you use the term addiction, then you will follow a disease model and an abstinence-based treatment approach. It is difficult to hear professional colleagues claiming you are working unethically, but changing the historic tide will take time. My contribution to turning this tide was to develop models that did not pathologise sexuality, models that broadened people's thinking, rather than limited it. But most importantly, I wanted to develop models that helped clients, and those who cared about them, to diagnose and understand their compulsive sexual behaviours and give them a choice of ways to overcome them. I wanted to help them find a way out of addiction that allowed them to celebrate and enjoy their sexuality without shame and secrecy; a way that could be self-defined and self-determined.

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The models

There was no way to win an argument with my father, but you at least had a fighting chance if you knew your Bible. Whatever conflict arose whilst growing up, my father's opinion would be upheld by referencing the Good Book, both chapter and verse. Hence, I learned from an early age the importance of research; of knowing the facts, who said what, where and when, but it took deeper study to know why. Unknowingly I became proficient in hermeneutics from an early age and learned how easily, and powerfully, words could be taken out of context and become meaningless, or even damaging.

Within the professional field, understanding psychological and medical research was a critical component of training as a psychosexual therapist and I discovered it was something I found stimulating and enjoyable. I reluctantly undertook my first piece of research in 2003, on the recommendation of my supervisor, and the experience has been significant in my ongoing professional development. In 2002 I decided to set up a service providing online psychosexual therapy. I was comfortable communicating online and I saw this as a practical way of building my private practice within what was, at the time, an untapped market. I enrolled on one of the UK's first ever training courses for counselling online and began building the website, sextherapyonline.co.uk. When I excitedly shared with my supervisor that I was ready to launch, she said I should first undertake, and publish, a pilot study. My obvious discouragement was met by a caution I have never forgotten – "don't under-estimate professional envy". She warned that my pioneering enthusiasm could be viewed as ignorant, or arrogant, or both, by my professional colleagues if I did not first evidence, through peer review, that my approach was considered and evaluated. In January 2004, 'Online psychosexual therapy: a summary of pilot study findings', was published in the journal Sexual and Relationship Therapy (Hall 2004) and I was subsequently recruited onto the ethics committee of my professional body to advise on working online and was also asked to deliver training workshops. My online work was met by some professional cynicism, but not by ethical objections, and I was able to reflect on how differently I could have been received by my colleagues if I had not heeded my supervisor's warnings. Whilst sextherapyonline.co.uk never became a reliable source of income for me, the lessons I learned about the importance of research have remained and underpinned the work I would go on to do in sex addiction.

What follows is an explanation of core models I developed for conceptualising, assessing and treating sex and porn addiction and an outline of the background research that was involved. The models are pan theoretical and hence are not dependent on, or lead to, any particular therapeutic modality. There are many different ways to view the psychological component of addiction and in an earlier paper I explored psychodynamic, systemic, cognitive behavioural and transactional analysis views (Hall 2011). I chose these theories because they reflected my training as a couple and family counsellor and continue to provide the framework for my clinical work, but as explained earlier, I do not get on with manualised, 'handbook' approaches to therapy and hence I felt it was important to develop models that could be viewed through any lens. Over the years I have been greatly influenced by the work of Mick Cooper and in particular his research on working at relational depth (Mearns and Cooper 2005) and the essential role of the therapeutic alliance in counselling outcomes (Cooper 2008). Hence, first and foremost, the aim of the models was to help clinicians understand, and therefore relate to, a client with sex or porn addiction with empathy, congruence and unconditional positive regard (Rogers 1957).

Each of the models were also developed from a desire to capture what felt like many complex threads into a coherent shape. I have always been a visual person and someone who finds it easiest to retain information from image and metaphor, and hence the models were a way of providing myself with an aide memoir of information to share, or explore, with clients and colleagues. Whilst there is an ever-growing body of research in the field, there is still relatively little, and it was scant when I began. An ongoing challenge is separating the research on porn as a medium from the impact of compulsive usage, and in particular, separating research on the ethics and morality of porn and sexual practices, from the impact of addiction to it. Whilst evaluating research, it has been essential for me to consider the context of the researcher, the subjects, the methodology and the journal. This is especially important as the shortage of research means there are almost no meta-analyses or systematic reviews. Hence, each of the models I developed were the result not only of research, but also observation of, and discussion with clients. It's hard to say when the models that follow were created as they evolved, and continue to evolve, as I continue to learn more about this field and more research becomes available, but all but the CHOICE Recovery Model were first published in 2013 in Understanding and Treating Sex Addiction, published by Routledge (Hall 2013).

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The BERSC model

The BERSC model is an expansion of the biopsychosocial model first theorised by Dr George Engel in 1977 (Engel 1977)within the medical and healthcare field. Biopsychosocial models have gained in popularity among addiction professionals (Griffiths 2005, Lewis 2011, Heather 2018) and it was first applied to sex addiction by Charles Samenow in 2010 (Samenow 2010). Whilst a biopsychosocial lens provided advantages over a pure medical model by allowing space for psychological factors to be explored along with a client's socio-cultural constructs and context, it missed some crucial elements when applied to sexuality. In theory, some of these elements could be encompassed by social context, but with the heightening controversy around sex addiction, I felt it was important to be explicit about the role of relational and cultural factors. Hence the BERSC Model evolved; an acronym that stands for Biological, Emotional, Relational, Social and Cultural. As you can see in figure 1, Biological equates to the bio of biopsychosocial, emotional and relational expand on the psycho of biopsychosocial and social and cultural expand on the social of biopsychosocial. (Hall 2011)

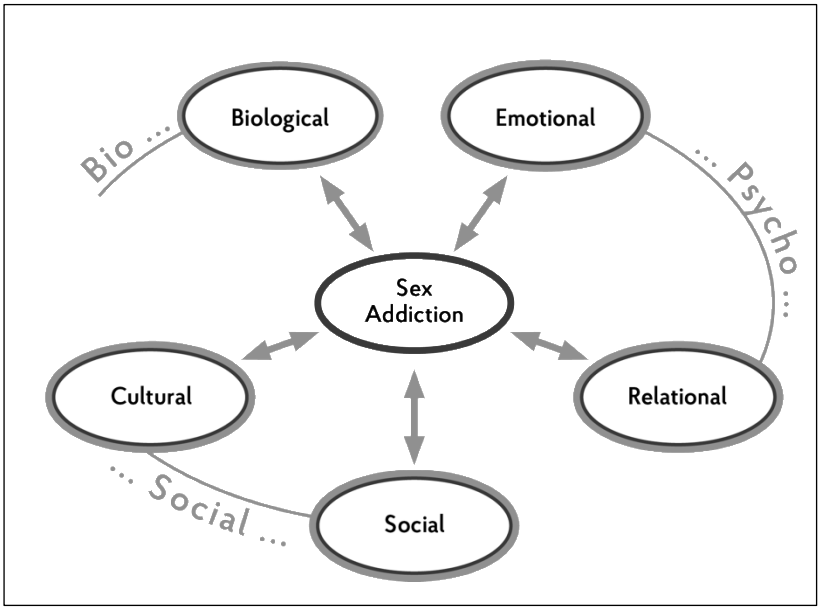

Figure 1, BERSC Model

When I originally drew the model, the arrows went in one direction towards sex addiction, indicating that each of these factors had an impact on the development, and understanding, of the problem. But as I explored further, I realised that sex addiction also directly impacts each factor. Emphasising this bi-directional process provided a mechanism to address a number of research controversies around correlation and causation. One amusing example of this was a Daily Mail headline which read 'Does porn make men stupid or do stupid men watch porn?', an article that was referencing research on the impact of heavy porn use on the grey matter of the brain. Whilst the bi-directional arrows couldn't answer the debates, it at least provided a conceptualisation that acknowledged they were there.

The field of neuroscience has grown extensively (Laier 2013, Voon 2014, Gola 2017, Seok & Sohn 2018) since the early writings of Carnes and there is now evidence that sex and porn addiction changes the brain, both in the reward centre through the influence of dopamine and the frontal cortex areas responsible for decision making and impulse control (Kuhn & Gallinat 2014, Love 2014). Whilst this could be seen as evidence to support a disease model of addiction, neuroscience was also teaching us that the distinction between biological and emotional was more complex than we had previously known and crucially, we were also learning that our brains are constantly changing and environment plays a key role (Doidge 2008, Kolb 2013). Learning about the biology of addiction enabled me to make sense of why behavioural change was often so difficult for people with addiction. The emotional factors were equally important and whilst I heard more and more clients talking about stress, anxiety, loneliness and low self-esteem as major triggers, they also described how their behaviours fuelled these very same emotions. Like all addictions, they used their behaviour to escape pain, only to discover it created more. I chose to highlight relational factors because my experience was showing how sex and porn addiction damages personal relationships in a way no other addiction did. In the therapy room I heard the pain of sexual betrayal from both the person with the addiction, and the partner, and worked with a growing number of people who felt unable to develop or maintain an intimate relationship because of their porn use and the impact it had on their sexual functioning. Another significant component of the relational factor that is pertinent to sex addiction is how a dysfunctional couple relationship can escalate the behaviours from an attachment perspective. Whilst it's true that a difficult relationship may lead someone to drink more, there is a level of solace and connection that may be found in, for example visiting a sex worker, that cannot be found in a bottle. I chose to separate cultural from social to provide more emphasis on the importance of exploring individual cultural factors such as gender, ethnicity, sexual orientation, religion and work culture. Broadly speaking we are all influenced by the explosion of the internet and increasingly liberal sexual attitudes, and the bi-directional arrows of the BERSC model indicate how demand for sexual resources reconstructs social norms, but that there is great diversity within society. Having worked with evangelical Christians, Ahmadi Muslims, members of the gay and poly communities, military personnel, city financiers, oil rig workers and sex workers, I learned how each has a unique experience and view of social mores and their own sexuality, and their own definition of addiction and compulsivity. For many of those opposed to the label of sex addiction, acknowledgement of cultural difference was the crucial missing piece. Furthermore, I increasingly understood how the cultural context of researcher and professional influenced their position and viewpoint. For example, Carnes was

mid-American, right wing, brought up in the days when homosexuality was a crime. His conceptualisation of sex addiction fitted his cultural perspective.

The BERSC model provides a view of sex addiction that bridges the gap between the traditional disease model of addiction and the reality that addiction is often a response to deeper psychological needs, whilst also emphasising the need to understand and explore sexuality from a culturally sensitive perspective. Furthermore, it provides a framework for a therapeutic approach that is sex positive and holistic. However, I soon realised that there was much more to consider when working within the psychological components of the model, i.e., emotional and relational, especially as porn addiction was becoming more prevalent along whilst new professionals in the field claimed porn addiction had no psychological cause. The OAT model explained below, was developed to conceptualise the most common psychological factors.

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The OAT model

'Addiction is an intimacy disorder' claimed Rob Weiss (Weiss 2005). As a gay man from Los Angeles, he had a refreshingly different approach to Carnes, but my clinical experience led me to believe attachment was not always at the root. Meanwhile Gary Wilson, an American researcher and creator of yourbrainonporn.com, claimed porn addiction was fundamentally different from sex addiction because porn addiction is not a symptom of poor attachment, but a consequence of biological brain changes (Wilson 2015), I found myself in the middle again of two opposing arguments believing that both of them were right, in part, and this was being backed up by my client experiences of working with young men from happy homes who became increasingly isolated as a consequence of their porn addiction. And whilst attachment disorders are common in other addictions (Flores 2004), I agreed with Wilson that the free availability of internet porn, combined with no education about risk, was distinct from most other addictions. Furthermore, it was nonsensical to me to separate porn addiction from sex addiction as so many of my clients were addicted to both; if we were to separate porn from sex, where do you put webcam sex and online sexchat? Making this distinction also seemed to miss a crucial point, which is that we become addicted to how something makes us feel, not the substance itself, so to separate them would be akin to having different concepts and approaches in alcohol

dependency for gin drinkers and whiskey drinkers. If Weiss and Wilson were both correct, we needed a model that recognised and validated the differences between addict populations.

Around this time, I was also greatly influenced by reading The Fix by Damian Thompson (Thompson 2012) in which he proposed that availability was a much-underestimated cause of addiction. The people who were writing about sex addiction in the 80's and early '90's were writing before the internet and smart phone explosion. Accessing pornography meant going to a newsagent or sex shop and visiting a sex worker involved finding a printed advertisement and telephoning for an appointment. Acting out on impulse could only be possible if you 'accidentally' found yourself in a red-light district. The internet revolutionised the way society could access sexual stimuli and sexual services. Al Cooper explained the rapid growth of compulsive online sexual behaviours with the Triple A engine (Cooper 1999), Accessibility, Anonymity and Affordability – the factors that reduce the usual inhibitors of seeking sexual pleasure outside of a partnered relationship. Furthermore, there was increasing evidence that the process of using the internet could itself be compulsive (Griffiths 1998). I had personal experience of this as I frequently used a computer game called Doom to relax and was often shocked by how many hours were lost in the game. I had also previously developed an interest in cyberpsychology and how the disinhibition effect (Suler 2004), could be used to the advantage of providing psychosexual therapy online (Hall 2004). Another significant influence on my learning was the notion of pornography as a supernormal stimulus (Barrett 2010); it seemed obvious to me that if one combined supernormal stimuli, the triple A engine, and no education or concrete evidence of risk, then there would be a growing proportion of society becoming addicted. And since there are no immediate harmful consequences, such as a hangover, come-down, or financial loss, many might find themselves becoming increasingly addicted without knowing it was happening.

By the time I was developing my models, the links between trauma and addiction were well documented (Carruth 2011) as were the function of addiction to reduce the symptoms of hyper and hypo arousal (Fowler 2006, Fisher 2007), but there was little that distinguished trauma from attachment. Coincidentally I found myself working simultaneously with two clients whose compulsive porn use was triggered by a single traumatic event in adulthood. One was a paramedic who had been signed off work with PTSD and the other had witnessed the near death of his 12 year old son. Both had secure attachments in childhood and hence I felt it important to have a distinct category for trauma.

The OAT model (figure 2) provided a framework to classify addiction as either Opportunity induced, Attachment induced or Trauma induced, or a combination of each. Whilst opportunity had to be part of each group, it could stand alone and the model gave space for those who had a secure attachment but had experienced a significant trauma. The model that was published in my first book in 2013 was a hypothesis, grounded in clinical experience, and partly supported by the results of the survey published in my first book, as were the proportions indicated in the diagram, but an ongoing online survey I developed as part of the self-help Kick Start Recovery Kit in 2013 has substantiated the model through self-report (Hall 2013). Of the 740 respondents, 39% said their addiction was purely opportunity induced, 32% said it was attachment induced, 13% trauma induced and 23% attachment and trauma induced. See Evidence part 1.

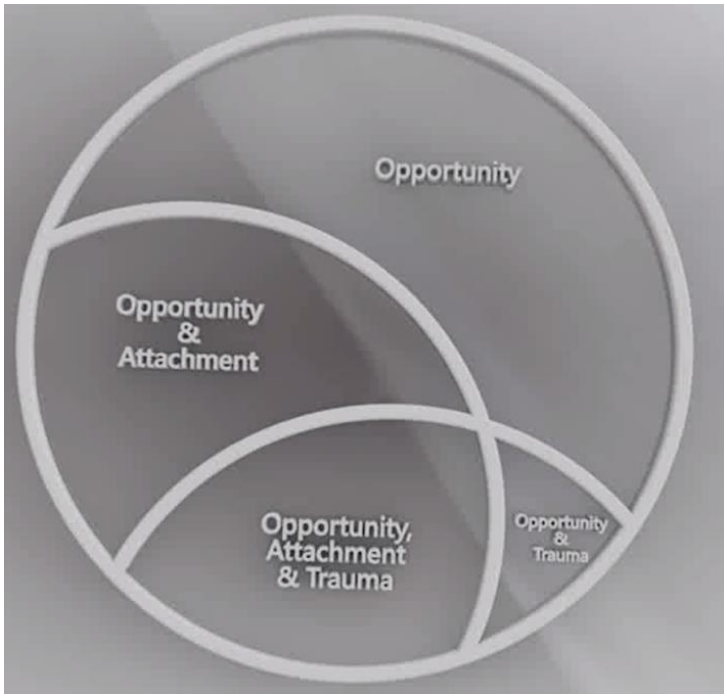

Figure 2, The OAT Model

Although I didn't know it at the time the OAT model would also become a critical component of assessment to prioritise therapy interventions, particularly where trauma was identified. For example, a client was referred to me by a colleague after being arrested for assault and vandalism. He was a heavy porn user who had completely ceased his porn use for three months at the time of the incident. Both he, his wife, his young children, whom he was with at the time of the assault, and his therapist were shocked and confused. Through assessment, we quickly ascertained that his porn use was a direct consequence of a series of significant traumas and his sudden withdrawal from porn had taken away his only defence mechanism against potential triggers. When trauma is identified the priority is resourcing the client to broaden their window of tolerance (Siegel 1999), not relapse prevention. Conversely the OAT model enables therapists to prioritise relapse prevention strategies for those with a purely opportunity induced addiction rather than searching for an underlying cause in childhood.

Having said that, it's important to remember that viewing addiction through the BERSC lens means that opportunity induced addictions will still have an emotional/relational component that will benefit from therapeutic exploration. As discussed earlier, none of the models determine the therapeutic approach or modality, but rather the focus of any intervention. Hence a trauma induced addiction may be worked with through EMDR or sensori-motor psychotherapy, whereas an opportunity induced addiction could be approached through CBT or ACT (Acceptance and Commitment Therapy). As a fan of psychodynamic theory, I am always interested in exploring the past and understanding its role in the present, but with an opportunity induced addiction I would place more emphasis on how unconscious issues block recovery in the present, than their role in developing the problem in the past.

As more research has been undertaken (Kuss and Lopez-Fernandez 2016, Pan 2020) we're developing a greater understanding of the magnetic draw of the internet in general as well as internet porn. Since developing the OAT model the ICD (World Health Organisation 2019) has accepted both online gambling and gaming as an addictive disorder and research is ongoing to classify other internet based addictions such as social media and shopping. The OAT model could be equally applicable in each of these areas to understand the client and prioritise treatment protocols and I hope this may be an area for research in the future.

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The six phase cycle of addiction

This is probably the model that I'm best known for as it is the one that resonates most with the experience of clients who struggle to understand why they keep returning to behaviours, in spite of their attempts to stop. It also provides therapists, whatever their therapeutic modality, with a clear model for change, namely personalising the cycle and getting off it.

When I first began working in the field I was aware of two models. The first was Patrick Carnes' four step cycle (Carnes 1992), which explained how sex addiction builds in intensity throughout each stage. It began with a 'preoccupation' step which he described as a trance-like state as the addict seeks their source of sexual stimulation, then 'ritualisation' as routines are used to build excitement and arousal, then the resulting 'compulsive behaviour' before the final 'despair' step where the addict is overwhelmed with shame and hopelessness. To escape the pain of despair, the addict will return to preoccupation with the behaviour and so the cycle begins again. With early clients I used this model, but for many it didn't resonate, either because they did not feel

despair, or they had no associated rituals. It was obvious to me why this model often didn't work and that was to do with technology. When Carnes developed his model we had no broadband or smart phones. By the time I was seeing clients in 2010 most homes had broadband and you could browse the internet on your smart phone. Inevitably this meant that people's sexual behaviours changed and the 'trance-like' state of seeking and ritualising were no longer necessary as you could access porn or arrange a sexual meeting within seconds. Furthermore, as discussed earlier in this paper, my experience with clients was that many did not feel despair, because differing sexual attitudes meant they experienced less shame. The other model I knew was one that was primarily used in treating adult sex offenders and developed by Freeman-Longo and Bays (Freeman-Longo & Bays 2000). The four phases were 'build up', 'act out', 'justify', 'pretend normal'. This model was easier to correlate with my clients' experience, particularly as it allowed for a period of relative normality. I heard many clients struggling to understand how their behaviour could be described as addictive, or compulsive, when they had periods of not 'acting out', sometimes for many months – the 'pretend normal' phase addressed this unlike any of the chemical addiction models, but 'justify' was happening before, as well as after the acting out phase.

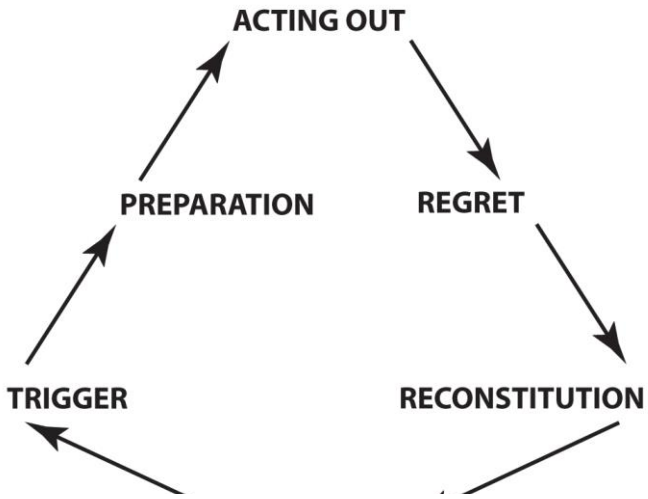

Figure 3, Six phase cycle

The six phase cycle (figure 3) includes a 'trigger' phase, which encompasses both environmental and emotional triggers; a 'preparation' phase where both practical and cognitive strategies are consciously or unconsciously used to enable acting out to occur; the 'acting out' phase; 'regret', which resonated with all clients, ranging from overwhelming regret and fear to mild frustration; 'reconstitution' which describes the process most sex and porn addicts go through to either hide their behaviours, or minimise their impact and finally the 'dormant' phase where unresolved issues and unmet needs reside. Initially I drew the cycle as a triangle with dormant at the bottom, but clients shared that there was a sense that they began to seek triggers or respond to them differently and so the diagram should build towards the trigger. Similarly, they felt the reconstitution phase was a gradual sink back to dormant, rather than a

sudden change, hence the sloping down. Other feedback from a few clients has been that the acting out phase should not be at the top, implying a crescendo to a peak, but more often, they are already beginning to feel regret and want to get the behaviour 'over and done with' so they can go into reconstitution and dormant. As this resonates with only a few clients I did not change the shape further, but when explaining the cycle, I always cite this difference.

Whilst the six phase cycle is probably what I'm best known for and what is most often used in treatment with accompanying worksheets to personalise triggers and cognitive distortions, it's also the model that has proven to have most limitations. Many clients who present with porn addiction do not recognise the dormant phase as acting out is more habitual and frequently happens on a daily basis. The preparation phase may also be less cognisant as the time lapse between trigger and watching porn may be the few seconds it takes to open a web browser. In these cases the cycle is often more useful for slowing the process of the behaviours down and injecting relapse prevention strategies into the phases as a client establishes recovery. Hence, they may not be aware of their cycle when in active addiction, but they become increasingly aware of it as they try to stop.

The six phase cycle was devised primarily as a psycho-educational treatment resource, but it has increasingly evolved into a tool that is also used as part of formulation. Whilst some clients can easily identify and personalise their cycle, others struggle, most commonly with issues in the dormant phase. Sex addiction, like all addictions, is an anaesthetising behaviour and until a client has a period without acting out, they may not know what they're anaesthetising against. I learned that personalising other areas of the cycle can provide crucial clues and bring the unconscious issues in the dormant phase into conscious awareness. An example of this is a client, I'll call Dave, who visited sex workers. His main trigger was being away on business where the triggers of opportunity and loneliness kicked in. He could easily identify his cognitive distortions in the preparation phase, of generalising 'all men do this', entitlement 'I work hard to provide for my family' and invincibility 'I'll never get caught', but he had no idea what was in his dormant phase. He described himself as very happily married with 2 children he adored and enjoying his successful career. He had a good sex life with his wife and described 'stumbling' on sex worker sites on a business trip abroad some years previously. His porn use was occasional and non-compulsive, but his use of sex workers was escalating and he came for therapy when his wife contracted an STI and he was forced to confess, at least in part, to his infidelity. Like his current life, he described his childhood as happy and content, in spite of his mother being

diagnosed with breast cancer when he was 13 and him being catapulted into a parenting role for his 4 younger siblings, a role he continued after his mother's death when he was 16. Whilst he rationally accepted this was a huge loss and a stressful time for the whole family, he didn't believe there were any ongoing emotional or psychological issues related to the tragedy. When Dave began personalising the acting out phase of the cycle by identifying the positive affect states he experienced when with a sex worker, he described feeling validated, affirmed and wanted. He went on to explain how he would spend many hours selecting the sex worker he wanted to meet and would always take her out for dinner and buy an expensive bottle of champagne for them to share. His eyes lit up as he talked about how interested the women were in him and how much he enjoyed their enthusiasm when he shared every aspect of his life. For Dave, this was the best part of the evening, and indeed, he often didn't have sex with them, though they offered to do whatever he wanted to please him. He agreed when I said that the real buzz for him wasn't the sex at all (as is the case for many), but was having the undivided attention and affection of a woman, where his needs were paramount, without any responsibility to give back. Having acknowledged this, he was then able to see what was missing in his childhood and, for the first time, he began to understand why this particular behaviour had become so compulsive. He had found a way of filling a hole that had been in his life for many, many years, a hole that he didn't consciously know he had.

The other benefit that I hadn't expected from the six phase cycle was how much it would teach me about my client group. Each worksheet that clients use to personalise the cycle has a box marked 'other, please specify', and over the years this has meant that my knowledge of common triggers, cognitive distortions, positives of acting out has grown and grown and grown. One example of this was the addition of 'creative' to the list of positives of acting out which I subsequently found is one that resonates with many clients, especially those who embody an alter ego in their acting out or who generate their own anime or manga porn. I have also learned that the worksheets are a useful tool for expanding emotional literacy. Whilst my natural fall-back position, particularly in individual therapy, is to ask clients 'what they feel', I'm increasingly aware that this is difficult for addicted clients to answer, which is perhaps understandable when you consider the function of addiction is to numb emotion. However, when a word is written down it seems much easier for clients to identify with it and it's common within the groupwork programme to hear clients sharing with each other, 'I'd never thought of it till I saw it written down'. There are an ever-growing number of worksheets that can be used within an individual or group environment, but it is of course important to ensure that the intervention is beneficial to

the client and is not separated from the development and maintenance of the therapeutic alliance.

Like the OAT model, the six phase cycle has also become a useful tool for prioritising treatment. For example, if someone presents for therapy in the trigger or preparation stages of the cycle their most urgent need may be to focus on therapy interventions that will prevent relapse. If they are in regret, a client's priority may be minimising or reducing the harmful consequences, particularly in relationships. whilst someone in the dormant phase may be more available to explore underlying issues.

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The SASAT (Sex Addiction Severity Assessment Tool)

The SASAT (Appendix I) was initially created in response to a request from Relate who were seeing an increasing number of people saying they were struggling with sex and porn addiction and needed a semi-structured assessment tool to help counsellors decide whether they were competent to work with the client or if they should be referred for specialist support. Having been a Relate counsellor for many years I had been asked to provide basic awareness training to Relate centres, but it soon became apparent that Relate Central Office (RCO) needed a protocol for how to work when clients presented. In consultation with RCO it was agreed that psychosexual therapists who had attended my training days could work with 'the milder end', but more severe cases would be referred. Hence, I was asked to develop a tool that would provide a measure of severity, rather than a binary, addict or not an addict, response.

It has long been my belief that we are all addicts to a lesser or greater degree to a range of benign or more damaging substances or behaviours. Common parlance talks of chocoholics and coffee addicts as well as problem drinkers and alcoholics (Alexander 2008), therefore it made sense to ask questions to ascertain the level of dependence as well as risk. As described earlier I was also aware of the pathologising and misleading nature of the most prominent tool available at the time, the SAST (Sex Addiction Screening Test), which relied primarily on reported levels of shame for diagnosis. Until Relate's request, the only written assessment I had was for training therapists and then for self-assessment within my first book. The 12 questions I used helped to identify sex addiction using Griffiths component model (Griffiths 2005); namely salience, mood modification, tolerance, withdrawal, conflict and relapse, but it gave a binary

response which I soon learned could be misunderstood and misused. Two examples of this; firstly, a professional colleague who skewed the questions within a videoed conference to demonstrate how sex addiction pathologises LGTBQ communities (Davies 2016); secondly a client who, to my amazement, managed to answer yes to all but one question even though he masturbated to porn only once a month. Hence, the need for a more sophisticated tool became apparent, not just for Relate, but for training and the second edition of the book.

The SASAT was designed to be used by a therapist, not as a self-assessment tool, and any client who accesses it within the book, or the shortened version on our website, is strongly advised that this is an indicator only and encouraged to discuss it with a trained therapist. It begins with six questions that ask about longevity of the problem and history of other addictive or compulsive problems and also asks about tolerance, which is key to diagnosing addiction. There is also a question about trauma which is not specifically related to diagnosis, but I believe is an essential assessment question for ethical practice, as is a later question on suicidality. The subsequent 10 questions are scaled to ascertain level of acting out, emotional dependency and risk arising from harmful consequences and the results can be totalled to give a score. The scoring system follows the same protocols of CORE OM which we use for outcome measures. The final score range indicates mild, moderate or severe addiction, but only when combined with other key information. For example, a client whose score may be mild, but says there is a high chance they would commit suicide if they acted out again, would then be worked with as if the addiction were severe; and someone whose score was moderate, but has only been acting out for two months, would be worked with as if the addiction were mild. To date, the tool has not been validated for reliability or validity, but this is something I would very much like to undertake in the future. It is not an area of research that I know much about so I would want to collaborate with a psychologist with experience in this field. However, the scoring, along with therapist's experience, has made it a useful assessment tool for Relate as well as many other independent therapists.

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The CHOICE Recovery Model

A question I was often asked at early presentations and by readers of my first book was 'so how do you treat it'? Coming from a pluralistic tradition I found this particularly difficult to answer and would often simply say 'personalise the six phase cycle of addiction so you can help the client

get off it'. This was certainly true, but the cycle missed crucial interventions such as exploring positive sexuality and building motivation. Furthermore, it reduced the therapeutic goal to stopping the unwanted behaviours, rather than building a happy, fulfilled, recovered life. Hence the CHOICE Recovery Model was developed and first published in the 2nd edition, Understanding and Treating Sex and Pornography Addiction (Hall 2018).

CHOICE is an acrostic to highlight the stages of recovery that anyone with an addiction needs to work through and hence it became a treatment roadmap. But it is more than that: the CHOICE Recovery Model also encapsulates my philosophy to addiction recovery, namely that people have the right to choose how they want to live, but addiction robs them of that choice. Recovery is not simply about stopping compulsive behaviours, but about choosing a different way to live. The CHOICE stages of recovery are briefly described below.

C - Challenge core beliefs. My experience with clients had taught me that one of the biggest blocks to recovery was negative thinking patterns and self-limiting core beliefs. Broadly speaking these fell under three headings; 'I don't need to change', 'I don't want to change' and 'I can't change'. Therapy is most effective when it addresses denial, motivation and low self esteem. The OAT model is useful here to identify beliefs that may be rooted in disordered attachment or trauma.

H – Have a vision. There are two ways of looking at addiction recovery: either you can see it as giving something up, or you can see it as starting something new. In my experience, helping clients focus on the latter is more successful and hence creating a vision provides motivation and momentum.

O – Overcome compulsive behaviours. This is the stage where the six phase cycle is personalised and practical relapse prevention strategies are developed to stop the unwanted behaviours.

I – Identify positive sexuality. Being in recovery means giving up addiction, not giving up sex, so working with a client to identifying what positive, non-compulsive sexuality means to them is essential for long term success. If there are sexual dysfunctions, psychosexual therapy may be indicated.

C – Connect with others. Author and broadcaster Johann Hari has become famous in the addiction world and beyond for his quotation 'the opposite of addiction is connection' (Hari 2019). As explored later, groupwork is one of the most effective therapeutic interventions in this

phase, but this may also include couple work and help in individual therapy to build stronger friendships and family connections.

E – Establish confident recovery. There's a saying in 12-step that I love: 'recovery is not about what you give up, but what you take up'. This stage is where therapy can encourage and support clients in developing a positive and healthy lifestyle to strengthen recovery and avoid relapse.

Other models

In addition to the models described above, a number of other models have been developed. One that has proven particularly popular is an illustrated metaphor to explain the neuroscience of sex and porn addiction and how to overcome it. Another is a cycle to explain the impact on partners and why they so often react in ways that are alien to their identity. There is also a life wheel exercise used both by partners and the addicted partner to rebuild their lives and another metaphor model for couples and couple therapists to understand the stages of recovery for couples. Further information on each can be found in Appendix II.

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Applying the models in clinical practice

Throughout the time that I was developing the models I was continuing to work as a lone practitioner in private practice. Having published five books, two on sex and three on relationships, I was keen to publish a book on sex addiction, but my agent could not find a publisher who felt there was a market for the title. Initially application of the models was in individual counselling sessions with pen and paper; they were hypotheses that resonated with clients and I began to share them in supervision and within supervision groups. Today they are published in books and papers and taught to therapists, which I will explore in the next section, 'Sharing the learning', but here I'll focus on application in clinical practice.

Whilst controversy was a key driver in developing the models and working in the field of sex addiction, developing my clinical practice was primarily motivated by financial need. I have been the main income producer for my family since my first husband was made redundant in 2001. What little assets we had were depleted by our divorce in 2003 so I had to find a way to provide a home and support my two growing daughters alone. Having worked in advertising and

marketing for six years prior to counsellor training, I had knowledge and experience of both promotional and strategic marketing. I knew it wouldn't be easy to earn a living as a general therapist, nor as an author, so I decided to build my practice by specialising in what I believed would be an expanding field of sex and porn addiction.

As my clinical practice grew, the models became the bedrock of what would become the Laurel Centre and the Hall Recovery Course, both of which are shared below. As explained earlier, the models did not depend on, or lead to, any particular treatment approach, but provided a foundation and a roadmap for helping people quit their addiction. Following assessment with the SASAT, most clients will be encouraged to have individual therapy to provide focussed depth work for unconscious issues and to explore positive sexuality, and join a groupwork programme to develop relapse prevention tools, though some are referred from external therapists specifically for group. All of the models are applicable to both individual and groupwork, some may be explicitly shared with the client, others may simply inform the work - whichever works best for the client and therapist.

The Laurel Centre

The Laurel Centre was founded in 2017, formally Paula Hall & Associates, and before that, just Paula Hall. Over the past eight years, I have gone from being a sole trader in private practice, to director of two limited companies with two centres, London and Leamington Spa, 18 freelance clinical associates, a full-time practice manager, a part-time communications executive, a part-time programme director and a part-time bookkeeper. In addition to training which I'll cover later, we provide individual and couple therapy from the two centres and also from a number of regional locations where associates are based and also online via zoom video conferencing. We deliver a monthly six-day residential groupwork programme and a partner residential and couples residential three times a year, all from Leamington Spa. We also deliver bi-monthly workshops for partners and people presenting with addiction from the London office and an intensive recovery course. As an indication of numbers, in 2019 we provided individual or couple therapy with over 550 clients.

In early 2015 I met a friend at a conference where I was speaking and he asked how work was. I described how I had spent the last five years feeling isolated and alone, pushing an ever-growing heavy boulder up a hill with numerous spectators watching and wondering why I was

bothering. Now I was over the summit and the boulder was rolling away from me, getting faster and faster and I was chasing it. In other words, business was booming and I had no idea how to keep up. I had taken on more associates and bigger premises and developed more programmes; I was spending more and more time on admin and less and less seeing clients; and whilst turnover was increasing, the bank balance was decreasing. My friend asked if I would like to meet a friend of his, a recently retired business consultant, who liked helping small businesses, especially interesting ones. I jumped at the opportunity.

Business ethics

I first met Rod Street in May 2015 and he asked me what my goals were for the business. The answer was to provide effective, accessible and affordable help to people struggling with sex and porn addiction and to those who cared for them. As will be seen in the next section, I had already been involved with the professional body ATSAC (Association for the Treatment of Sex Addiction & Compulsivity) and had been delivering training for some years, so this ambition wasn't specifically a business goal, but rather a personal one. Writing, training and speaking on the topic, whether paid or pro-bono, was equally part of the plan, not just delivering therapy. But as the volume of work increased, I was getting stretched ever thinner and frankly, was heading for burnout. Rod asked many other questions and when he returned two weeks later, having undertaken his own research, his advice was that I should double my fees and start seeing clients in London where I could charge even more. The rationale was two-fold. Firstly, it's much easier to reduce fees for those who can't afford them than to put them up for those who can, and secondly, if I wanted to continue to do pro-bono work, without collapsing with exhaustion, I needed to charge more when I had the opportunity.

I found myself thrown into a moral dilemma. I needed to work fewer hours and earn more money, so this was the logical way to solve the problem, but charging clients more to see me than an associate felt egotistical and charging clients different amounts for exactly the same therapy service felt unfair. Working through these dilemmas with Rod, a highly experienced business consultant, helped considerably. He would ask why a therapy business was different from a legal one or accounting, where rates could vary widely. And why was it ok for a medical professional to earn one fee in the NHS and another in the private sector? Most pointedly, he asked "how much is your service worth"? The ethics of charging for therapy is complex and can cause many inter psychic, and intra-psychic conflicts (Myers 2012), but as Rod continually

pointed out, anyone who does pro-bono work is funded from somewhere, if not by their own efforts, then someone else's. I followed Rod's advice and increased fees across the board, for individual therapy and groupwork programmes. It was made clear to clients that we had a flexible fee structure as well as interest free payment plans, and low-cost options. In 2017 we began a bursary scheme for our groupwork programmes which is managed by a registered charity and is funded through an annual 10% of profit donation from the Laurel Centre and donations from previous course attendees. At first, I felt uncomfortable with the disparity between fees, but being completely transparent about it has proven to be welcomed by almost everyone. The wealthy, be they clients or organisations, seem even more content to pay when they know that others less able to afford the service are not turned away.

Becoming a team

Becoming a business, and a team, has been both a blessing and a curse. The greatest blessing by far has been the camaraderie of the team and the ongoing support and learning that a team brings to me personally, and to the practice. We have grown rapidly and the geographic spread, from Plymouth to Leeds, has brought many challenges, not least, staying in touch with each other. Over the past three years we have established a pattern of having two practice meetings a year with a social in the evening and a CPD event the following day. One of the CPD days will be with an external trainer and the other is skill sharing within the team. All associates are experienced therapists who have undertaken additional training in sex addiction, but we come from different therapeutic backgrounds and have varying fields of interest. Hence our skill sharing CPD includes topics such as working with autistic spectrum disorders, EMDR, hypnotherapy, internal family systems, embodiment and erotic transference.

On a more personal level there are other joys and challenges of being part of a practice team. My greatest joy is being able to provide work that my associates love doing. I have the privilege of witnessing this when I hear them talking to each other about the work and particularly when a new member joins the team. For example, hearing them enthuse about groupwork and praising a colleague and just generally laughing and joking together. Seven members of the team gave up full-time employment to work at the Laurel Centre and each of them describe it as the best decision they ever made and, whilst I feel honoured to hear this, it is also anxiety provoking. The Laurel Centre is now responsible not just for generating income for myself, but also for many

others, including some with mortgages and children and no other source of income. When business is quiet, knowing this can result in sleepless nights.

Policy Development

The challenge that being a team brings is twofold; administrative systems and clinical policies. At times these are quite separate issues, but often they interrelate and like the models, they are constantly evolving as I learn.

One example of this was triggered by a complaint that was made against one of my associates just over three years ago. The associate had taken on a Laurel Centre client, a married man with sex addiction and then began also to work individually with the spouse. As a practice we had a verbal agreement that if a partner, or couple, wanted therapy, they would work with a different therapist, but my associate did not abide by this and became caught in the drama triangle (Karpman, 1968). The complainant asked me to handle the complaint and stated that if he wasn't happy with the outcome, he would take the associate to the BACP. As an organisational member of BACP, this was an appropriate process. A number of practical issues became apparent. Firstly, our good practice guidelines were verbal, not written and secondly the associate contract focussed almost exclusively on confidentiality and fees and had no mention of handling complaints or fitness to practice issues. Fortunately, the associate was fully cooperative with the process and we now have written good practice guidelines, a more robust associate contract and a formal complaints procedure. Karpman's triangle went beyond the clients and associate though as I found myself oscillating between a desire to rescue my associate and feeling victimised by the client. But then on other occasions, being asked to rescue the client who felt victimised by the associate. I also became aware of a parallel process between what I was experiencing with my associate and many partners experience with their addicted partner. I felt angry, betrayed and taken for granted, but I also felt compassion when confronted with my associate's remorse and fear of loss. The parallel went further in as much as it has become a secret within the practice as most other associates are unaware of what happened, in the same way as addiction so often becomes a secret within the couple's family and community.

Another policy issue we found we urgently needed to address was with regard to working with clients who have viewed child sex abuse images. We were seeing a growing number of clients

disclosing offending behaviour who were not in the judicial system and some who were under investigation and wanted us to write court reports. Hence, we needed to develop policies to protect the practice, the therapists and the clients. In consultation with Dr Andrew Smith, a specialist in offending, we created a supplement to our working agreement for those who offend and developed a risk assessment tool based on RSVP (Hart et al 2003) and SAPROF (Vogel et al 2011).

GDPR was another significant challenge for the Laurel Centre with so many regional associates who needed to relay data securely to our central office in Leamington Spa. I extensively researched other practice policies and consulted with the BACP and other professional bodies and found nothing that we could use. Therefore, I worked with a data protection consultant to draw up our privacy notice and data protection policy and we engaged an IT company to develop a bespoke, cloud-based, client management system. Inevitably this resulted in further amendments to our client working agreements and further training of the team and admin staff to use the new system. It was both costly and time-consuming, but I am confident that we now have an ethical and robust data management system. Furthermore, the new system provides the opportunity to analyse client work by geographic area, referrer, associate, risk factors and so on.

As we developed more and more policies and more and more online systems, it became apparent that we also needed a comprehensive handbook for staff and associates to communicate this. This is constantly updated and contains all the information required to ensure the practice runs smoothly and ethically – what I haven't yet resolved is how to ensure staff and associates read it!

The Laurel Centre continues to grow and evolve. Our current goals are to develop services that could be delivered through the NHS, universities and the Crown Prosecution Service for offenders. We are also exploring a subscription based digital service that might be delivered online or through an app. More immediately though, we're all focussing on how to survive the Coronavirus.

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The Hall Recovery Course

In 2008 I attended a 4-day training workshop with Thaddeus Birchard who delivered groupwork for sex addiction in London and having read further about groupwork with addiction, I was keen to provide a programme in Warwickshire. In addition, groupwork had the potential for being more profitable than individual therapy. I began developing my own groupwork programme, branded as the Hall Recovery Course, based on Birchard's weekly format incorporating my models, but I knew of no male therapists to co-facilitate. Unperturbed, later in 2008 I delivered the first Hall Recovery Course, co-facilitated by my new husband-to-be, who, though not trained as a therapist, was experienced in working with psychosis groups within the mental health service. Whilst I took responsibility for delivering the psycho-educational content, Steve was responsible for group dynamics. My early attempts at groupwork were rather chaotic as I attempted to deliver individual therapy to eight clients in the same place, at the same time. To my surprise, clients were revealing considerably more information than in individual work and often became overwhelmed with emotion. As Steve had no experience of individual work, he trusted the group process more than I did and whilst I would worry about how to intervene therapeutically, for example, on the revelation of child abuse, Steve would respond 'ask the group', or 'the group will hold it'. He helped me develop a mantra that I continue to this day, 'the group is my client', not the individuals within the group. Furthermore, I learned that the group really could 'hold it' if I ensured the focus was equally on process as on content.

In early 2012, a former colleague from Relate, Nick Turner, attended one of my CPD days on sex addiction and I was delighted that he agreed to co-facilitate groups with me. I was grateful to have learned a lot about groups by working with my husband Steve, but I discovered working with another therapist gave an additional depth and perspective that had previously been missing. Equally as important, it gave me additional support in the group and Nick and I soon learned how to work with, not only the process between group members, but also our process as facilitators with each other, and with other group members. After much searching, we found someone to supervise us specifically with our groupwork, Chris Rose, a UKCP Group Analytic Psychotherapist. Chris has been, and continues to be, invaluable to the development of myself personally as a groupwork facilitator, and to the other group facilitators and also to the practice.

Due to the growing number of enquiries from beyond the Warwickshire area, in late 2012 Nick and I delivered our first residential groupwork programme in a local hotel. When I look back now I realise what a bold step this was, but at the time, the reasoning was purely pragmatic. Beyond

knowing that there were practices in the US that offered residential treatment for sex addiction, I had no experience and no format. I adapted the existing weekly programme to fit a different schedule. The residential was undoubtedly more profound as group members were cut off from other distractions and bonded deeper with each other over dinner and breakfast. Each morning Nick and I would return to the hotel to what seemed to be a different group and this experience, perhaps more so than any other, cemented my trust and belief in the group process.

Why group works

Groupwork has been widely written about in the treatment of addiction (Flores 2007, Reading and Weegmann 2004, Wenzel et al 2012, Yalom and Leszcz 2005) and more recently in the treatment of sex addiction (Nerenberg 2002, Birchard 2018, Griffin-Shelley 2018). The residential programme appeared to be, not only more profound, but also more effective than the weekly course and my colleague Nick Turner, or Nick Picky, as we affectionally call him in the team because he is such a stickler for detail, encouraged me to begin evaluating the groupwork. We were now delivering approximately three residentials per year and one or two weekly programmes and in 2014 we started to use CORE OM and a supplement to specifically measure acting out behaviours. One of the first things we learned from CORE was the alarming level of suicidal risk. I was already aware of suicidal risk within this client group as the survey undertaken for Understanding and Treating Sex Addiction (Hall 2013) had indicated 19% of the 350 respondents had felt actively suicidal as a direct consequence of their behaviours and whilst we asked about suicide risk on the SASAT assessment form, it became apparent that clients were often not disclosing in one-to-one therapy, but would self-report when completing CORE. This information allowed us to work more ethically and directly address the risk with the individual and/or within the group. We began summarising the CORE data in 2016 and discovered a recording error which meant we had to scrap the data and start again. Latter results have subsequently been published (Hall and Larkin 2020). We have learned much from the data. Firstly, we learned that the compliance for completing forms when not in person, i.e., the six-monthly intervals, is very poor, hence we have little longitudinal data. Secondly, we learned that our residential programme is significantly more successful than the weekly programme and hence we stopped the weekly programme and are currently piloting an alternative intensive format in London. We also learned that whilst there is a significant reduction in acting out behaviours, general psychological distress remains the same for 30%

and worsens for 30%. This has resulted in further development of our aftercare groups and providing each group member with an aftercare plan on completion of the course.

In addition to the CORE evaluation, we also evaluated the elements of the course over a two year period. At the end of the course, whether weekly or residential, we provided each member with a list of the psycho-educational elements of the course, and the process elements, and asked them to put them in order of importance. Whilst there were a few variations, the psycho-educational element of personalising the cycle of addiction and the process element of story-telling were consistently in the top three. We used this evaluation to change the programme further, dropping some elements altogether and making more time for others. We have also recently undertaken a piece of qualitative research exploring clients' experience of groupwork (Hall et al, 2020) using Yalom's therapeutic factors (Yalom and Leszcz 2005). The results of this research has helped me to understand more fully why groupwork is so powerful and we now put even greater emphasis on group cohesiveness and catharsis, particularly around shame reduction.

Diversification

Over time, the Hall Recovery Course has become more widely known and we receive ever more enquiries and referrals from other therapists and health professionals. Consequently, I have needed to take on more therapists to deliver the groupwork programme, and to provide individual therapy to the clients before and after group. In addition, two Relate Centres, Oxford and Nottingham, began delivering the programme within their centre under licence as did a therapist in Amsterdam. Practices in Copenhagen, Dubai, Johannesburg and Helsinki also have a licence, but to date, none have delivered a course. All of this has been driven by demand.

As the client base grew, specific client groups began to emerge, such as women struggling with sex and porn addiction, Christians and gay clients who often had con-current drug issues. At the same time, therapists were coming on board who had specific interest and experience with these client groups who felt the programme could be tailored to the specific needs of the client group. This resulted in developing separate recovery programmes for Christians, ChemSex and women. The success of these special client group programmes has been mixed, primarily because of the difficulty of having enough clients presenting at the same time to form a group. Most people approach our service at a time of crisis and hence do not want to wait six months

for a group to begin, hence they would join a non-specific group. We have subsequently stopped advertising our Christian and ChemSex groups and will only form them on an ad-hoc basis when there is sufficient demand. To date, 328 people have attended a Hall Recovery Course at the Laurel Centre, 32 of which have been international clients.

Another way that the programme has diversified has been through delivering it online via Zoom. Initially I adapted the course pro bono, following a request by the Naked Truth Project, as an eight week online group that could be delivered by trained mentors. Named Click2Kick, this provided them with a vehicle to help others at low, or no cost, and they have delivered approximately 40 courses. Within the Laurel Centre we also deliver the online course in an eight week format and have just completed piloting a shorter, intensive format as a consequence of lock-down restrictions caused by Covid-19. We have delivered nine online groups since the start of Covid-19 and are awaiting the results of CORE to see how these compare to face to face groups.

Whilst I was seeing the profound impact that groupwork was having on people with addiction, especially in terms of reducing shame and providing a long term support network, I wondered if the same would be true for partners who often feel desperately alone and isolated. In 2013 the Hall Recovery Course for Partners was launched and this has been delivered in both a weekly and a residential format. It's designed to complement the addict groups for people presenting with addiction by giving the same psycho-educational content on understanding sex and porn addiction, but the focus is primarily on helping partners recover from betrayal trauma. We do not currently evaluate the partner programmes and have not undertaken any research, but data collected from feedback forms and testimonials demonstrate that partner groups are greatly valued (see Evidence part 3).

The most recent addition to the Hall Recovery Course has been the couples residential which I developed and delivered for the first time in August 2019. I was sceptical about delivering groupwork with couples, but following the publication of my book for couples earlier the same year, clients were requesting the service. The programme is based on the three-stage model on which the book is based (described on page 39 under background research for writing) and the process element is founded on systemic reflective teams to provide the opportunity for each part of the couple to witness being in another chair. I have been blown away by the power of these groups and the feedback has been amazing (see Evidence part 3). Like the partner

programmes, to date we have not undertaken any formal evaluation or research on these groups, but I hope to do so in the future.

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Sharing the learning

It was never my intention to become known as an 'expert' in the field of sex and porn addiction: like my models, this has been something that has evolved. Sharing the knowledge has developed in three key areas, writing, teaching and public speaking, as expanded on below, but my first experiences of writing and talking to professionals was much earlier whilst working for Relate. Due to my marketing background, as well as being a counsellor, I had worked with Relate on local and national marketing initiatives and in 2001 I was invited to join the media team as a spokesperson on sex and relationship issues in the press and on regional and national radio and television. As my husband had recently been made redundant, this was a financial lifeline, though a terrifying one. The media exposure provided the opportunity to author five books on sex and relationships, particularly divorce, which was regrettably close to my heart at the time, and I began training and speaking at conferences on behalf of Relate. These earlier experiences were undoubtedly a training ground for the work that would follow in sex addiction.

Another contributing factor in my development as someone known in the field began in 2009 when I was invited to be a founder trustee for ATSAC, Association for the Treatment of Sex Addiction and Compulsivity. We met four times a year, organised an annual conference and in 2011 we launched the first ever UK training in sex addiction, the Professional Certificate in Sex Addiction. I went on to become Vice Chair for two years and then Chair for three years before resigning from the trustee board in 2015. Whilst my role in ATSAC was influential in becoming known by other professionals as someone who specialised in sex and porn addiction, it was through writing, training and public speaking that I had the chance to share what I'd learned, and indeed, learn more.

Writing

I began writing at 20 years old when I was working in an advertising agency in Brighton and I continued to copywrite within a variety of marketing positions until I began therapy training. Copywriting then switched to writing for local Relate centres, various media channels as part of the Relate media team, then authoring books and professional articles and papers. I am

fortunate that I love writing and it has always come relatively easily. For me, writing is undoubtedly a flow activity, though getting the flow started can at times be agonisingly slow.

Books

When I received the commission from Routledge to write Understanding and Treating Sex Addiction (Hall 2013) it was with the proviso that it was written as an academic title for professionals, not a self-help book which was my usual style. At the time, other self-help publishers had turned down the title because they didn't believe the market was big enough, but Routledge saw a gap in the academic market. My book was to be the first book on sex addiction in the UK and the first in the world to be written by a sex therapist. It was a daunting task that took an arduous 12 months to write and with a meagre advance, I had to continue to work throughout, but the kudos of writing for Routledge was undoubtedly instrumental in providing the subsequent opportunities to teach and speak.

One of the chapters in the book was about the impact of sex addiction on partners, but I soon realised it was a topic worthy of its own book. Routledge understandably wanted to see book sales of the first book before commissioning another, but they were confident enough 12 months after publication to commission Sex Addiction: The Partner's Perspective which was published in 2016 (Hall 2016).

Shortly after completing the book for partners, I was asked by the Naked Truth Project, a charity that works in the field of pornography education and addiction, to write Confronting Porn: A Guide for Christians (Hall 2016). I had been a behind the scenes consultant for Naked Truth and had been providing my materials and time gratis for a number of years before this approach, but being asked to write a book posed a significant dilemma for me. On the whole, I had managed to be professionally discreet about my faith, but publishing a Christian book would require coming out of the closet. There are many conscious and unconscious assumptions and prejudices about Christians, both in and out of the therapeutic world; biases that, on the whole, are not projected onto other faiths, such as Islam or Judaism. I had been a victim of these prejudices in the past, before specialising in sex addiction, and hence I was anxious about the effect an awareness of my faith might have on people's opinions of my work. I felt I was taking a risk, but hoped that my credentials were strong enough to withstand any attack, or indeed, that most might never know! But I also felt strongly that writing a book for Christians gave an

opportunity to demonstrate that there are multiple Christian perspectives, not just one. Indeed, one of the biggest challenges in writing this book was ensuring it was non-denominational and appropriate for readers from any Christian context, from evangelical right-wing to deconstructed liberal. I would describe myself as closer to the latter and hence another challenge was writing from an inclusive, sex-positive perspective without offending more conservative readers. Approximately 1,500 copies of Confronting Porn have been sold so far, all royalties going to the work of the Naked Truth Project. As can be seen in the reviews in Evidence Part 1, I failed not to offend some evangelicals!

In 2018, I was commissioned by Routledge to write a book on sex addiction for couples, but before doing so I felt strongly that I needed to update the first book with a second edition. Although it was only five years since writing the first, I had learned a lot. Most significantly, through the ongoing client work and development of therapeutic services, I had learned the difference between sobriety and recovery and felt my first title had fallen short of communicating this. Furthermore, 'pornography addiction' was now a term gaining independent recognition and there were an additional 50+ research papers available since my first title which meant much of the research needed updating. I also had much more experience of working with women and gay men with sex addiction as well as working with people who crossed the line into offending. So where in the first edition these topics had a paragraph, in the second edition, each had a chapter. Understanding and Treating Sex and Pornography Addiction (2nd Edition) (Hall 2018) was published in Autumn 2018 and Sex Addiction: A Guide for Couples (Hall 2019) was published in 2019.

Background research for writing

Ten years of working within the media has made me cynical whenever I hear or read the words 'research shows', because there are so many ways of conducting research, some more academic than others. My options were limited by time, finance and, to a certain extent, experience, but I wanted my books to have some grounding within the experience of people struggling with the issues the books were aiming to address. Hence the surveys I undertook were informal, background research, rather than academic. For the first two books I used Survey Monkey and sought the opinion of other therapists working in the field before finalising the questions and posting the surveys online. My goal in each survey has been three-fold; to collect basic profiling data, such as age, gender and sexual orientation; to test hypotheses

relating to my models, approach and clinical experience and to collate the voices of experience for the reader to relate to.

My desire to test my hypotheses meant of course that the questions were biased towards that objective, as discussed below, but I wanted to ensure I went beyond my client base whom I did not deem to be a robust enough sample. I remember a colleague who ran a prestigious practice just off Harley Street in London telling me that 'all sex addicts are rich and successful men'. That was not my experience in Leamington Spa and I realised the difference in client groups was due to our practice location and fees, not the clients. Hence, I realised my clients worked with me because they already agreed with my concepts and approach, and my concepts and approach were being strengthened because they resonated with my clients. I knew therefore that I needed to try to reach clients who were working with other therapists and ideally, participants who weren't in therapy. Examples of background research are offered in Appendix III.

In preparation for Understanding and Treating Sex Addiction (Hall 2013) an invitation to answer the survey consisting of 30 questions was sent to clients, both my own, and those working with other therapists, and an advert was also posted on the Relate website where I hoped people may look for help. In total, 350 people responded, 75% male and 25% female, which was a much higher proportion of females than I expected. 280 of the responses were from an advert on the Relate website, 70 from personal invitation. In support of my OAT model hypotheses, 70% reported no experience of trauma or attachment issues. There was also a variety of questions that explored the role of relationships and emotions which, when linked to the opportunity questions, gave further weight to the BERSC model. For me, the most significant consequence of the survey was how it cemented the devastating impact that sex addiction has on people's lives and how hard it had been for most of them to find help. As I came to analyse the data, I realised I had failed to ask about ethnicity and faith orientation. Whilst this was not of particular interest to me at the time, I now believe this would have been useful data to have. The biggest failing in the survey was with regard to asking about the genres of pornography that were viewed. 'Teenage' is a popular search term and I wanted to differentiate this from those who viewed child images. I was surprised by the results with nearly 10% viewing child and over 50% viewing teenage. What the data failed to differentiate was those who viewed images of 13-17 year olds which would also be illegal, from those who openly confessed to viewing prepubescent images. A sample of survey responses is offered in Evidence part 1.

126 partners responded to the survey, consisting of 40 questions, for Sex Addiction: The Partner's Perspective (Hall 2016). 86 were either existing clients, or partners of clients, and the remainder responded to an advert on the Relate website. In this survey I was keen to explore the issue of co-dependency. Having worked as a relationship psychotherapist for many years I had never been comfortable with the label of co-dependency for partners of sex addicts and it did not fit with my clinical experience, nor indeed the experience of others (Steffens and Means 2009). The starkest reading was the pain that the partners experienced, including shame and self-blame. One of my hypotheses when designing the survey was that the way a partner found out about the behaviour would impact their emotional response. This was certainly true, but what became apparent was that they were all equally as painful, but in different ways. In addition to incorporating these insights into the book, it also enabled me to develop greater understanding, and empathy, with the varying reactions of partners to disclosure and/or discovery.

When I received the commission for Sex Addiction: A Guide for Couples (Hall 2019) I chose to undertake a qualitative, rather than quantative survey. Although I have worked with couples for 25 years, working with couples with sex addiction is undoubtedly the hardest work I've done because of the overt split agenda. I sent an identical questionnaire with 20 scaled and open-ended questions to each individual within the couple so I could see how they responded from their different perspectives. The couples who responded were all clients of the Laurel Centre who had received at least 10 months of therapy and each discussed with their therapist the impact the questionnaire might have on them. The questions were designed to test my hypothesis that Baucom's three-stage model of recovery from infidelity could be tailored to this client group (Baucom et al 2011). The responses showed that three distinct phases could be identified, but my hypothesis that the first impact phase lasted 6 months was overly simplistic. What became clear was that any new disclosure or discovery lengthened the impact phase, or returned the relationship to it and this reinforced my view that therapeutic disclosure is essential for couples to move forward. The responses were brutally honest and showed the pain of the split agenda. One addicted partner profoundly captured this when he said "*I gained my freedom at the cost of hers*"; this is something I often share when training and speaking.

Writing Confronting Porn (Hall 2016) required a far more personal piece of research where I explored what impact my spirituality had on my work and my work had on my spirituality. The questions I asked myself included - were we created to crave? Is addiction a cause or

consequence of sin? What are the similarities between recovery and redemption? I read extensively around the topics of spirituality, sexuality and desire (May 1991, Scruton 2006, Ryan and Jetha 2010, Dunnington 2011) and developed a particular interest in the principles of Christian hedonism (Piper 2011) which crudely concludes that it is human nature at least to seek pleasure, but better still, euphoria. I feel this period of personal reflection helped me to develop an even deeper level of compassion for clients as I understood a desire to avoid pain and seek happiness is inherent throughout humanity. Where we seek our solace and ecstasy, may vary, but our desires are the same.

Other writing

In addition to writing books, I was also invited to write chapters for two edited books and have published five peer reviewed papers and written articles for the professional press. Further details in Evidence part 1.

One final area that perhaps fits most within this writing section is the creation of the Kick Start Recovery Programme which is hosted at www.sexaddictionhelp.co.uk and www.pornaddictionhelp.co.uk. The programme is a free downloadable PDF that includes a variety of questionnaires and exercises to help people 'kick start' their recovery. To access it, users answer 10 anonymous questions which collects information such as age, gender, orientation, geographic location, age the problem started and types of unwanted behaviours. On completion, users are invited to complete another evaluation questionnaire. To date, 27,274 people have used the Kick Start programme and 756 have completed the evaluation. The ongoing evaluation has been a helpful resource for confirming hypotheses, particularly around the OAT model and the resonance of the cycle of addiction. You can see samples of the collated survey responses in Evidence part 1, including user comments. An unexpected benefit of the programme has been that it has become a resource for therapists, either to signpost clients to it who cannot afford therapy, or to use within free or low-cost therapy sessions. Each year, an average of 150 therapists and other professionals have requested a copy of the programme to use with their clients.

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Teaching

Whilst I have undoubtedly learned much from clinical work and writing, there's no doubt that teaching other professionals has sharpened my knowledge more than anything else. The first training days I delivered about sex addiction were in 2010 where I shared my limited knowledge and clinical experience and the models developed by Carnes. By the following year I was beginning to introduce my models, initially to Relate centres where the audience were couple counsellors and psychosexual therapists, and then later that year to mixed counsellor audiences on behalf of BACP. Since 2012, as you can see in Evidence part 2, I have delivered a further 50 continuing professional development workshops to a variety of different audiences. Training professionals from different disciplines has required further research to tailor the training to their specific needs and I've benefited by learning from the audience during the event. Examples of this include understanding the interplay between sex and porn addiction when working with sexual health professionals; recognising common co-morbid presentations seen by psychiatrists and identifying cross-addictions that appear in rehabs. I've also been able to expand my knowledge and thinking about working within different therapeutic modalities including psychoanalytical, existential, CBT, gestalt, ACT (Acceptance and Commitment Therapy) and MI (Motivational Interviewing) and working within particular communities such as GSRD (Gender Sexual and Relationship Diversity) as well as people from different faiths and socio-cultural backgrounds.

Whilst CPD workshops were enough for some, during which a brief overview of the models would be presented, other organisations began to approach me for more in-depth training. The first of these was a rehab in Poland who wanted to host an event to train their team and others within the country. Having worked alongside other ATSAC (Association of the Treatment of Sex Addiction & Compulsivity) colleagues in developing and teaching the Professional Certificate in Sex Addiction (PCSA), which was delivered over 6 weekends, I devised a four-day programme that allowed more time to explore the models and included the most essential components of the PCSA to allow addiction therapists to adapt their work to treating sex addiction. By this time Nick Turner was also working with me full time, and as someone with an education background, he provided essential additional experience in ensuring the pacing and mix of content and practice was balanced. I learned that training over four consecutive days was very different from one or two days in terms of maintaining a conducive learning environment for people with a variety of learning styles. In Poland, we had the additional challenge that we would be delivering the whole programme through interpreters. Nick and I went on to deliver the same four day

programme the following year in Copenhagen (in English) and also to rehabs in the UK including One40, Priory and Innisfree. Throughout my training experience I have worked with many people where English is not their first language and this has provided a unique opportunity to break down concepts into straight-forward language. I also found training a team of psychologists, psychiatrists and psychotherapists in Dubai very enriching as I learned more about the cultures in the Middle East.

In 2014 Nick and I set up a separate limited company for training, initially known as Turner & Hall, but then renamed in 2018 to ISAT (Institute of Sex Addiction Training). All training is now delivered under the ISAT banner and there are a team of six of us who regularly deliver CPD days and workshops to a wide variety of interested professionals and our CPCAB level 5 accredited diploma to qualified counsellors and therapists. ATSAC decided to stop delivering training in 2014 due to the increasing burden it was putting on the organisation so Nick and I began developing the diploma as an alternative. I was keen to achieve accreditation, in part to encourage therapists to undertake the training by offering a formal qualification, but also to provide accountability for Nick and myself. I could not have developed the diploma alone, 'learning outcomes' and 'learning criteria' were terms that were new to me, as was the concept of having to mark a student's work. I particularly enjoyed finding creative ways of providing experiential learning opportunities for professionals who had never worked within this field that would provide insight into the client, but also expose personal assumptions and prejudices. Having experienced CSAT training in the US which specifically trains students to deliver Carnes' 30-task approach, an approach that, as explained earlier, did not work for me, I was keen to develop a diploma that provided therapists with tools they could adapt to their individual therapeutic modality and environment. As a post-qualifying qualification, students attend the diploma with a range of experience as therapists and with a variety of therapeutic approaches and modalities. This has encouraged me to ensure the training is pluralistic, and in turn, strengthens my preference for a pluralistic approach. Whilst all the models are taught in depth, the diploma is not prescriptive and I enjoy hearing students talk of how the models can be used within their modality. As can be seen in the progamme in Appendix IV, module three focusses specifically on a variety of techniques and modalities that can be used to develop a therapeutic toolbox. No doubt this stems in part from my rejection of the Carnes approach, but also from a place of committing to ongoing learning and being open to new and innovative interventions. Consequently, the diploma is constantly evolving as more research is published and as I continue to learn from research, clinical experience and from other professionals. A recent

example of this is an acknowledgement of the risk of attempting to 'convert' a client's erotic template and hence we have recently updated our module on working with GSRD and clients presenting with kink behaviours.

The Diploma has just completed its 14th cohort, with an average of 10 students per cohort, of which 12 have been international students. Covid-19 has resulted in us delivering our latest cohort entirely online and I'm delighted that CPCAB have agreed to accredit an online version permanently which I hope will allow us to reach even more international students. Therapists have been trained from private practices, Relate, rehab centres, offender units and sexual health clinics and has included psychiatrists, psychotherapists and counsellors from a range of therapeutic disciplines. We have consistently had positive feedback from students and from CPCAB verifiers – testimonials provided in Evidence part 3.

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Speaking

I absolutely hated public speaking and my first few presentations were only possible with Propanol to ease the panic! Fortunately, I have overcome those fears and I have found that I quite enjoy it. I have now presented at 30 conferences, most prestigiously the ISSM (International Society of Sexual Medicine) in Lisbon in 2018 and most recently at the Sexology conference in Helsinki, where the first translation of my book was also launched. I also had the dubious honour of speaking to 600 youth workers at the 02 Arena. Like training, I have needed to adapt presentations to the audience as well as to the timeframe provided. As you will see from Evidence part 2, presentations have been to both professional and public audiences and have ranged from lecture theatres to panel discussions, to debates and a TEDx talk that has now had over 350,000 views. I find the enthusiasm of audiences energises me in my work in a way that providing therapy and writing cannot. It brings out the campaigner in me and it is my sincere hope that I will gain platforms in the future where I can get the problem of sex and porn addiction onto government agendas.

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Conclusion

I have been specialising almost exclusively in sex and porn addiction for just over ten years and it continues to be the most satisfying therapeutic work I have done. I have the privilege of watching people turn their lives around. “Transformative” was the word a client used just this week to describe the work we’d been doing. Occasionally colleagues ask if I get bored working in the same field, which demonstrates how little they know about addiction. Addiction has the capacity to wreck every area of a client’s life and recovering from addiction means changing your life. This means that anything and everything in the client’s world, past, present and future, comes into the therapeutic space. But the work is not without its challenges. Listening to a client’s sexual acting out can at times elicit feelings of disgust, disapproval, arousal or envy; hearing partner’s stories of betrayal can rouse fear, anger and pity. I’m grateful for my excellent supervisor and being part of a team where I can openly share and process these feelings, but the impact of the work can leak into the personal realm. Working with the extreme consequences of addiction has sometimes led me to deny or minimise my own compulsions; and working with secrecy and betrayal has on occasion left me struggling to trust people close to me. Partners often describe how discovering the addiction has robbed them of their innocence; a basic faith in humanity and the goodness of the world. There are times when that sentiment has resonated with me. But conversely, I have also found working in this field to be inspiring as I wonder at the tenacity and courage shown by so many clients as they fight for a better life. One political consequence of the work has been an ongoing anger at the lack of education around the potential risk of pornography addiction and the scarcity of knowledgeable help providers and accessible services. I firmly believe that as a society we have a responsibility to stem the tide of sex and porn addiction and the first step has to be education. It is my hope that I will be able to contribute in some way to that task.

As I reach the end of this statement, I find the world in a very different place from where it was when I started. The UK is still in the midst of coronavirus with various parts of the country in and out of lockdown and thousands of people around the world losing their lives, their loved ones and their livelihoods. It’s a strange and surreal time as we all grapple to adapt both to, and within, a traumatised world.

The Laurel Centre offices are closed and all face to face groupwork and training is suspended until further notice. Most ongoing work, whether individual, couple or group aftercare has moved

to Zoom and I've spent the last few months changing the format of our groupwork programmes, and piloting them, so they can be delivered effectively online. Initially new enquiries almost completely disappeared, but over the past few weeks they have doubled. Some clients are using lockdown as a forced opportunity to change their habits and focus on recovery, others have relapsed, deeming the current crisis as impossible to survive without their addictive behaviour. Some take greater risks than ever by failing to maintain social distancing from sex workers and their families.

The controversies around sex and porn addiction have not abated since the arrival of coronavirus. Pornhub, the world's largest porn website, reported a significant increase in traffic and offered special discounts to people self-isolating to help them through the crisis. This was met with a barrage of accusations on social media of exploitation by anti-porn campaigners and dire warnings of a porn addiction pandemic to follow Covid-19. As always, it's the extreme voices that shout the loudest and fuel the polarities. At the start of this statement I described how controversy motivates me, and whilst this is true, regrettably it's equally true that it has the power to preoccupy and distract. It's hard hearing others say that the work I feel passionate about is unnecessary, or even, unethical, especially from the mouths of fellow professionals. I often consider seeking peace by withdrawing from the debates, but that's increasingly difficult as team members, trainees and clients bring them to my attention. Furthermore, it would feel like a betrayal of the work I've done, and the people I've done it for.

In the famous serenity prayer, composed by Reinhold Niebuhr and adopted by the 12-Step fellowships, he prays 'grant me the serenity to accept the things I cannot change and the courage to change the things I can'. I cannot change the fact that the addiction field has always been contentious, from opium and cannabis to cigarettes and gambling. Whenever a society identifies potential risk of harm, legislation is changed and some will defend the loss of personal liberty that inevitably ensues. What I can change are the outdated conceptualisations and treatments that have polarised opinions about sex and porn addiction and it's my hope that receiving a doctorate for this work will give me the courage to continue to engage in the debate.

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Professional descriptors for assessment

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Appendices

Appendix I – SASAT

1. How long have you been struggling with the sexual behaviours that have brought you here today?

2. Have you had similar difficulties in the past? If yes, please specify

3. Have you noticed that you need more and more stimuli or risk in order to achieve the same level of arousal and excitement or spend an increasing amount of time engaging in your behaviours? If yes, please specify

4. Do you currently, or have you in the past, struggled with any other addictions, compulsive behaviours or eating disorders? Such as drug, alcohol addiction, compulsive gambling, gaming, work or exercise, collecting? If yes, please specify

5. Has anyone in your family currently, or in the past, struggled with any addictions, compulsive behaviours or eating disorders such as those listed above? If yes, please specify

6. Have you experienced, or witnessed a significant trauma? If yes, please specify including details of any associated treatment and/or therapy

7. Over an average 6 months of active addiction, how often have you engaged in the following behaviours: -

	Never 0	Only occasionally 1	Sometimes 2	Often 3	Most or all the time 4
Using pornography *(including internet, smart phone, TV, DVD's, magazines)*	☐	☐	☐	☐	☐
Visiting sex workers *(including prostitutes, masseurs, strip clubs)*	☐	☐	☐	☐	☐
Cyber sex *(including chat sites, dating sites, adult apps, hook up sites, web cams)*	☐	☐	☐	☐	☐
Fetish behaviours or paraphilias	☐	☐	☐	☐	☐
Telephone sex or live TV adult channels	☐	☐	☐	☐	☐
Sex with strangers/one night stands/cruising	☐	☐	☐	☐	☐
Multiple affairs/casual sex/swinging	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐

Comments _____

_____

	Never 0	Only occasionally 1	Sometimes 2	Often 3	Most or all the time 4
8. Do you find yourself pre-occupied with either planning for, fantasising about or recovering from your sexual behaviours ?	☐	☐	☐	☐	☐
9. Do your behaviours have a negative impact on your relationship? Or your ability to start a relationship?	☐	☐	☐	☐	☐
10. Do your behaviours have a negative impact on your family, friends, work, relaxation time or finances?	☐	☐	☐	☐	☐
11. Do your sexual behaviours leave you feeling isolated from friends and family?	☐	☐	☐	☐	☐
12. Do you engage in sexual behaviours in spite of potential risk of physical or emotional harm to yourself or others?	☐	☐	☐	☐	☐
13. How often have you engaged in your behaviours to relieve /depressed feelings/ low mood or boredom?	☐	☐	☐	☐	☐

14. How often have you engaged in your behaviours to alleviate stress and stressful feelings?	☐	☐	☐	☐	☐
15. How often have you tried to stop your behaviours?	☐	☐	☐	☐	☐
16. Have you ever felt suicidal as a result of your sexual behaviours?	☐	☐	☐	☐	☐

Comments _____

_____

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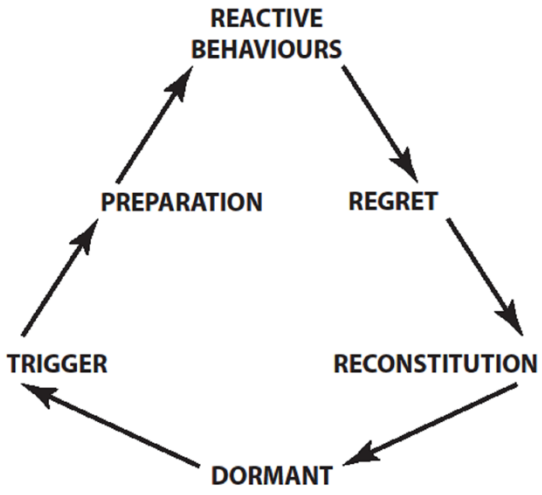
Appendix II – Other models

Six phase cycle of reaction

Whilst the addict has the six phase cycle of addiction, partners have a six phase cycle of reaction. Partners have their own history of unresolved issues in the dormant phase which will feed into the triggers that they struggle most to manage; triggers that can continue for many years, reminding them of the pain of discovering the acting out behaviour and infidelity. Partners also have a preparation phase after a trigger that leads them to their reactive behaviour, which they often experience as out of control.



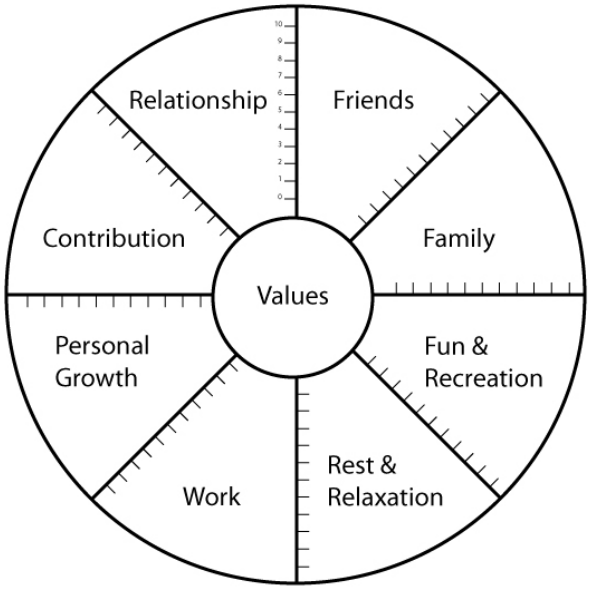
That behaviour may be an angry outburst, extreme anxiety or depression, or self-harming or acting out with another addiction. After the reaction they often feel regret and in the reconstitution phase will make resolutions not to repeat the reactive behaviour. But unless they manage their issues in the dormant phase, the cycle will continue. Like the addict, understanding and personalising their cycle of reaction helps them to break it and move forward.

The similarity of the models between the person with the addiction and the partner has been helpful for each partner of the couple to understand the impact of triggers and cognitive distortions and unresolved issues.

Like the six phase cycle of addiction, this model does not lead to any particular modality, though it can be helpful for ascertaining priorities for work. For example, a partner who is constantly being triggered may focus on managing triggers, or having identified a reactive behaviour, for example angry outbursts, may highlight the need to focus on emotional regulation and management.

The Life Wheel

For working with both the addict and the partner I developed a life wheel which allows them to explore eight key areas of their life and consider how they can gain further fulfilment from those areas as a resource for overcoming the addiction, or the trauma of betrayal. The life wheel consists of relationship, family, friends, work, relaxation, fun, personal growth, and contribution – each of which extend from the hub of being grounded in personal values. Clients are invited to mark how satisfied they are with each area of their life on the appropriate axis of the wheel with 0 meaning not at all and 10 being very. The points can then be joined up to provide a visual representation of how content they are with their life overall. The principle of the wheel is that the larger and smoother it is, the easier the journey of life will be. Once complete, clients can be supported in considering how they can expand their wheel. This simple tool has proven to be popular for providing focus for recovery for people with addiction and also for partners.



A metaphor model for couples

In my most recent book, Sex Addiction: A Guide for Couples, I used the metaphor of a boat throughout to illustrate recovery based on Baucom's three stage model of recovery from infidelity; impact, meaning and moving on (Baucom 2011) The impact phase is illustrated by a tidal wave capsizing the relation-ship as each partner comes to terms with the knowledge of the addictive behaviour and each must find a way of ensuring they stay afloat by focusing on their own individual recovery. The meaning stage is when the relation-ship is taken into dry dock to assess the damage and see if there is anything worth salvaging. This involves the process of therapeutic disclosure so both can acknowledge the damage and analysing the relationship strengths and weaknesses. The final moving on stage is when the couple either decide to set sail again in separate boats, or reconstruct their relation-ship together by rebuilding trust and intimacy. This metaphor and model have proven very effective in helping couples to understand

the profound impact sex and porn addiction has on their relationship and the work that will be required to save it; it has also helped therapists navigate through the distinct phases of couple work. I have learned from experience that trying to rebuild trust in a relationship is futile while a partner is still in the shock of discovery and/or when the addicted partner is still in denial. Similarly focusing on intimacy before the addicted partner can demonstrate they're in full recovery, if possible at all, is more likely to backfire and be triggering for both. Working with couples with this three stage model is still relatively new to the practice, but it is undoubtedly the most effective, and I would add, most ethical, approach.

A mind map of sex and porn addiction

This is not a model per se, but a metaphor that puts into simple layman's terms, the neuroscience of addiction and an explanation of recovery. The metaphor evolved from a training exercise I was delivering to students where I asked them to consider how they would communicate the neuroscience of addiction to a client. The 'Road to Brighton', as it is commonly known, was a consequence of that discussion which was then produced as a video. I have had positive feedback on the video from around the world and it is used in a number of training environments. It is linked from a variety of websites and has now received over 120,000 views on YouTube. It's hard to put into words what the model says, which is precisely why a metaphor was required, but in a nutshell, it explains the principles of neurogenesis. With Brighton representing the acting out behaviour, and London representing everyday life, it explains why repeated acting out (journeys to Brighton), become more compulsive. Using other coastal towns as metaphors for other rewarding behaviours, it illustrates how these become less rewarding (as fewer journeys are made) and how some may not even be known (if you've never travelled there before). The metaphor goes further to explain the process of recovery, namely not going to Brighton nor thinking about Brighton so the neural pathways can begin to disintegrate; but equally as important, the need regularly to visit other coastal towns to build alternative neural pathways. You can watch the video by following the link below.

Video link - https://www.youtube.com/watch?v=1BHAREf9zmU

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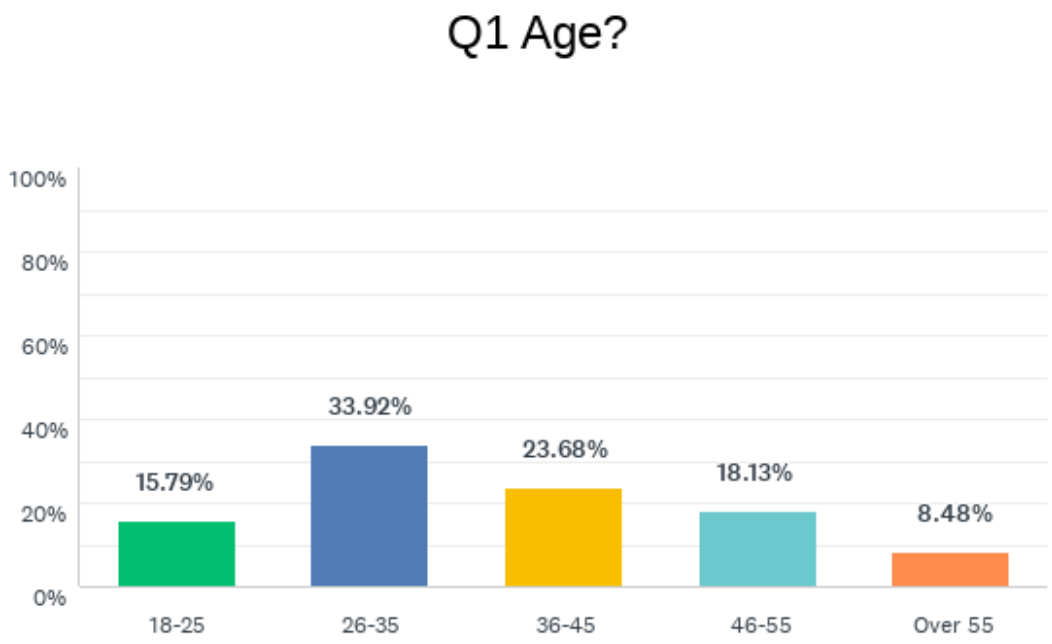
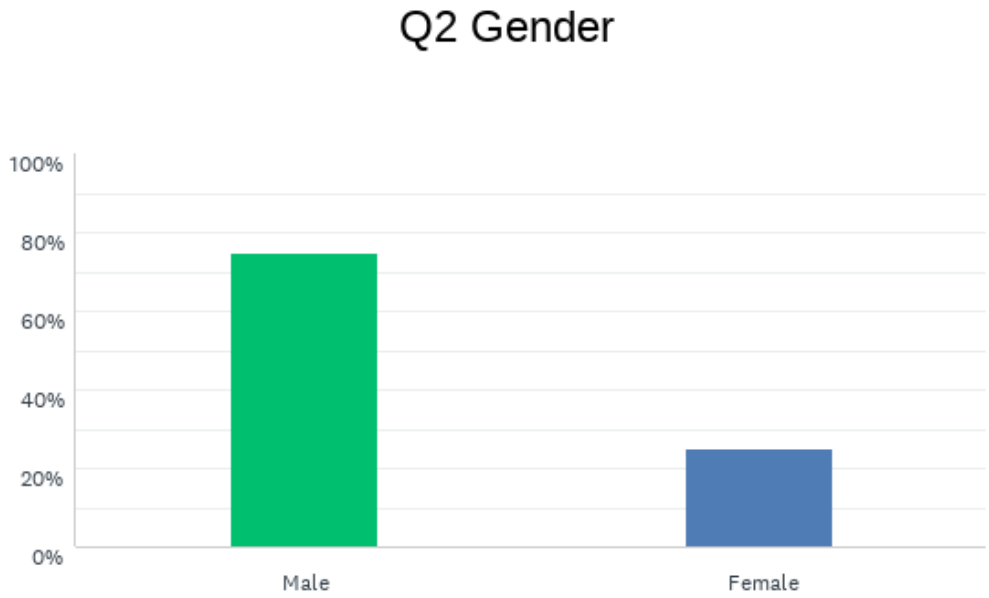
Appendix III – Surveys

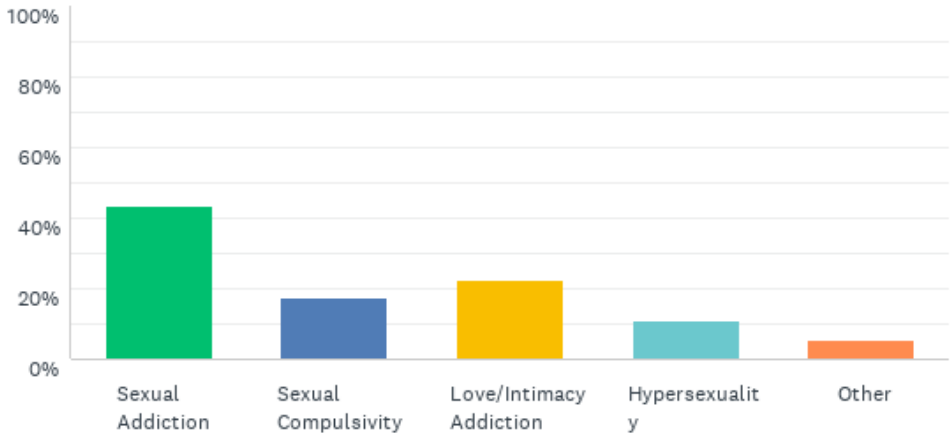
Sex addiction background survey

Below is a summary of results from a selection of questions from Survey Monkey of the background survey conducted for Understanding and Treating Sex Addiction, first edition.

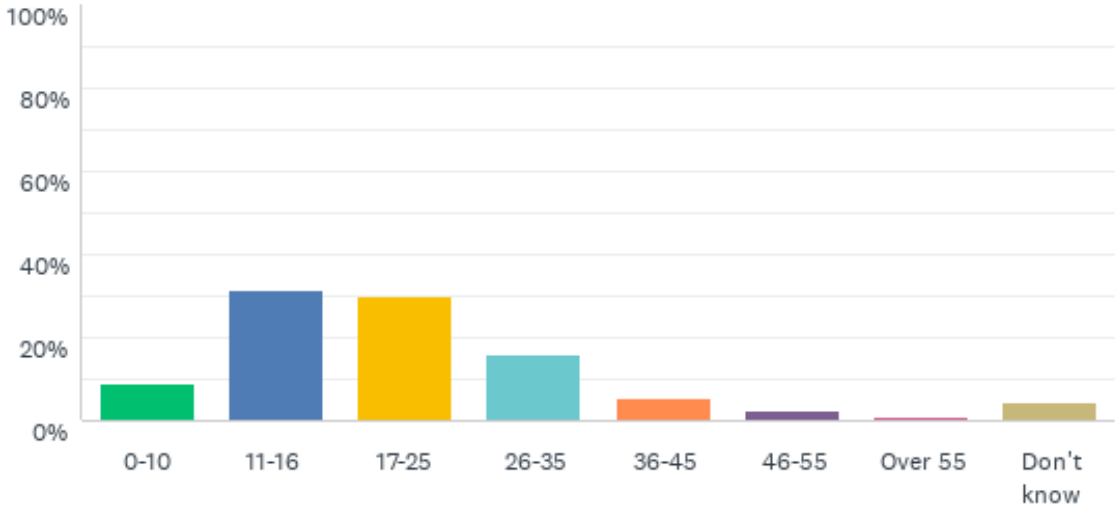


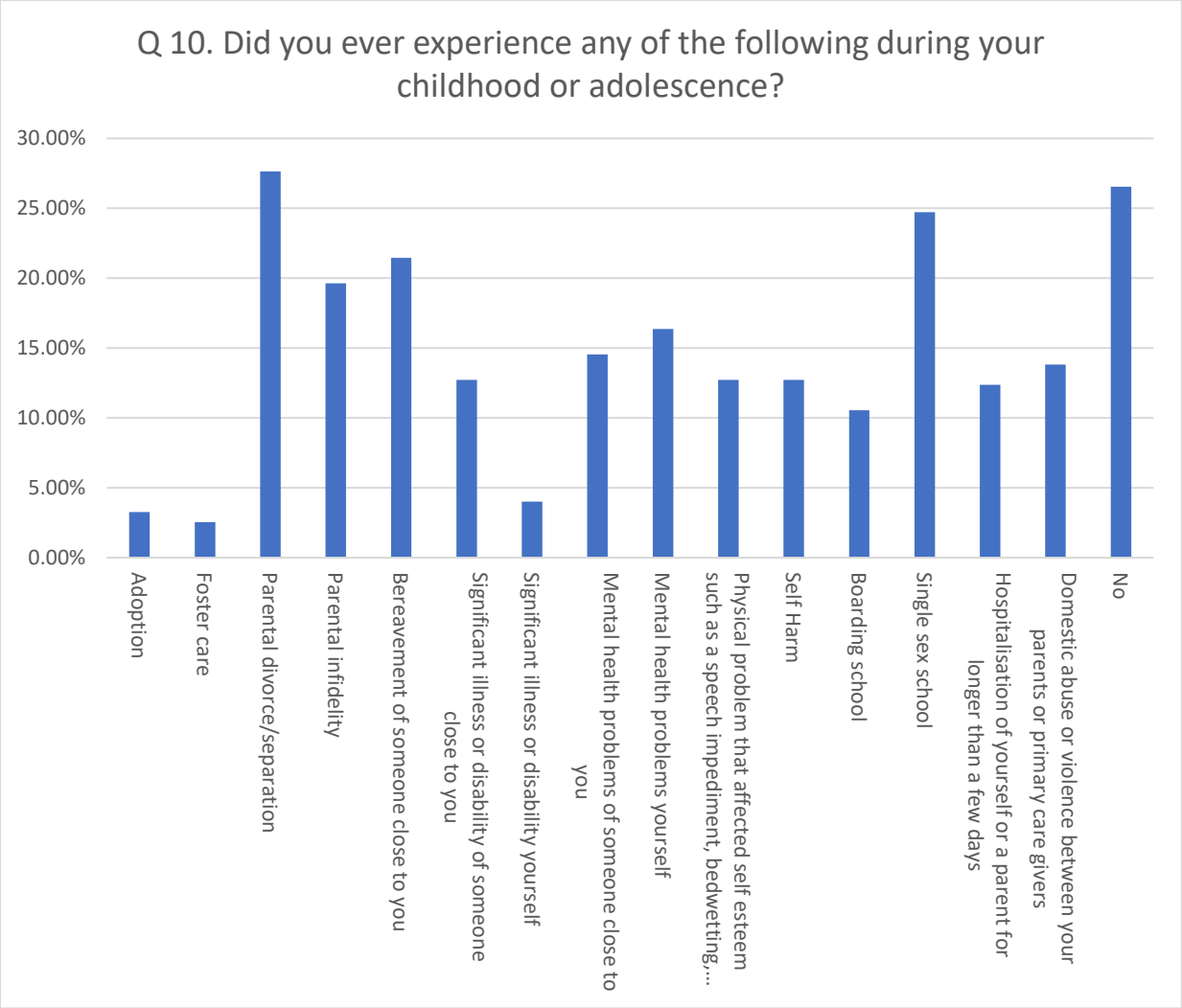


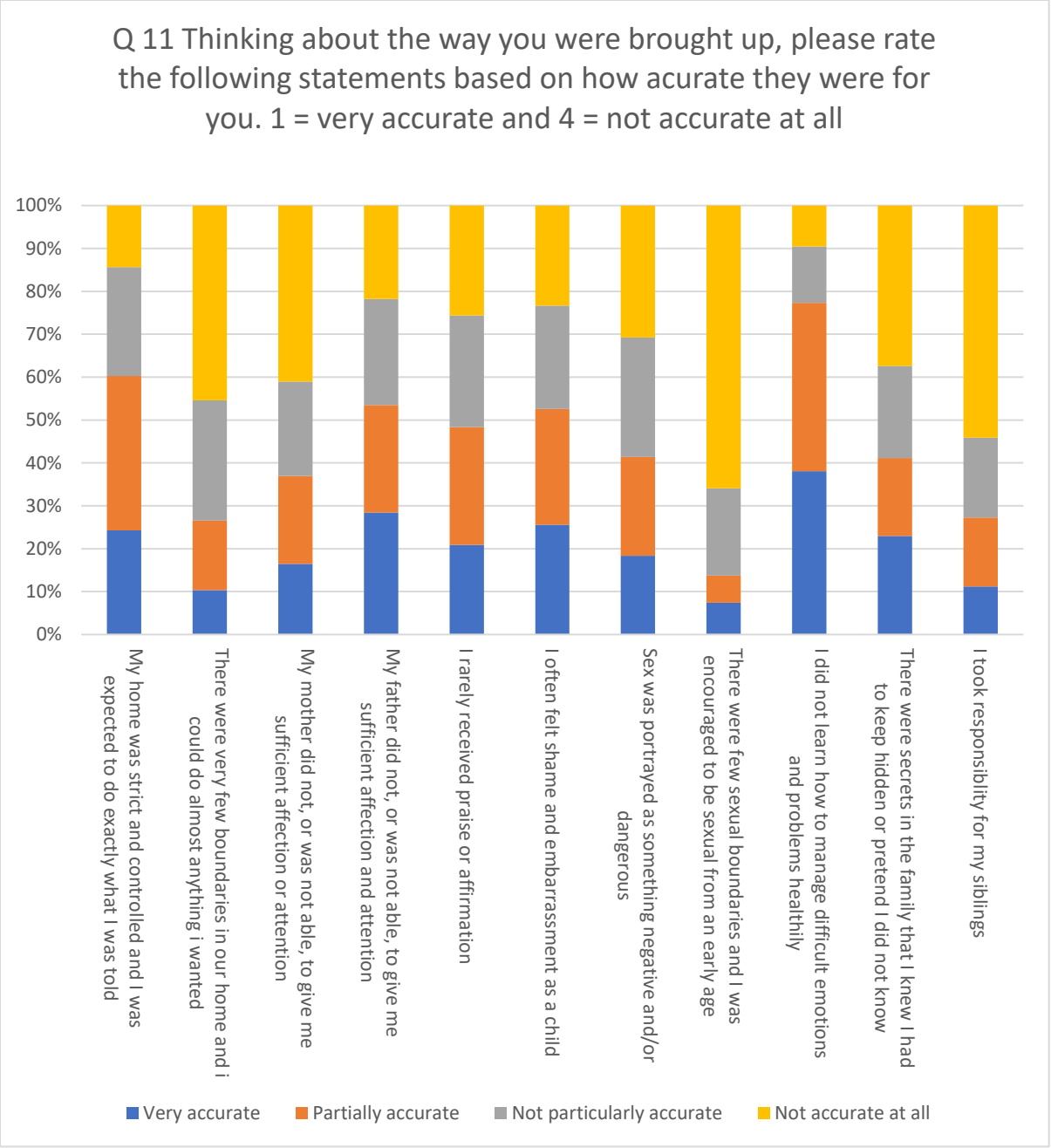
Q4 Which term best describes the problem that you struggle with?

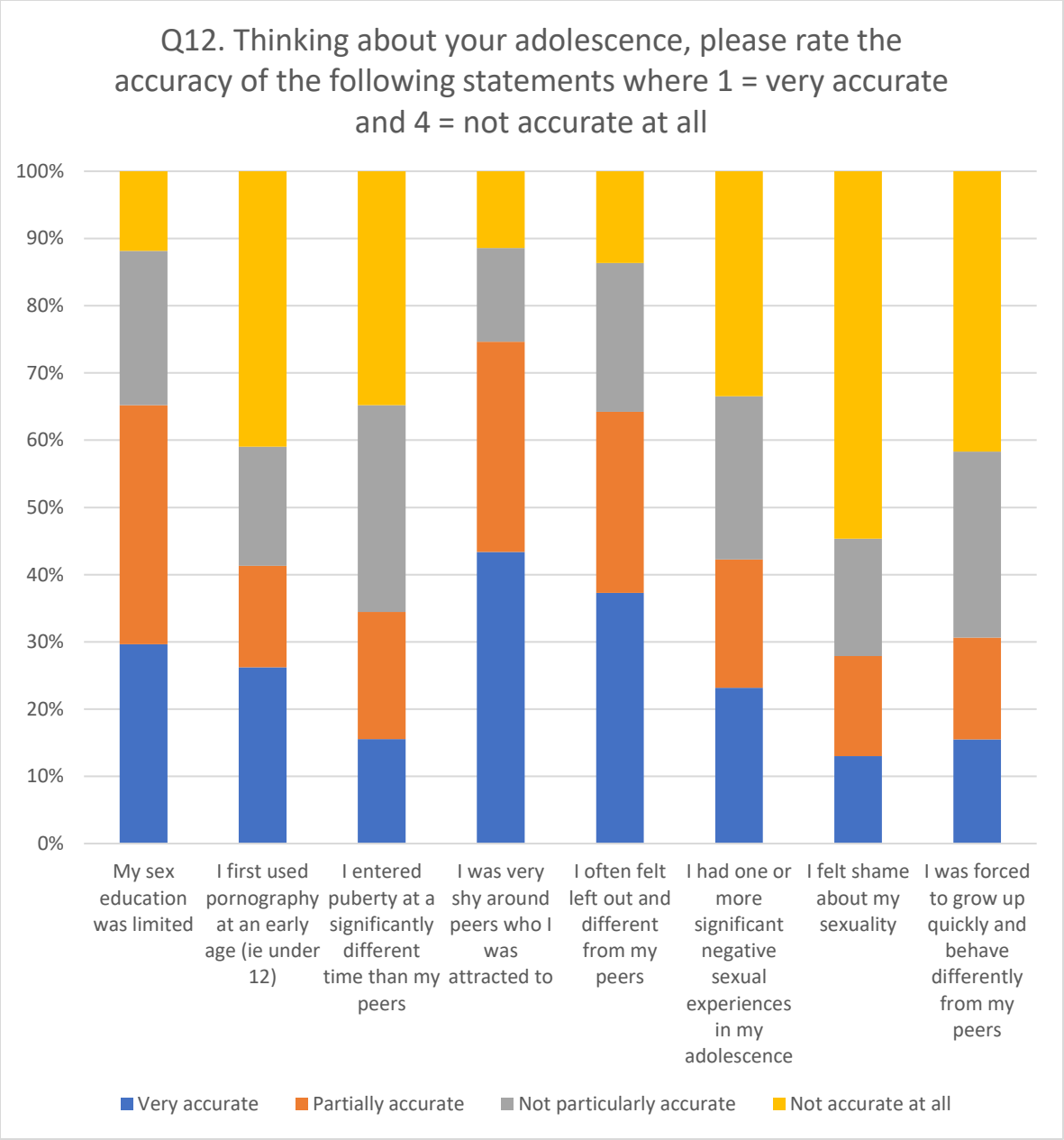


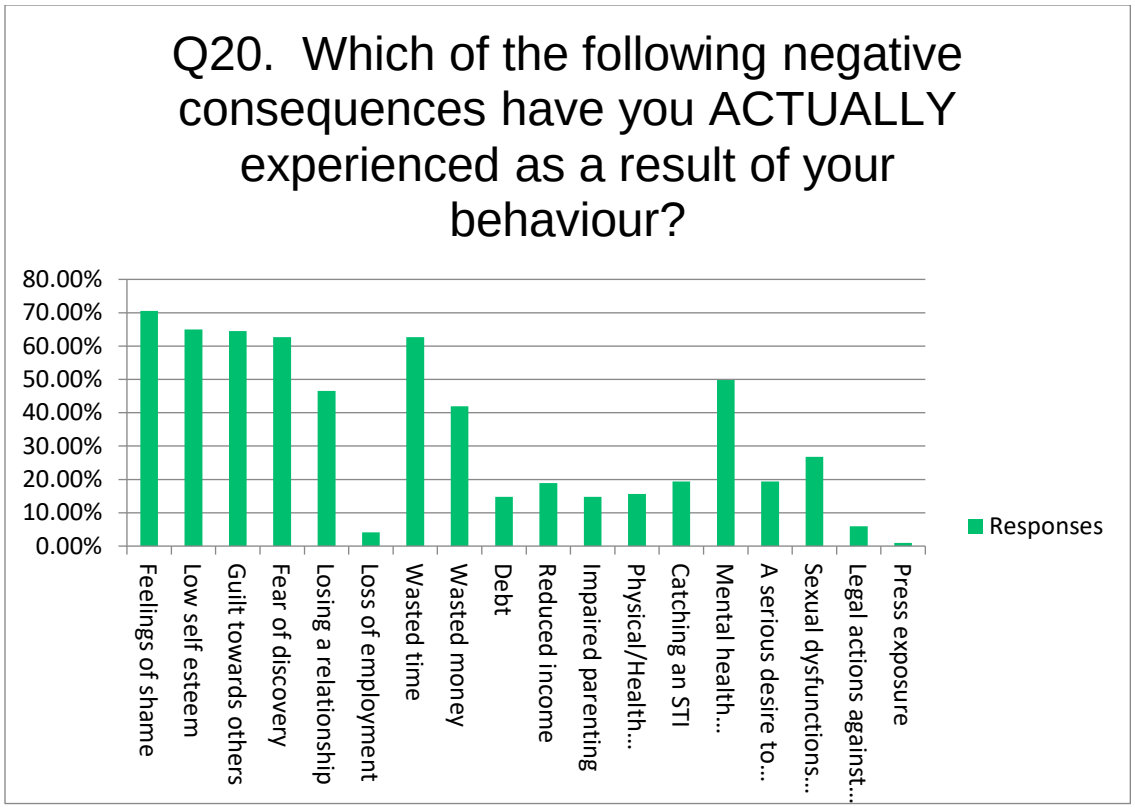
Q5 At what age do you think your problem started?

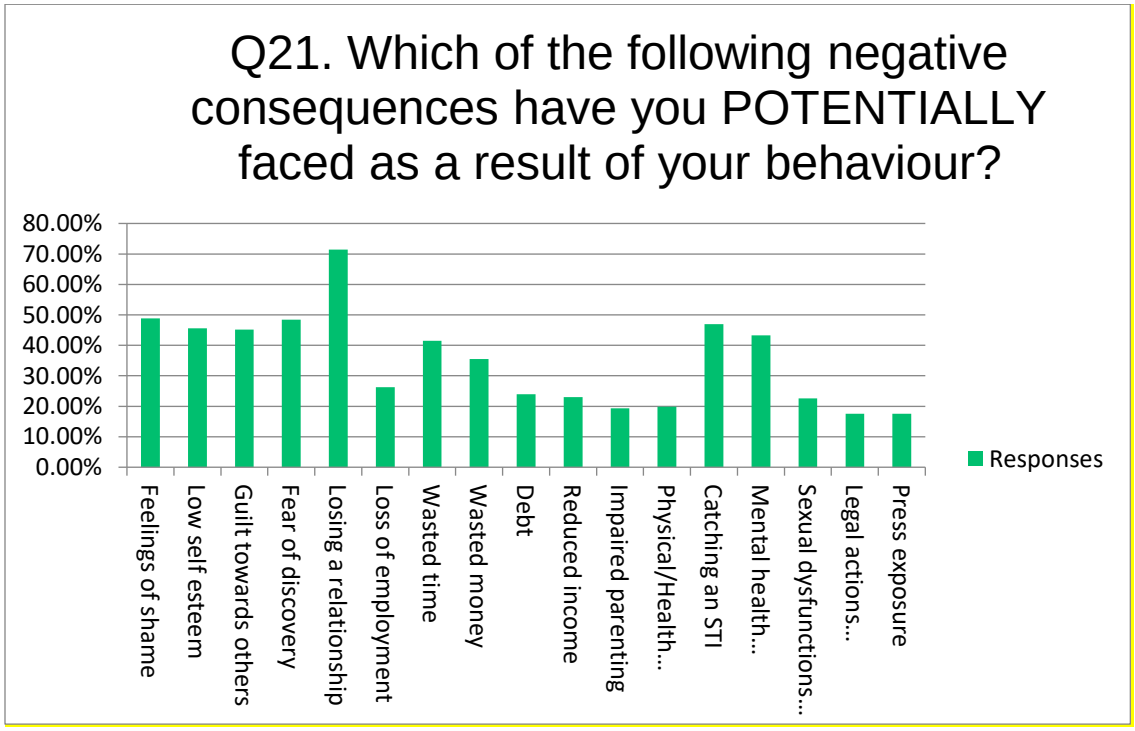



Q 10. Did you ever experience any of the following during your childhood or adolescence?
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Adoption
Foster care
Parental divorce/separation
Parental infidelity
Bereavement of someone close to you
Significant illness or disability of someone close to you
Significant illness or disability yourself
Mental health problems of someone close to you
Mental health problems yourself
Physical problem that affected self esteem such as a speech impediment, bedwetting,...
Self Harm
Boarding school
Single sex school
Hospitalisation of yourself or a parent for longer than a few days
Domestic abuse or violence between your parents or primary care givers
No


Q 11 Thinking about the way you were brought up, please rate the following statements based on how acurate they were for you. 1 = very accurate and 4 = not accurate at all
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
My home was strict and controlled and I was expected to do exactly what I was told
There were very few boundaries in our home and i could do almost anything i wanted
My mother did not, or was not able, to give me sufficient affection or attention
My father did not, or was not able, to give me sufficient affection and attention
I rarely received praise or affirmation
I often felt shame and embarrassment as a child
Sex was portrayed as something negative and/or dangerous
There were few sexual boundaries and I was encouraged to be sexual from an early age
I did not learn how to manage difficult emotions and problems healthily
There were secrets in the family that I knew I had to keep hidden or pretend I did not know
I took responsibility for my siblings
Very accurate
Partially accurate
Not particularly accurate
Not accurate at all


Q12. Thinking about your adolescence, please rate the accuracy of the following statements where 1 = very accurate and 4 = not accurate at all
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
My sex education was limited
I first used pornography at an early age (ie under 12)
I entered puberty at a significantly different time than my peers
I was very shy around peers who I was attracted to
I often felt left out and different from my peers
I had one or more significant negative sexual experiences in my adolescence
I felt shame about my sexuality
I was forced to grow up quickly and behave differently from my peers
Very accurate
Partially accurate
Not particularly accurate
Not accurate at all


Q20. Which of the following negative consequences have you ACTUALLY experienced as a result of your behaviour?
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Feelings of shame
Low self esteem
Guilt towards others
Fear of discovery
Losing a relationship
Loss of employment
Wasted time
Wasted money
Debt
Reduced income
Impaired parenting
Physical/Health...
Catching an STI
Mental health...
A serious desire to...
Sexual dysfunctions...
Legal actions against...
Press exposure
Responses


Q21. Which of the following negative consequences have you POTENTIALLY faced as a result of your behaviour?
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Feelings of shame
Low self esteem
Guilt towards others
Fear of discovery
Losing a relationship
Loss of employment
Wasted time
Wasted money
Debt
Reduced income
Impaired parenting
Physical/Health...
Catching an STI
Mental health...
Sexual dysfunctions...
Legal actions...
Press exposure
Responses

Background survey with couples

The questionnaire that was sent out by the couple therapist to selected couples who, it was felt, were in an appropriate place in their recovery and expressed an interest in helping other couples.

Thank you for agreeing to take part in this survey. This survey is completely confidential and anonymous and your answers will be used to help me write, and help readers understand, the impact of sex and porn addiction on couple relationships in the forthcoming book 'Sex Addiction – A Guide for Couples'. Please answer as many questions as you are comfortable with, either with your therapist or alone, whichever is best for you. I am aware that this survey may trigger uncomfortable feelings for some, if that happens, please do discuss them with your therapist.

Finally, thank you again. Real (anonymised) voices of people who have been through this are so important for readers to help them break through their feelings of isolation. And I know that it is only with the generous help of people such as yourself that I am able to write and give help to so many.

Paula Hall

Please complete this survey individually. You will see that some questions will be common to both of you, but it's important for me to see the differences in experience and perspective for each partner in the couple in other questions.

General background information

1. Your age: _____
2. Gender: _____
3. Length of relationship: _____
4. Do you have children or step-children, if so what age/gender:

   _____
5. Brief outline of acting out behaviours: _____

   _____

About disclosure

6. How was sex/porn addiction discovered or disclosed? _____

   _____

7. How long ago was sex/porn addiction discovered or disclosed? _____

8. Did you undertake a therapeutic disclosure? If so, how long after initial disclosure and was it helpful?

   _____

   _____

9. Who else did you tell? Why? And was it helpful? _____

   _____

10. Has there been any slips/relapses disclosed? How has this impacted your relationship?

    _____

    _____

Any advice for readers about disclosure

The first six months

11. Just thinking generally about your relationship, what did you do? What helped, what hindered? For example, did you talk a lot, try not to discuss it, carry on as normal, argue a lot, seek therapy, etc, etc

    _____

    _____

12. What did you do to rebuild trust? _____

    _____

    _____

13. Did you use an accountability contract? Did it help? _____

    _____

    _____

Any advice for readers in the first 6 months

General relationship

14. On a scale of 0-10, where 0 is low and 10 is high, how would you rate your satisfaction with the relationship before disclosure? _____

    (please provide more information about your reason for the rating you have chosen)

_____

On a similar scale of 0-10, how would you rate your relationship satisfaction now? _____

(please provide more information about your reason for the rating you have chosen)

_____

_____

15. On a scale of 0-10, where 0 is low and 10 is high, how would you rate your satisfaction with your sexual relationship before disclosure? _____

    (please provide more information about your reason for the rating you have chosen)

    _____

    _____

    On a similar scale of 0-10, how would you rate your sexual relationship satisfaction now? _____

    (please provide more information about your reason for the rating you have chosen)

    _____

    _____

16. On a scale of 0-10, how close have you got to seriously deciding to end the relationship? _____

    (please provide more information about your reason for the rating you have chosen)

    _____

    _____

    _____

    Where are you now? _____

(please provide more information about your reason for the rating you have chosen)

_____

_____

_____

17. How has your communication changed between you since before disclosure and the time since?

_____

_____

_____

18. How has the way you manage conflict and differences changed between you since before disclosure and the time since?

_____

_____

_____

Any advice for readers about communication and conflict

19. How confident are you about your recovery?

_____

_____

_____

20. How confident are you about your partner's recovery?

_____

_____

_____

Anything else you'd like to share

Please can you provide your first name and indicate if you are the person with the addiction or the partner – this is for internal use only

Name: _____

Partner / Person with the addiction (please circle)

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Appendix IV – Diploma programme

CPCAB Accredited (Level 5)
Diploma in Sex Addiction Counselling

MODULE 1 - Introduction to Working with Sex Addiction

Day 1 – What is Sex Addiction and Compulsive Sexual Behaviour?

- Session 1 – What is sex addiction and compulsive sexual behaviour? (BERSC Model)
- Session 2 – Stats, facts and cyberpsychology
- Session 3 – Function and origins (OAT Model)
- Session 4 – Assessment – part 1

Day 2 – Understanding Sex Addiction and Compulsive Sexual Behaviour

- Session 1 – Ethics, accrediting bodies & the law
- Session 2 – GSRD (gender, sexual and relationship diversity)
- Session 3 – Shame
- Session 4 – Assessment – part 2 (SASAT)

Day 3 – Principles of Recovery

- Session 1 – Neuroscience
- Session 2 – The CHOICE recovery model
- Session 3 – Positive sexuality
- Session 4 - Recognising harmful consequences and breaking denial

Day 4 – Relapse Prevention

- Session 1 – Personalising the 6 phase cycle of addiction
- Session 2 – Avoiding triggers
- Session 3 – Relapse prevention strategies
- Session 4 – Formulation of the case and evaluating the work

MODULE 2 - Working with Contexts and Underlying Issues

Day 1 – Attachment and Trauma

- Session 1 – Brain development and attachment 1
- Session 2 – Brain development and attachment 2
- Session 3 – Trauma
- Session 4 – Therapeutic interventions

Day 2 - Complex Cases and Cultural Issues

- Session 1 – Cross addictions & commonly associated issues
- Session 2 – Social GRRAACCEESS
- Session 3 – Understanding paraphilia, fetish & kink
- Session 4 – Implications of working with offenders

Day 3 – Understanding the Partner's Perspective

- Session 1 – Impact & reactions
- Session 2 – Working with a relational trauma model
- Session 3 – 6 phase cycle of reaction and learning to SURF
- Session 4 – Recognising and working with co/pro-dependence

Day 4 – Implications for Relationships

- Session 1 – Impact on relationships
- Session 2 – Stages of couple recovery
- Session 3 – Rebuilding trust
- Session 4 – Impact of disclosing to others

MODULE 3 – Maintaining Recovery and Beyond...

Day 1 – The Essentials of Recovery Work

- Session 1 – Working with slips and relapse
- Session 2 – Positive psychology
- Session 3 – The role of sex therapy
- Session 4 – Why group work?

Day 2 – Therapeutic Interventions 1

- Session 1 – Modalities, interventions and skills
- Session 2 – Mindfulness
- Session 3 – ACT (acceptance and commitment therapy)
- Session 4 – CFT (compassion focused therapy) and hypnosis

Day 3 – Therapeutic interventions 2

- Session 1 – Motivational interviewing 1
- Session 2 – Motivational interviewing 2
- Session 3 – Internalised other interviewing
- Session 4 – Creative techniques

Day 4 - Maintaining Recovery

- Session 1 – Evaluating the recovery journey
- Session 2 – “Sharpening the saw”
- Session 3 – Case discussion groups
- Session 4 – Final plenary Q&A, assignment setting and what’s next?

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