jack hirose & ASSOCIATES INC.
Quality workshops & community resources

SEX, INTIMACY & ADDICTION IN THE DIGITAL AGE

WEDNESDAYS: OCTOBER 10- NOVEMBER 14, 2018 | 11:00AM - 1:00PM PST

WORKSHOP AGENDA

PART 1
- Healthy Sex vs. Sexual Pathology
- Cruise Control: Understanding Sexual Addiction/Compulsivity in Gay Men

PART 2
- Understanding the Diagnosis of Sexual Addiction/Compulsivity
- Applied Sexual Addiction/Compulsivity Treatment

PART 3
- Narcissism and Addiction: The Price of Surviving Trauma
- Out of the Doghouse, Healing Relationship Betrayal

PART 4
- Not in my Neighbourhood: Understanding Non-Violent Sexual Offenders
- Addiction in the Digital World

PART 5
- The Digital Generation Gap
- Kids, Sex and The Internet: A SWOT Analysis

PART 6
- Sex + Tech = Sexnology: Where Tech and Sex Combine
- Prodependence: Moving Beyond Codependency

LEARNING OBJECTIVES

- Attendees will be able to differentiate casual 'cheating' from sex addiction
- Attendees will learn how to assess for compulsive sexual behaviour problems
- To outline the origins of sexually addictive behaviours.
- To provide basic referral resources and information, including: self-help groups, 12 step groups, online resources, and articles and books.
- To gain empathy and compassion for the struggles of addicted
- Attendees will be offered a new definition for 'infidelity" considering the reality of todays' digitally driven sexual opportunities (porn, apps, online hookups etc.)
- Attendees will be able to identify 3 typical mistakes made by a partner seeking to heal relationship betrayal
- To build common understanding of the relationship between early childhood abuse/ neglect, adult intimacy problems and addiction.

Robert Weiss LCSW, CSAT-S is a digital-age intimacy and relationships expert specializing in infidelity and addictions—most notably sex, porn, and love addiction.

Author; Sex Addiction 101, Out of The Doghouse: A Step-by-Step Relationship-Saving Guide for Men Caught Cheating and Cruise Control: Understanding Sex Addiction in Gay Men

Subject expert for multiple media outlets including CNN, HLN, MSNBC, and NPR

Blogger for Psychology Today, Huffington Post, and Psych Central

Skilled international clinical educator

Creator of more than a dozen high-quality addiction and mental health treatment facilities and programs including residential, workshop, IOP and outpatient.

Healthy Sex vs. Sexual Pathology

Robert Weiss PhD MSW
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
www.seekingintegrity.org

@RobWeissMSW on Twitter
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Common Sexual Issues in Therapy

- All therapists encounter clients seeking help with sexual issues.
- Clients worry about too much sex, not enough sex, no sex, bad sex, solo sex, strange sex, addictive sex, problematic sex, etc.
- Occasionally these concerns are a primary presenting issue, but more often these issues lurk in the background—thanks to personal/cultural shame about sex—coming to light when exploring related problems with self-esteem, relationships, mood/personality disorders, addiction, trauma, etc.
- Sadly we are undertrained and under educated in assessing, diagnosing and treating problems in human sexuality

Basic Assessments Shouldn't Ignore Sex

It is useful to incorporate a few basic sex-related questions into an initial phone inquiry or client evaluation. Non-threatening queries include:

- Do you have any concerns about your current or past sexual or romantic behaviors?
- Has anyone close to you ever expressed concern about your sexual or romantic behaviors?
- Is there anything about your sexual or romantic life that feels shameful to you or that you keep secret?

What is Healthy Sex?

- Healthy sex is different for every person and every relationship.
- What "variations" have you seen in your own life? In the lives of the people around you?
- As therapists, our job is to explore the concerns and help clients make peace with them, not to judge the issues or change the client's arousal template.

What Sexual Issues Do Clients Struggle With?

- Sexual Orientation
- Gender Identity
- Kink, Fetishes, Paraphilias
- Sexual Dysfunction
- Infidelity
- Highly Sexual vs. Asexual
- Sexual Compulsivity/Addiction
- Sexual Offending
- Porn
- Values Conflicts

Sexual Orientation

You can't change a person's sexual orientation, no matter how ego-dystonic those feelings might be. A gay man is attracted to other men whether he likes it or not, a lesbian woman is attracted to other women whether she likes it or not, and bisexual men and women are attracted to both genders whether they like it or not. No amount or type of therapy is going to change this.

- Research shows that "gay conversion therapy" is harmful.
- The proper therapeutic approach is helping the client understand and accept what he or she is feeling and desiring as a natural and healthy part of who he or she is.

Therapeutic path here is:

- Acceptance
- Integration

Gender Identity

- Psychological gender identity is fixed and immutable by birth. Physical gender can be altered with surgery.
- Gender Dysphoria is evidenced by a significant, longstanding level of discontent with one's birth sex and/or the gender roles associated with that sex.
- Dealing with transgendered clients who want gender reassignment surgery is a highly specialized endeavor. If you are not trained for it with significant clinical experience under your belt, you should refer such clients to a specialist.

Treatment path here is:

- Acceptance
- Support
- Integration

Gender Expression

- Gender expression relates to the way a man or a woman outwardly expresses their masculinity or femininity. Most important to know when working with gender expression is that it exists on a separate axis than does sexual orientation and on a separate axis from gender Identity.

Treatment path here is:

- Acceptance
- Support
- Integration

Kink, Fetishes + Paraphilias

What's the difference? All are versions of the same thing—non-vanilla sex—but in varying degrees.

- A *kink* is something you might use to spice up your sex life a little bit.
- A *fetish* is a deep and abiding object-driven sexual desire
- A *paraphilia* is a fetish taken to an extreme, resulting in negative life consequences, arrest able behavior, self injury etc.

If you're still a little confused by these differences, think about the difference between a casual drinker, a heavy drinker, and an alcoholic. The basic behavior, drinking alcohol, is the same, but the causes and effects are quite different.

Sexual Dysfunction

Sexual dysfunction is extensively addressed in the DSM-5. Issues covered include: delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder, premature (early) ejaculation, and substance/medication-induced sexual dysfunction. Not yet covered: Porn-Induced Erectile Dysfunction (PIED).

- Clients with sexual dysfunction should always be referred to a medical professional *before* psychotherapeutic treatment is engaged in earnest, as the issue may be more physical than psychological.
- If you lack formal training in sexology and run into cases where sexual dysfunction is found to be more of a psychological than a medical issue, clients are best referred to a sexologist.

Infidelity

From a clinical perspective, infidelity is not inherently pathological—though it can become so if it takes on a life of its own and spirals out of control, as occurs in cases of sexual addiction/compulsivity, or if it causes concurrent problems with the client's life functioning and/or mood. I like to think of infidelity as a form of immaturity.

Typically, the therapeutic approach taken when dealing with marital infidelity depends on whether you are treating the cheating partner or the cheated-on partner or both.

notes -open marriage, polyamory.

Infidelity: Treating the Cheater

With a cheating partner, directive forms of therapy are recommended, especially if the client wishes to stop what he or she has been doing. Treatment is build on remorse and a desire for change -in the cheater -

- Behavioral contracting
- Understand the meaning behind the cheating (dissatisfaction with the relationship, addiction/compulsivity, mood/personality disorder, etc.)
- Encourage truth-telling, as continued secrets can further damage the relationship

If the client shows no remorse and doesn't want to stop cheating, there is not much you can do except support the partner.

Warning -Don't Keep Secrets. And know who your client is …

Infidelity: Treating Betrayed Partners

For betrayed partners, it's usually not any specific sexual act that does the most damage; it's the lies, secrets, and loss of relationship trust. Many betrayed partners experience symptoms of PTSD. They often resent the idea that they might need therapy when they didn't do anything wrong.

- They need: empathy, validation for their feelings, help processing the shame/rage of being cheated on, and direction, education and support for moving forward.
- They may also need guidance with setting boundaries, healthcare issues (including STDs), and curtailing their ever-present desire to question the betrayer about his or her sexual past and present.
- They need help with self care and creating a cohort of support

Hyper-Sexual vs. A-Sexual

Clients sometimes ask: "How much sex should I actually be having?" Well, the answer depends entirely on the client—his or her background, emotional make-up, libido, ethics, emotional state, physical health, childhood trauma, and sexual orientation, along with how much credence he or she gives to the "more sex is better" tenet.

- If people are comfortable with the amount of sex they're having and they're not experiencing relationship problems or other consequences related to the sex they're having, then there is nothing wrong with their sex life.
- It is just as normal to want sex multiple times a week as it is to want sex a few times a year.
- Most problems arise when there is a disparity in sexual arousal in a couple-ship.

Sexual Compulsivity/Addiction

There will be a several video segments to follow that are focused on the assessment diagnosis and treatment of sexual addiction. Please go to those segments to learn more.

Sexual Offending

There is an hour long segment to follow directly focused on the assessment and etiology of sexual offending. Please go to that segment to learn more.

Child Sexual Abuse

There are two types of sexual abuse: overt and covert.

- Overt sexual abuse is hands-on.
- Covert sexual abuse is the surreptitious, indirect, sexualized emotional use/abuse of a child by a parent, step-parent, or any other long-term caregiver.

Both experiences over time will leave the victim with: shame, feelings of inadequacy; potential dissociative or addictive disorders, difficulty with long-term intimacy; enmeshment; difficulties with self-care; love/hate relationships; perpetuating the abuse; etc.

Addressing Sexual Issues in Therapy

When sexual issues surface in therapy, it is useful to consider the following:

- Is this a primary therapeutic issue that should be addressed directly?
- Should this be addressed immediately? (Think client safety, partner safety.)
- Is this a secondary concern that can be explored later, after other, more pressing issues are under control?
- Is what I'm hearing pathological or simply troubling to the client (most often due to moral, cultural, or religious values)?
- If this issue requires direct intervention and treatment (either right away or later), do I have the skillset, temperament, and experience? Or do I need to refer?

Refer Refer Refer

If you are not trained or comfortable treating certain sexual issues, you should still work to identify those issues, and then you can refer your client to an appropriate specialist. Referral sources include:

AASECT.ORG – For non-addiction, non-offending sexual issues
ATSA.ORG – For sexual abuse/offending issues
IITAP.COM – For sex addiction/compulsivity
RobertWeissMSW.com – For all sexual issues
Safer Society Foundation – For sexual abuse/offending issues
SASH.net– For sexual health issues
SexandRelationshipHealing.com – For all sexual issues
SSSS – For the study of human sexuality

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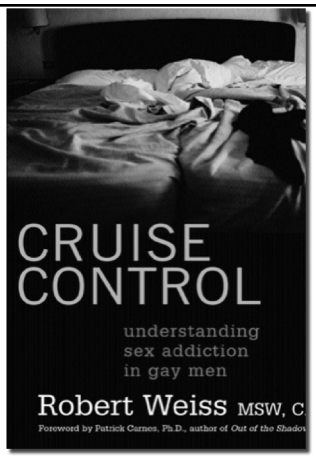
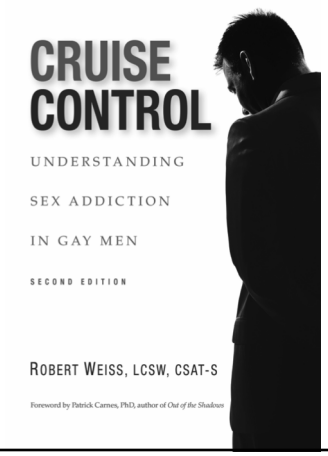




Gay Male Specific Life and Relationship Challenges (developmental trauma)

1. Differing Cultural Sexual Behavior Patterns and Norms
2. Fewer of cultural boundaries for potentially problematic excessive sexual behavior
3. Lack of Cultural Validation for Intimacy Building
4. A learned response to homophobia often leads to: social isolation, learned compartmentalization of the self. An adaptive coping mechanism and a perfect precursor to being an addict.
5. Extended adolescence
6. Few role models for healthy dating, intimacy, long-term relationships.
7. Male/Male relationships = intimacy is harder to initiate, achieve and maintain because we're men, not because we're gay
8. A subculture exposed to extensive cultural, legal and religious oppression directly correlated to the individual's sexuality, romantic attraction and sexual self definition.
9. A culture with an under-acknowledged specter of AIDS related death.

Male Sex Addicts Gay vs Straight

- The underlying emotional, relationship and social deficits that drive straight men to sexually act out are the same in gay and straight men
- The feelings before, during and after acting out act are the same in gay and straight men.
- Preexisting struggles and challenges with intimacy, self regulation and social engagement are the same in both gay and straight men.
- The differences are cultural and genetic
- But gay men are competing for MALE attention and men are more visually oriented & more likely to sexually objectify. In this way (dress, looks, physical perfection, beauty, weight etc.), they are in the same boat as straight women.

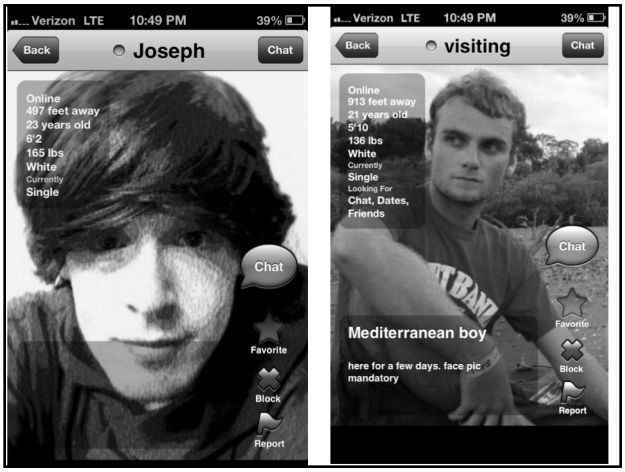
Male Sex Addict Venues

Gay Men
Paid Webcam Sex
App- Hook-ups (GRINDR)
Bathhouses
Sex Clubs
Escort Services/Massage
Public Sex - Anonymous
Bars/Clubs
Adult Bookstores
One Night Stands/Affairs
Travel

Straight Men
Online Hook-ups (Craigslist)
App based Hook-ups (Ashley Madison)
Strip Clubs
Escort Services/Massage
Pick-ups in Bars/Clubs
Adult Bookstores
One Night Stands/Affairs
Travel

And sometimes they have sex with each other!

The Gay Game Changer



Stimulants and Sex in Action

Half the guys I meet online end up offering me Tina and then we usually spend the weekend watching porn or having sex with other men who show up. If I am too high to get it up or keep it up, I always keep Viagra or Levitra around or can get it in one day over the Internet. Out at the bars there is a constant supply of Special K or X and when I do that I end up in the sex clubs 'till after the sun comes up. I wouldn't know where to begin dealing with my sexual acting out since the whole problem feels so tied together with drug use, partying and my social life, it always has.

Philip, 29 years old, seeking help for the first time.

Stimulant Abuse and Gay Sex Chemsex

•Stimulant Abuse/Addiction (METH) is the #2 substance abuse disorder in gay men behind alcohol addiction.

•Stimulant Abuse/Addiction is the most likely to lead to HIV infection, physical and sexual abuse, jails, institutions and death.

• Most sexual environments offer readily available stimulants that are combined with Viagra and related drugs which turn into 3-5 day sexual marathons for the participants

•Recovery from meth/sex addiction is a long, challenging, anhedonic road. Sexual intensity and drug abuse become paired, making sex in sobriety empty and dull if it happens at all and sex is a trigger to return to drug abuse.

In Dedicated Drug Addiction Treatment for Meth/Stimulant Addicts, this is required …

Do a thorough, private (to start) detailed sexual history (focused specifically on when client was using. (look for shame)

Co-create a sex/dating/intimacy plan for drug sobriety (look for relapse prevention)

What is different about treating gay male (sex) addicts?

1. You need to know the lingo - educate you
2. The client needs to learn about male/male intimacy - educate them
3. You need to be prepared for differences in frequency of sex, #'s of partners, fetish interests- to not pathologize
4. You need to understand and accept how **men** typically think about casual sex- vs. most females
5. You need insight into heathy gay culture- what is available recreationally, spiritually, socially etc.
6. You have to be prepared to confront significant denial that is harder to confront than when you are seeing a straight married client
7. A long-term committed spouse may not be "bothered" by the addicts sexual acting out- even resent that he may be asked to address his behaviors as well
8. You have to be ready for open discussions about potentially (non-typical therapy topics like: open relationships, sex toys, threesomes) etc.

What is Sexual Sobriety?

- A mutually agreed upon clear, written and signed, behavioral *contract* based on client goals.
- Sobriety plans don't change without prior discussion.
- Similar to how we handle eating disorders

A Sexual Sobriety Contract

List of Behaviors ***I Want to Stop***	List of Behaviors ***I Want to Add***
A	A
B	B
C	C
D	D
E	E
F	F

All the above are tied directly to client goals. What he/she hopes to avoid and achieve in this process, thus reducing client/therapist power struggles about sex

Lifestyle Changes to Support Chemsex Sobriety

- Non-sexual socialization. Affiliation with gay and non-gay social groups, religion, teams, hobbies & recreation. GLBT 12-step groups.
- Ongoing non-sexual peer support for behavior change
- Education about dating, intimacy, communication, relationship skill-building specific to men
- Increased interaction with recovering heterosexual males who have similar sexual issues (to take the "gay" out of sex addict") This reduces shame for SA & homophobia.
- For some: useful to consider either a female or a heterosexual sponsor
- Education: how to safely use apps or eliminate and monitor
- No casual sex period. No bars, no wet areas of the gym, no "Friend Finder" apps" etc.

A word about supporting non-sexual male/male relationships

Sex Addiction is an Intimacy Disorder. Healing requires growing skillsets toward both community and relationship intimacy

Cruise Control: Understanding Sex Addiction in Gay Men

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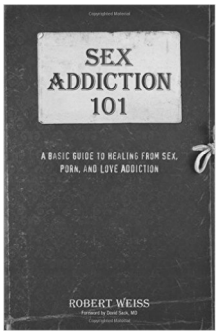
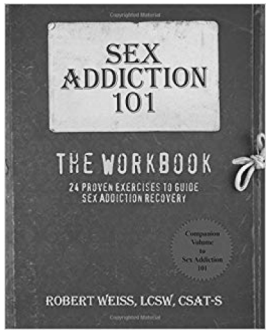
SEEKING INTEGRITY

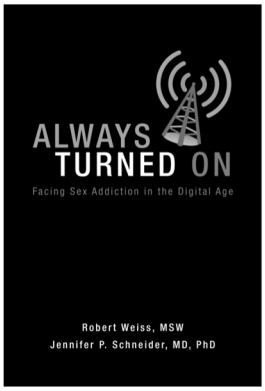
Sex and Relationship Healing

Useful Client Content for Sexual Addiction Treatment Available on Amazon Internationally





Free Podcast **Sex, Love and Addiction** is on iTunes, stitcher, etc.



mplete clinical guide to Sexual Compulsivity + Addictio

Is Sexual Addiction a Legitimate Mental Health Diagnosis ?

- Yes - It was in the DSM-III as a descriptor
- No - It was removed in the DSM-IV
- No - Not in the DSM-5 or appendix
- Yes - In the ICD-11 released 2018
- Yes - Will likely be in DSM-5R - 2019

Nomenclature is a BIG problem in my professional world.

Nomenclature is the science or system of choosing names for objects, experiences and processes.

All of the labels below have policy, social, medical, assessment and treatment ramifications and egos involved!

Sexual Addiction - Why I use this one!

Sexual Compulsivity

Hypersexuality

Hypersexual Behavior Disorder

Out of Control Sexual Behavior

Sexual Impulsivity

Compulsive Sexual Behavior Disorder

What does it mean to lack a DSM diagnosis?

Moral/Religious Judgment

Misdiagnoses

Misdirected Treatment - often with meds

This is familiar … same as alcoholism pre 1970's

Why I Use the Term Addiction

With addiction integrated into the treatment as a concept, clients receive:

- Social support
- Online support
- Peer support and guidance
- Direction, hope and shame reduction

All at no cost forever. Available ongoing throughout the lifespan- unlike therapy.

12-step Support Groups for Sexual Addicts and Partners All have international phone and VOIP meetings available

Sex Addict Support	***Partner Support***
SAA	S-Anon
SA	Alanon
SCA	COSA
SLAA-Women	CODA
SRA	RCA - Couples

SexAndRelationshiphealing.com

Sexual Addiction is not …

- Diagnosed until we rule out major mental health disorders that exhibit hypersexual symptoms: ADHD/OCD/Bipolar Disorder/Substance Use Disorder
- Fun
- A guy thing or a gay thing
- Symptomatic of moral or religious failing
- Sex negative, culturally biased or sexually conservative
- Related to fetish behavior or kink
- Ego-dystonic, or related to gender dysphoria or sexual orientation
- Sexual offending

Typical Sex Addict Behaviors

- Compulsive Use of Porn (with or without masturbation)
- Anonymous Hook-ups (met online or via hook-up apps)
- Adult Bookstores and Strip Clubs
- Sexual Exchange (i.e. drugs or favors for sex)
- Prostitutes and "Sensual" Massage Parlors
- Consistent Cruising, Intriguing, Objectifying, Seducing
- Pushing Boundaries, Viewing "No" as a Challenge
- Multiple Affairs / Anonymous Infidelity
- Sexting / Abusing Social Networks / Virtual Sex
- Repeated Predatory Crossing of Professional Boundaries
- [illegible]

Sexual Addiction Symptoms Follow the Characteristics of All Addictions

Criteria for Sex Addiction parallels guidelines for assessing Substance Use Disorder, Alcoholism, and Compulsive Gambling:

- **Preoccupation to the point of obsession**
- **Loss of control**
- **Continuation despite adverse consequences**

These are the criteria that operationally define addiction to any drug or behavior.

OK, but <u>how much sex</u> = addiction?

How many drinks = Alcoholism?

How much money lost = Addictive Gambling?

How many meals = Eating Disorder?

OK, but <u>what kind of sex</u> = addiction?

What kind of Alcohol consumed = Alcoholism?
What kind of gaming activity = Addictive Gambling?
What kind of food consumed = Eating Disorder?

Addictive disorders are determined NOT quantitatively, <u>but qualitatively</u>.
Meaning, how is this substance or behavior affecting the person's life & functionality?

Consequences

- Empty, non-intimate relationships or no relationship ability
- Multiple relationship losses and relationship damage
- Disconnected, disorganized family life
- Job and educational losses
- Sexually transmitted disease, unwanted pregnancy
- Depression, anxiety, suicide
- Co-occurring addictive disorders - inability to stay sober
- Reduced self-care - physical psychological, relational
- Arrest and loss of community standing
- Self-injury and isolation
- Self-hatred, internalized shame, self-loathing

How Can You Be *Addicted* to Hyper-Stimulating Behaviors

- Increased Heart Rate
- Pupils Dilate
- Hearing More Acute
- Shallow Breathing
- Perspiration - palms, underarms, etc.
- "Rush" or "Intensity" Feeling
- **Reduced Intellectual Functioning!**

Sexual addiction is the abuse of intense fantasy to induce the neurochemical release of:

- Serotonin - mood stability
- Dopamine - pleasure
- Adrenaline - energy jolt
- Endorphins - calm
- Oxytocin - love/connection

These are our naturally occurring mood hormones, which psychiatry already manipulates via medication.

ADDICTS CALL IT...

- The Bubble
- The Trance
- Spaced Out

- Think ...
- Dissociative State
- Trauma
- Self-Soothing

In 12-Step Language ...

POWERLESS!

Etiology

There appear to be several early-life challenges that lead to the adult-life brain dysfunction that we call sex addiction.

- Addictive behaviors help the self defend against overwhelming stressors, often related to preverbal trauma
  - Early, profound emotional neglect and abuse
  - Sexual abuse (overt or covert)
  - Extreme narcissistic parenting (covert incest)
- Conditioning (little research, much needed area of study)
  - Pre-teen/adolescent conditioning to porn = adolescent and adult intimacy disorders

Useful Popular Films to Understand the Issue

- Shame- about a male sex addict. Urban, smart, attractive, successful, who is also very, very broken
- Nymphomaniac Part One- Lars VanTrier film about a female sex addict, painful to watch, shows her childhood trauma and how it plays out in her adult intimate life
- Thanks for Sharing- a good general and more lite film on co-occurring addictions and recovery

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Applied Sex Compulsivity/Addiction Treatment

Dr. Robert Weiss LCSW, CSAT-S
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ICD-11: Compulsive Sexual Behavior Disorder

"Compulsive Sexual Behavior Disorder is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behavior. Symptoms may include repetitive sexual activities becoming a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities; numerous unsuccessful efforts to significantly reduce repetitive sexual behavior; and continued repetitive sexual behavior despite adverse consequences or deriving little or no satisfaction from it."

This is how our field has been identifying sex addiction for decades.

ICD-11: Compulsive Sexual Behavior Disorder

"Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviors is not sufficient."

Sex Addiction specialists have been using this criteria as a diagnostic rule-out for decades. Other possible rule-outs include:

- Compulsive sexual activity that only occurs as a symptom of another diagnosable disorder (often the manic phase of Bipolar Disorder)
- Compulsive sexual activity that only occurs in conjunction with drug use (usually the abuse of stimulants like cocaine and meth)

Assessment Considerations

- Like other addicts, sex addicts typically use their behavior to "numb out" and escape from stress and emotional (and sometimes physical) discomfort.
- Like other addicts, sex addict's behaviors typically escalate over time. They develop tolerance to older behaviors, and they must spend more time or engage in a more intense behavior to get the same neurochemical high.
- Like other addicts, sex addicts experience withdrawal when they step away from their compulsive behaviors, often manifesting as irritability, anxiety, depression, and similar issues.
- And there may be co-occuring addictions active or pending

Diagnosis: Recognizing Porn Addiction

Porn addiction is a common form of sex addiction. It occurs when an individual loses control over whether he or she views and uses pornography, the amount of time he or she spends with pornography, and the types of pornography that he or she uses.

- Research suggests that in today's world most porn addicts spend at least **11 or 12 hours per week!** looking at (and usually masturbating to) pornography. Many porn addicts devote double or even triple that amount of time to the addiction.
- Porn addicts often deal with Porn-Induced Sexual Dysfunction (PIED), where they can achieve and maintain an erection with porn, but not a real-world partner.

Diagnosis: SAPASA-2018

1.Do you feel overly distracted by, obsessed with, or preoccupied by your sexual fantasies and behavior?

2.Do you ever have trouble stopping your sexual behavior, even when you have more important things to do?

3.After having sex (with self or others), do you sometimes feel depressed or regret it?

4.Have you made promises to yourself or another person to change aspects of your sexual behavior, only to break those promises later

5.Did you experience abuse, neglect, or other serious trauma as a child or adolescent?

https://sexandrelationshiphealing.com/for-addicts/sex-addiction-test/

Diagnosis: SAPASA-2018

6.Do you look forward to events with family and/or friends being over so you can engage in sexual behavior?

7.Do you have trouble maintaining relationships once the sexual newness and intensity has worn off?

8.Have you ever kept secrets or lied about money and/or time spent on sex, porn, affairs, and similar behavior?

9.Do you sometimes regret the amount of time you spend with porn, webcams, hookup apps, and other forms of tech-driven sexual behavior?

10.Does your sexual behavior, real-world or online, interfere with your personal goals or create negative consequences in your work, community, or academic life?

https://sexandrelationshiphealing.com/for-addicts/sex-addiction-test/

Diagnosis: SAPASA-2018

11. Have your family, friends, or partner(s) ever worried or complained about your sexual behavior?

12.Does your sexual behavior potentially offend others, violate community standards, or place you in danger of arrest?

13.Do you ever find yourself "lost" in sexual fantasies and behavior as a way of coping with stress, boredom, loneliness, or other forms of emotional discomfort?

14.Do you keep certain elements of your sexual behavior hidden from partners and/or friends?

15.Do you believe that porn use, casual sex, and similar behavior may have kept you from creating and maintaining a successful long-term intimate relationship?

https://sexandrelationshiphealing.com/for-addicts/sex-addiction-test/

Diagnosis: SAPASA-2018

16. Do you repeatedly engaged in unsafe or "risky" sex?

17.Have you had certain kinds of sex (alone or with a partner) that you later regretted?

18.Does your sexual behavior ever leave you worried about or at risk of contracting or sharing sexually transmitted diseases?

19.Do you find yourself feeling restless, irritable, or discontent when you are unable to engage in certain sexual fantasies and activities?

20.Has your involvement with porn, hookup apps, sex/dating websites, and other online sexual environments become greater than your intimate contact with romantic partners?

https://sexandrelationshiphealing.com/for-addicts/sex-addiction-test/

Diagnosis: SAPASA-2018

21.Has anyone ever been hurt by lies and secrets related to your sexual behavior?

22.Do you ever feel compelled to seek out porn, hookups, and other forms of sexual activity, online or real world, even though you are trying to stop these behaviors?

23.Has the nature and/or intensity of your sexual fantasies and behavior escalated over time?

24.Do you find that you spend more time with sexual fantasies and behavior than you would like?

25.Have you ever been approached by the police, arrested, or charged with a crime related to your sexual behavior?

https://sexandrelationshiphealing.com/for-addicts/sex-addiction-test/

Who is the Sex Addict? Case Study #1

Max is a 22-year-old college senior. Until a few months ago he had a steady girlfriend, but when he told her that he didn't want to get married after graduation, she broke up with him. Now he is experiencing significant anxiety about his life and has started seeing a therapist. He tells his therapist that ever since the breakup he's been looking at "a lot" of porn, using it as a substitute for the time and sexual energy once expended with his girlfriend. He says that he first discovered Internet porn at age 13 and he has used it off and on ever since. He is keeping up with his schoolwork and he socializes at least a few times per week with his friends. As of now, he has no real interest in dating anyone else, nor does he want to have casual sex with anyone. He is worried that online pornography has taken precedence over real world sex and relationships. He asks his therapist if he might be a sex addict.

Who is the Sex Addict? Case Study #2

James is a 22-year-old college dropout. He is depressed, feels as if his life is going nowhere, and has started seeing a therapist. He tells the therapist that he started looking at porn when he was 13, and by the time he finished high school he was using porn daily, often for several hours at a time, despite several attempts to cut back. He has lost interest in nearly all the other activities he once enjoyed, preferring instead to view porn and have webcam sex with anyone who's willing. Since dropping out of college, he has held several menial jobs, none for more than a few months. He tells his therapist that he views cybersex as a solution to his problems, not a potential cause. He says does not want to even discuss the concept of sexual addiction, that he only wants to treat his depression.

sider Max vs. Jamie Using Diagnostic Cri

1. Which user of sexnology is preoccupied to the point of obsession with sex?
2. Which user or sexnology has lost control, most likely evidenced by failed attempts to quit or cut back?
3. Which user of sexnology is experiencing significant life consequences?
4. Which user of sexnology is engaging in sexual behavior to "numb out"?

Sex Addiction in Women

Female sex addicts are often more difficult to diagnose than male sex addicts. Understandable culturally. Men who have a lot of sex are often celebrated as "studs" and "players," hypersexual women are typically denigrated as "sluts," "whores" and "nymphomaniacs."

Women will more frequently complain of problems with:

- Dating
- Relationships
- Disordered Eating

It is not unusual for the sexually compulsive female to act out in the same ways as a man involving disconnected, compulsive sexuality, but she will not see this as a sex problem

Denial

- Sex addicts rarely view their escapist sexual fantasies and behaviors as the cause of their unhappiness and life challenges.
- They typically see their sexual behavior as the solution to rather than the cause of their emotional discomfort and various life problems.
- They ignore blatant warning signs: destroyed relationships, workplace reprimands, related drug abuse, STDs, unwanted pregnancies, financial problems, etc.
- They are nearly always out of touch with the costs of their addictive sexual behavior—at least until a major crisis arises.

Breaking Through Denial

Breaking through the addict's denial is a primary task of treatment. Common forms of denial include:

- Blame/Externalization
- Entitlement
- Justification
- Minimization
- Rationalization
- Victim Mentality

These can be used as homework assignment, asking for three (or more) examples of each form of denial that the client has used to support his/h addiction.

e Right Therapeutic Process: Modality - C

The preferred methodology in sexual addiction treatment is cognitive behavioral therapy (CBT).

- With CBT, the clinician and the addict look at the people, places, emotions, experiences, and events that trigger and reinforce the addict's sexually addictive thoughts, desires, and behaviors, and then they identify ways to short-circuit the addictive cycle.
- The process is task-oriented, with assignments (reading, writing, attending support groups, etc.) to be completed between sessions and discussed during sessions.
- LET'S See How this works in an example of psychodynamic vs. CBT

Clinical Exercises: Breaking Through Denial

Breaking through the addict's denial is a primary task of treatment. As a homework assignment, ask for:

- Ten (or more) examples of the client's preoccupation/obsession with sex
- Ten (or more) examples of attempts the client has made to quit or curtain his/her sexual behaviors, noting the approximate length of success
- Ten (or more) negative consequences the client has experienced related to his/her sexual behaviors

Exercise: Life History

As a homework assignment, ask your client to create a sexual history, identifying key sexual events from age 0-10, 10-18, 18-25, 25 and up. Then ask the client to do the same for his/her substance use/abuse history, relationship history, school/work history, and critical life events (births, deaths, military service, moving, etc.)

Then, using a roll of butcher paper, have the client create a horizontal time line listing all important ages and events, from birth to current age, with sexual history written in red, substance use/abuse in blue, school/work in black, relationship history in purple, and life events in green.

Have the client examine the timeline, looking for best moments, worst moments, patterns, and ways in which life has impacted his/her addiction.

e Prevention: Identifying Sex Addiction: T

Triggers are the thoughts and feelings that induce the strong desire—the *craving*—to ingest an addictive substance or engage in an addictive behavior. When addiction cravings set in, it is very difficult to stop the addictive cycle.

- Internal triggers typically involve emotional (or sometimes physical) discomfort.
- External triggers can be people, places, things, and/or events.

Sex addicts must often deal with intertwined triggers—a combination of internal and external triggers.

cise: Understanding and Coping with Trig

As a homework assignment, ask your client to:

- List his/her top ten internal and top ten external triggers toward sexual acting out.
- Place an asterisk next to the triggers he/she struggles with the most.
- For each item with an asterisk, list a healthy activity that he/she can turn to instead of the addiction.

Escalation

Addicts of all types typically experience an increasing tolerance to the mood-altering effects of an addictive substance or behavior. As a result, addicts must, over time, use more of an addictive substance/behavior or a more intense substance/behavior to achieve and maintain the desired neurochemical high.

Exercise: Tolerance and Escalation

As a homework assignment, ask your client to:

- List ten (or more) examples of time-related escalation he/she has experienced with the addiction
- List ten (or more) examples of intensity-related escalation he/she has experienced with the addiction
- Write a paragraph about any behaviors that surprise the client or that violate his/her personal code of ethics

Dealing With "Why Me and Why Now?"

The first question almost anyone diagnosed with sexual addiction asks is usually: "How did I get this way?" Rather than focusing on the fact that they are sexually addicted and what they are going to do about it, these individuals want to know if there is some external influence they can blame for their problems. Ultimately, of course, why a person is sexually addicted is unimportant from the standpoint of healing. Nevertheless, this question is posed, often repeatedly, by sex addicts in recovery, and sometimes they are unable (or unwilling) to move forward without some sort of answer.

The best response is that sex addiction is usually a combination of nature vs. nurture, and knowing the "why" of their behavior is less important than dealing with it.

Withdrawal

Much like a heavy smoker trying to quit - sex addicts go through a period of withdrawal that can last from a few weeks to a few months depending on clients underlying issues.

Withdrawal is described by most sex addicts as being in a consistent dysphoric mood. Loneliness, longing, irritability and depressive affect predominate

How Does Sobriety for a (Disordered Naturally Occurring) Behavior Differ from Substance Abuse Sobriety?

Sobriety in Substance Abuse means elimination or abstinence

Sobriety in food/sexual/addictions goal is not to eliminate, the goal is to bring the behavior into concrete structure and that structure into relationship (accountability). This is self-regulatory.

Sexual Abstinence

Sex addicts new to treatment are generally asked to take a short timeout (usually 30, 60, or 90 days) from all sexual behaviors, including masturbation.

This brief period of total sexual abstinence is suggested because most newly recovering sex addicts have lost touch with reality when it comes to sexual behavior, and therefore can't distinguish between healthy and problematic sexual activity.

This is also a time for the individual to learn more about who they are when NOT focused on seduction, flirtation and sex/relationship conquest

What is Sexual Sobriety?

- A mutually agreed upon clear, written and signed, behavioral contract based on client goals.
- Sobriety plans don't change without prior discussion.
- Similar to how we handle eating disorders

A Sexual Sobriety Contract

List of Behaviors ***I Want to Stop***	List of Behaviors ***I Want to Add***
A	A
B	B
C	C
D	D
E	E
F	F

All the above are tied directly to what client wishes to avoid and achieve in his/her recovery process thus reducing client/therapist power struggles

Required Treatment Steps When Working with Sex Addicts

1. Do a thorough psycho-**sexual** history/assessment -individually and then in group- using motivational interviewing technique
2. Confront Denial and maintain high accountability- using a cognitive behavioral frame
3. Identify the genuine client treatment goals and co-create ***a sexual sobriety contract or plan*** aligned with those goals.
4. Hold clients ***accountable*** to all their agreements!
5. Have client evaluated for psychotropic medication (mood disorders, ADD, OCD, Spectrum Disorders
6. Group therapy and psycho-education (homogeneous by gender)
7. Spousal and family support
8. Direct healthcare, family and crisis resolution
9. Refer to long-term 12-step, therapy or faith-based groups
10. Long term - many will need life-long support and trauma therapy

Exercise: Defining Sexual Sobriety

- As a homework exercise, ask your client to:
  - List ten (or more) examples of his/her powerlessness over sexual behaviors using the following format: "Even though I (list a consequence), I continued to (list an addictive sexual activity)."
  - List ten (or more) examples of unmanageability (problems and consequences) related to his/her sexual behaviors.
  - Based on these lists, create a bottom line definition of sexual sobriety (the behaviors that are causing problems in his/her life and need to be stopped).

What About Masturbation?

- When crafting a sexual boundary plan, one potential gray area is masturbation. For many sex addicts, masturbation is an integral part of the addictive cycle, directly feeding the fantasies that produce the "high" of sexual addiction. In such cases, masturbation is either a slippery but still-sober Middle Boundary behavior or a bottom line Inner Boundary behavior. For other sex addicts, non-compulsive masturbation could aid recovery, encouraging appropriate intimacy and contributing to an overall sense of sexual health and wellbeing.

With masturbation and boundary plans, it is best to (at least initially) err on the side of caution.

Treatment Settings: What's What

- Inpatient Treatment
- Residential Outpatient Treatment
- Intensive Outpatient Treatment
- Standard Outpatient Treatment

Treatment Cures Everything NOT TRUE!

One common misconception about treatment for sexual addiction is that after completing the recommended program, sex addicts will never again struggle with problematic sexual behaviors. This is not in fact the case. There is no "cure" for sex addiction (or any other addiction).

The primary goal of treatment is preparing the sex addict for the lifetime of recovery work to come.

Co-Occurring Disorders

Sex addicts often arrive in treatment with co-occurring issues—unresolved early-life trauma, other addictions, depression, anxiety, shame, etc.

Until very recently it was believed that before a sex addict got sober, little else could happen on the therapeutic front. Unfortunately, for some sex addicts this meant that coexisting issues were never effectively addressed. At times, these problems were never even acknowledged.

If both addiction and interrelated issues are not treated in an integrated fashion, patients might not fully heal from any of their issues.

Co-Occurring Disorders

- **Stage One:** Client safety and early sobriety. Emphasis on crisis management, along with extensive psychoeducation about the addiction, the coexisting issue(s), and their interaction.
- **Stage Two:** Focused on the simultaneous issue. For instance, trauma survivors may be asked to work on the re-experiencing and processing of past trauma(s) in the safety of the therapeutic setting, learning coping mechanisms that can be used outside the therapy room.
- **Stage Three:** Focused on the client's newfound ability to make life choices based not on his or her history of addiction and the coexisting issue(s), but on freedom from those bonds.
- These stages are fluid rather than linear in their application.

Transference and Countert

Applied Sex Compulsivity/Addiction Treatment

Dr. Robert Weiss LCSW, CSAT-S
Clinical
Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
www.seekingintegrity.org

@RobWeissMSW on Twitter
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Narcissism and Addiction: The price of surviving trauma

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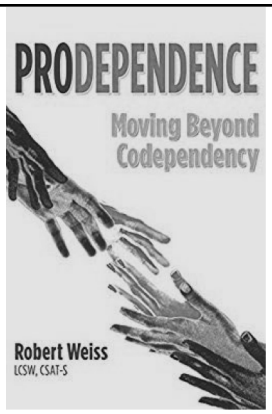
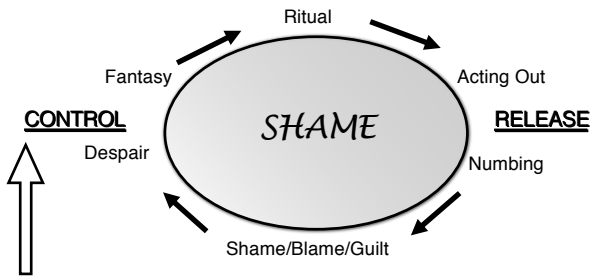


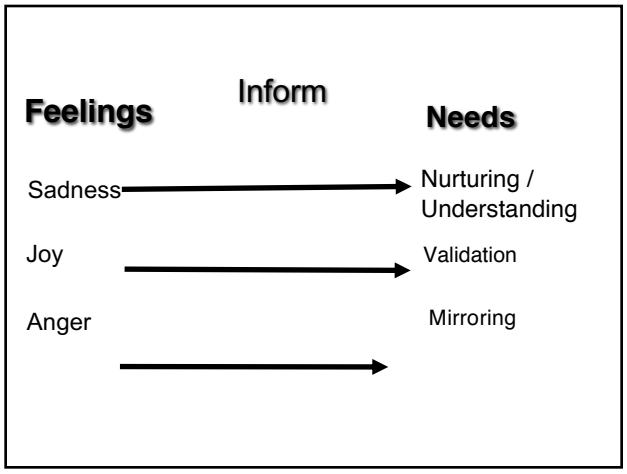
ıment Focused View of Addiction Recovery for Families and Lo

Typical Cycle of Addiction



Strong emotions and stressors generate and stimulate our dependency needs. Shame prevent us from getting them met.

Adapted from Fossum/Mason/Carnes et al.



What are the survival needs of infants?

- Food and Water = Nutrition
- Dry and Warm = Shelter
- Holding, Mirroring and Stimulation = Love

What happens to the infant/toddler if any of these are missing?

- Absent Food = Death
- Absent Shelter = Death
- Absent Love = Death (failure to thrive)

So, how long would any of us survive today *without*…

- Food/Nutrition
- Shelter
- Love

Note: We need LOVE to survive throughout the life cycle. So why don't we consistently seek it?

Internalized shame discourages us from reaching out to others to meet our basic human dependency needs.

Being fully known forces me to be vunerable, to risk rejection and pain.

Shame is the felt experience of being defective, wrought through early-life trauma & social deficits.

Shame is learned as essential dependency needs are denied or subverted and the child views himself/herself as being the problem.

Shame is the antithesis of self-esteem.

How does the self get shamed?

Primary Narcissism:

What the child internalizes about himself/herself is reliant on how the world responds to him/her.

So Who is the Problem?

Not Mom!
Not Dad!

Asking for help is the problem...
My needs are the problem...
***I* am the problem...**

Hence, the self is shamed.

Examples of Shame-Based Core Beliefs - The Shame Spiral

- No one would love me as I am.
- If you knew all about me, you would abandon me.
- Underneath I am a deeply flawed (unlovable) person.

In adult life this is a form of narcissistic self-obsession. To get my needs met AND be safe, I must be in relationship with people and experiences where I feel in control, even if the situation appears the opposite.

Patrick Carnes- "Out of the Shadows"

There's Nothing More Painful Than Loving Into a Void!

How Addiction Reinforces Shame & Emotional Emptiness

Time for a story...

Development of the Inauthentic (Shamed) Self

- Genetic or Predetermined Personality, Social Affect Management Skills
- Non-Responsive **or** Overly Responsive Caretaker Relationship
- Abuse - Psychological, Physical, Sexual
- Environmental/Cultural Factors

All of which can reinforce the idea that "I'm better off not needing anyone!"

"The child who is used and/or abandoned emotionally by their parent has the chance to develop his intellectual capacities undisturbed, but not the world of his emotions and this will have far-reaching consequences for his well-being."

Alice Miller: *The Drama of the Gifted Child*

What do addicts say to themselves about their need for interdependent relationships and intimacy?

- "I hate myself for being so needy."
- "I hate my neediness."
- "I hate my addict."
- "I can handle it myself."

Essentially, my needs are SHAMED so I don't reach out, but I still have to meet them because I'm human. Therefore I can only get them met when I feel a sense of CONTROL (i.e., where no one can hurt me ... again).

Many addicts desperately seek something they can never achieve in genuine relationships...

CONTROLLABLE INTIMACY

Time for an Art Therapy Story

Narcissism and addiction help to suppress, avoid and distract from deeper needs for intimacy and love by offering an illusion of control.

- Addictions (substance and behavioral)
- Intense Self-Focus, Self-Blame (shame)
- Pathological Caretaking/Codependency
- Thrill Seeking/High Risk Activities
- Dissociation/Fantasy
- Rage/Abuse
- Passivity/Helplessness and/or Drama
- Seduction and Objectification (both sexes)

Adaptive, survival-based emotional coping skills temporarily provide:

- Self-soothing
- Self-Regulation
- Distraction/Dissociation
- Stimulation
  - A Sense of Control

In the absence of and/or limited experience with healthier, more integrated relational means of self-stability, asking for help is SHAMEFUL.

In Simple Terms …

- Addicts Don't Learn About Their Emotions.
- Addicts Don't Learn From Their Emotions.
- Addicts Learn to Disavow Their Needfulness.
- Most Addicts Would Rather *Eat Dirt* Than Ask For Help (acknowledge need).

This should guide *every stage of therapy and treatment*

My Most Shameful Need …

At-A-Boy!

Narcissism and Addiction: The price of surviving trauma

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"Out of the Doghouse" Healing Relationship Betrayal

How couples get past the initial stage of shock, blame and trauma that accompanies profound infidelity

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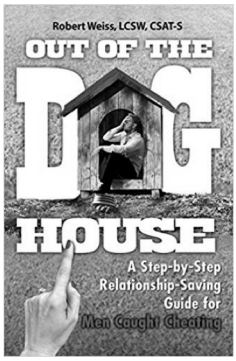
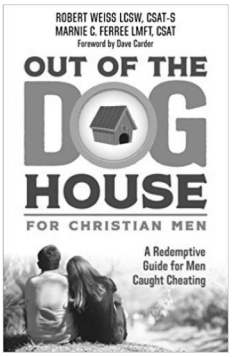




For Cheating Men seeking to understand and heal the hurt caused by cheating on a female partner

Spousal/Partner Betrayal

In a primary relationship, active cheating by one partner results in both betrayal and trauma for the other.

Initial concern for betrayed spouse = safety

- Physical health - STDs, pregnancy
- Family safety - Children at risk?
- Specific betrayals that might overwhelm or undermine later

Stay or Leave?

We advise: If violence or harm to spouse/partner or family are not present and there remains love, hope and commitment on both parts, give it 6 months to a year.

Considerations for leaving involve:

Social and Family Resources

Finances

Childcare

Healthcare

Commitment to Healing (on both parts)

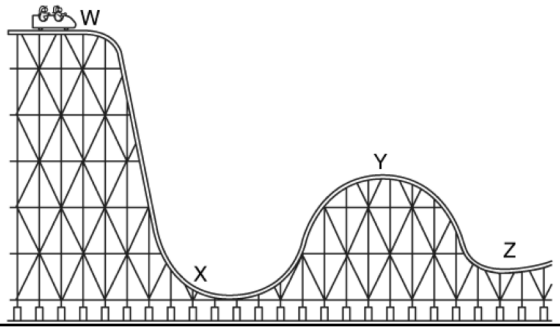
Spouses/partners are often newly introduced to information the cheater has known about for years. In early healing, each partner is in a different emotional place for this very reason.

What is the emotional state of a betrayed spouse?

The betrayed partner's emotional state is a form of trauma where he/she is understandably:

- Fearing further loss and abandonment
- Ashamed, self-hating, self-doubting
- Anxious - easily triggered to previous levels of trauma
- Worried about the future - parenting, finances, separation
- Having intrusive thoughts and images

Welcome to the *Emotional Rollercoaster, where CRAZY is the new norm.*



How long can it take to get off this ride?

9-18 months

- Provided there is an active recovery process in place in place *for both*
- Provided the lying and cheating have stopped

At the heart of the spouse's concerns

- How do I know if this is all there is to know?
- How will I know if he/she acts out again?
- Should I stay or go?
- How is trust re-established?

What emotional *engine* drives this 'coaster'?

Fear - Rage - Hurt - Disappointment - Loss - Grief - Shame

- Spouses are understandably fearful of further loss and abandonment (what else will I learn?)
- Ashamed, self-hating, self (and other) doubting
- Anxious - potential triggering of previous trauma
- Worried about the future - parenting, finances, separation
- Having intrusive thoughts and images, swiftly shifting moods
- Sleep and mood problems
- Overeating, under-eating

What helps spouses get off the Rollercoaster?

- Support & Validation: Consistent, nonjudgmental feedback and availability from friends, family, therapy, etc.
- Education: About the problem, the path to healing, encouragement for her/his boundaries
- Clear boundaries and structure for what is and is not acceptable to her/him going forward
- The Truth
- Creating and leaning into a community of caring women
- Therapy (cause they live with a crazy person…)
- Forgiveness - for themselves

Fatal Attraction reference for time

Typically, how does he BETRAY her right in this scene?

- He is still lying.
- His primary goal is forgiveness for him, NOW.
- He takes a passive (little boy) role.
- He has no sense of what he has brought into his home - the hurt, the harm, the fear, the uncertainty.

Partial Truths

It is tempting for an unfaithful partner to attempt damage control by initially revealing only some information, or none at all.

A majority of cheaters (58.7%) and partners (69.7%) reported that there had been more than one major disclosure (Corley & Schneider, 2002).

This is a nightmare for the spouse.

What is disclosure?

- **When the keeper of secrets reveals the truth**
- **It's not an apology**
- **It's not a plea for forgiveness**
- **It's not a bargaining chip**

Why Disclose Secrets?

- It's the road to intimacy.
- Secrecy is a powerful intoxicant. Healing means no more "double life".
- Reduces the cheater's shame which can often fuel relapse .
- Allows an adult-to-adult relationship on an equal basis.
- Empowers the spouse/partner with truth while helping them to feel less *crazy.*
- Gives the spouse/partner the ability to make healthy choices based in fact.
- Introduces potential for genuine intimacy.
- Disclosure reduces the 'crazy' feelings of the spouse- both past and present

Reactivity by a cheated-on spouse can sound like this…

- Expecting the cheater to be 100 % emotionally available now with no emotional unavailability - YOU OWE ME.
- Not allowing the cheater a learning curve toward better communication, emotional availability, empathy, etc.
- Questioning erections, inner thoughts, looks and fantasy - A SIGN!
- Dismissing a partner's natural need for solitude, reflection, healthy self-care (meetings, therapy groups, etc).
- Demanding the cheater now meet all of the spouse's needs as soon as they occur.
- **Physical or verbal abuse - This is unacceptable.**

earned your spot

Cheater Attitude Problems

- The problem is that people who have been cheating are used to living in a world where they perceive they have control (especially over the truth).
- By "giving-in" to going to therapy, support groups, workshops, disclosure, etc., they, in effect, feel like they are giving up control to their spouse.
- They express this as "being enough," as in "can you get off my back now" kind-of enough.

What does it mean to be "*In the Doghouse" for someone who has cheated?*

1) To listen and reflect rather than react
2) To listen with context of what has happened in mind
3) To be non-defensive, even if you have to bite your lip
4) To be grateful and express humility
5) To not assume your partner will see your point or understand
6) To not expect a gold star for meeting minimum relationship requirements
7) To find other recovering people to meet healthy needs and not *demand* them of the spouse (now)

How to remain in the Doghouse? "Poor me"

What happens now?

- The original trust in the relationship is gone forever and cannot be regained.
- The partner is in a trauma state and cannot move forward without first working through the trauma.
- The cheating person destroyed the foundation of trust in the relationship and is therefore no longer an equal in the relationship.
- The cheating person is responsible for building a new foundation of trust, which is how they regain equality in the relationship.
- The relationship must be put in a 'safe harbor' during the course of the recovery process (both agree to stay together).
- During this safety period - both spouses advised to place their primary emotional needs onto peers, support groups, therapy, and not their spouse.
- Put sex on hold until trust is restored.
- Trust is key now, thus the cheater must demonstrate trustworthiness.

* J. GOODMAN AND S. JASON 2012

How is Trust Regained? Hard, Consistent Work!

Trust is restored over time through…

- Reliable and consistent actions (not words)
- Fearless truth-telling - even when facing disapproval
- Keeping and meeting commitments!
- Acting as a full adult contributing family member
- Patience, empathy & understanding of the spouse's anger and hurt
- Healthy boundaries and self-care

The Trust Triangle *

* J. GOODMAN AND S. JASON 2012

"Out of the Doghouse" Healing Relationship Betrayal

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Sex and Relationship Healing

"Not in my Neighborhood!" Understanding Sexual Offenders

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

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Sex and Relationship Healing

What Is Sexual Offending?

- The **clinical definition** of sexual offending is *nonconsensual sexual activity*.
- The **legal definition** of sexual offending is often quite different, based not on clinical criteria but on statutes that vary by jurisdiction.

What Does Sexual Offending Look Like?

Clinical examples of sexual offending include:

- **Sex with someone unaware that a sexual act is taking place—voyeurism, sex with a person who is sleeping, etc.**
- **Sex when another i incapable of informed consent—a person who is drugged, mentally or emotionally incapacitated, too young, too ill, under your professional care, etc.**
- **Forcing a sexual act on another person—rape, snatch and grab molestations, exhibitionism, frotteurism, making or viewing child pornography, etc.**

Common Offender Myths

- **Only adult males engage in sexual offending.**
  - **Some sex offenders are female.**
  - **A significant percentage of sex offenders (especially with rape and child molestation) are adolescent males.**
- **Sexual offending is physically violent.**
  - **Many sex offenses are not physically violent—exhibitionism, voyeurism, frotteurism, looking at illegal pornography, etc.**
- **Sex addicts are sex offenders, and vice versa.**
  - **Only a small percentage of sex addicts escalate to offending, and even then they usually commit only lower level offenses.**

Five Categories of Sex Offenders

1. Violent Offenders
2. Fixated/Dedicated Child Offenders
3. Situational/Regressed Child Offenders
4. Situational Offenders (Non-Child)
5. Sexually Addicted Offenders

Violent Offenders

- Men (and sometimes women) who commit forcible sexual offenses, including rape and child molestations of the snatch and grab variety.
- These individuals are relatively rare, but they get a lot of press. As such, their behavior largely informs public opinion about sexual offending, creating a perceived need for harsh punishments for all sex offenders.
- Typically, these offenders do not respond well to treatment, and their risk for reoffending is high.

Fixated/Dedicated Child Offenders

- Their primary, often sole sexual attraction is toward children and/or teens.
- Generally they are unable to develop true sexual intimacy with an age-appropriate person.
- When attracted to prepubescent children, they are clinically referred to as pedophilic. When attracted to adolescents, they are clinically referred to as hebephiliac.
- Research suggests that around 3% of adult males have a primary sexual attraction to children, though only a small percentage ever act on it.
- These offenders typically have a difficult time in treatment and their risk for reoffending is high.

Seto, M.C., 2008. *Pedophilia and sexual offending against children: Theory, assessment, and intervention*. American Psychological Association.

Situational/Regressed Child Offenders

- Attracted to adults as well as minors. Many have healthy adult romantic attachments.
- Sexual behavior with minors tends to be opportunistic rather than planned. For instance, they may stumble across child pornography while surfing for porn in a more general way, and choose to explore that. Others offend related to drug or alcohol abuse, stress, too much free time, etc.
- These individuals, especially those who've not committed a hands-on offense, typically respond positively to appropriate treatment, and their risk for reoffending is generally minimal.
- There are numerous other possible contributing factors and depending on those the recidivism risk can increase from minimal to moderate.

Situational Offenders (Non-Child)

- These are men and women who occasionally, when an opportunity presents itself, engage in illegal sexual behaviors—peeping, prostitution, public sex, etc.
- These are people we would not typically think of them as sex offenders (a label we typically reserve for "perverted" individuals). Nevertheless, because their sexual behaviors do break the law, they qualify.
- Generally, these individuals respond positively to appropriate treatment, and their risk for reoffending is minimal.

Sexually Addicted Offenders

- **These are men and women who compulsively engage in sexual behaviors to avoid feelings of stress, depression, anxiety, and the like. They use sexual fantasy and the pursuit of sex to escape from life and to self-regulate their internal emotional state.**
- **Unfortunately, as with other addictions, sex addiction tends to escalate, sometimes from vanilla porn to illegal porn, or from affairs to the serial use of prostitutes, etc.**
- **These individuals typically respond positively to informed treatment, and they are unlikely to reoffend except, perhaps, in the early stages of sex addiction recovery when short-term relapses are relatively common.**

Addicted Offenders?

There are specific tests and protocols that can be used to determine if a person is sexually addicted/compulsive, such as:

- The Hypersexual Behavior Inventory
- The Sexual Dependency Inventory
- The Sex and Porn Addiction Self-Assessment, 2018

What's the Category Breakdown?

- We do not have official statistics on what percentage of sexual offenders fall into each of the five primary typologies.

- However, clinical experience and the small amount of available research strongly suggest that in today's world, where the internet is "creating" all sorts of sexual offenders, most of whom never enter the legal system, there are many more sexually addicted and situational offenders than violent and fixated/dedicated child offenders.

The Internet Influence

One study that collected and analyzed more than 400 million Internet searches (via Dogpile.com, a meta-engine combining search results from Google, Yahoo, Bing, and similar internet portals) found that the most commonly used adjectives when searching for pornography were variations of *young* and *teen*—used as modifiers in 13.5% of all sexual searches. So quite a lot of people are curious about, searching for, and possibly looking at underage pornography.

Ogas, O. and Gaddam, S., 2011. *A billion wicked thoughts: What the Internet tells us about sexual relationships*. Penguin.

Psychological Characteristics of Child Sex Offenders

- A significant percentage of sexual offenders are solid candidates for treatment, either in or out of prison.
- This is particularly the case when the underlying causes of their problematic sexual behaviors mirror the presenting issues of alcoholics and other addicts—unresolved trauma, attachment deficits, ongoing depression, severe anxiety, pathologically low self-esteem, etc.
  - The vast majority of situational and/or addicted offenders fall into this category.

Contraindications to Sex Offender Treatment

Factors that can complicate and/or hinder successful treatment include:

- The sex offense is merely one aspect in a larger antisocial or criminal lifestyle.
- The sex offense included bizarre or ritualistic acts, like extreme bondage or enemas.
  - Often, these offenders require as part of their treatment extensive trauma work, as they are typically reenacting a version of their own victimization.
- The offender consistently and persistently denies the offense occurred or that he/she committed it.
- The offender consistently and persistently externalizes the blame for the offense.
- The sex offense is secondary to an unremitting condition of serious mental illness or mental retardation.

The above factors can complicate and sometimes hinder treatment, but they do not automatically signal that an offender is untreatable.

Case Study #1: Robert

Robert was arrested after the IT department at his work, during a routine maintenance check, found about a dozen illegal (underage) images and videos on his laptop computer. There was no other pornography.

- In therapy, Robert initially denied that he downloaded the illegal material.
- A review of his life history reveals that he has never had a serious romantic relationship
- A review of his life history reveals he's been arrested multiple times for a variety of minor offenses (though none of a sexual nature, until now).
- Eventually, Robert admits that he "likes young girls," and that prior to his arrest he had a much larger stash of illegal porn.
- Robert is highly motivated to stay out of prison. Beyond that, he is unmotivated to make life changes. Mostly he wishes that people would stop "spying on him" and "intruding on his personal life."

Case Study #2: James

James was arrested after the IT department at his work, during a routine maintenance check, found about a dozen illegal (underage) images and videos on his laptop computer. In addition to the illegal material, there were hundreds more legal images and videos, mostly depicting adult women.

- In therapy, James immediately admits that he downloaded the illegal pornography even though he knew it was wrong and felt ashamed about doing it.
- He says, "This has been going on for a few years. My pattern is that I find some illegal content, download it, and then I end up completely hating myself and I delete it. But then a week or two later I do the same thing."
- James is highly motivated to permanently end his use of all pornography, to maintain his relationship with his long-term girlfriend, and to stay out of prison.

Case Study Comparison

- **After a thorough risk assessment is conducted, Robert will probably be typed as a fixated/dedicated child offender—with difficulty responding in positive ways to treatment, at least initially, meaning longer-term treatment is likely needed, with a higher likelihood of recidivism.**
- **After a thorough risk assessment is conducted, James will probably be typed as either a situational or a sexually addicted offender. And because he is internally motivated to make necessary life changes, he is an excellent candidate for treatment and less likely to recidivate.**
- **Unfortunately for James, when he goes to court he's going to be lumped in with Robert and sentenced based on the same outdated guidelines.**

So Who Needs What?

Sex offender treatment is NOT one-size-fits-all. Every case is different.

- As noted earlier, there are five primary categories of sex offenders. Some categories are more responsive to treatment than others.
- Of the categories that tend to respond well to treatment, different types of treatment may work better than others, depending on the category and the individual.
- Even violent offenders and fixated/dedicated child offenders can be helped if they are sufficiently motivated. Of course, many (maybe most) are not.

Ineffective Sex Offender Treatment

- All extensively utilized in the past, some continue into the present
- All ultimately ineffective
- Solo Use of Chemical Therapies - These typically involve the use of anti-androgenic hormones (Depo-Provera). Essentially, this is a form of chemical castration. This methodology is mostly ineffective because the human sex drive lives more in the mind than the body.
- Aversive Forms of Behavior Modification – This tries to change a sex offender's arousal patterns through negative association, most often electric shocks. This methodology is only minimally effective, and the efficacy diminishes over time.
- Psychodynamic Psychotherapy - Offenders will use what they learn in this work to maintain their denial. They will use this work to externalize the problem and diminish their role.

Effective Sex Offender Treatment

The first step toward useful clinical intervention is proper assessment.

- What kind of sexual offender are we dealing with?
- What is the offender's primary motivation for behaving this way?
- Is the offender likely to respond to treatment?
- Is the offender likely to repeat his/her offense?
- Beyond sexual offending, what other issues must eventually be dealt with?

Effective Sex Offender Treatment

- If, after a full assessment, an offender looks like a solid candidate for treatment, the most effective methodology is a combination of cognitive behavioral therapy (CBT), social learning, psycho-education, and external support.
- Sometimes selective serotonin reuptake inhibitors (SSRIs) are utilized in conjunction with other forms of treatment, as these antidepressant medications, as a side effect, often reduce a person's sex drive.
- The "Good Lives Model of Offender Rehabilitation," which essentially incorporates and formalizes all of the above, has also proven successful in the treatment of sexual offenders in many countries, including the United States.

Effective Sex Offender Treatment

- Most therapists who work with sex offenders (and sex addicts) rely heavily on CBT.
- CBT is a behavior-driven approach that looks at feelings, thoughts, and circumstances that trigger the desire to engage in problematic sexual activity, at the same time identifying and implementing ways to short-circuit the offending process.
- Essentially, sex offenders are taught to recognize their triggers and to respond in healthier ways, practicing new coping mechanisms and applying interventions that interrupt the cycle of abuse.

Effective Sex Offender Treatment

- With CBT, treatment is directive and reality-based, focusing on the here and now rather than on the exploration of childhood issues that may or may not have led to the offending behaviors.
- The exploration of childhood issues, if necessary, should occur only after the offender has taken full and total responsibility for and effectively halted his or her offending behaviors.
- A therapist's role, at least initially, is to implement a task-oriented, accountability-based program geared toward containment of the offender's problematic actions and the development of healthier in-the-moment coping skills.

Group Work

Very often, the treatment of sex offenders presents demands that cannot be met within the confines of an individual therapeutic relationship. Offenders typically require external reinforcement and support if they are to implement lasting behavior change.

Group therapy geared toward sexual offending is the recommended modality.

- In a facilitated group setting, offenders can see that their problem is not unique, which helps to reduce the guilt, shame, and remorse associated with their actions.
- Perhaps more importantly, the group format is ideal for confronting the denial used by offenders to justify their activities.

12-Step Recovery Work

Many sex offenders, especially sexually addicted offenders, also benefit from 12 step sexual recovery meetings, which provide both guided recovery and social support. Sexually addicted offenders are welcome in most groups.

- Sex Addicts Anonymous (saa-recovery.org)
- Sexual Compulsives Anonymous (sca-recovery.org)
- Sex and Love Addicts Anonymous (slaafws.org)
- Sexual Recovery Anonymous (sexualrecovery.org)

Further Resources

For more information about sexual offending and the treatment of sexual offenders, please visit the organizational websites listed below:

- **The Association for the Treatment of Sexual Abusers (www.ATSA.com): ATSA promotes evidence-based strategies for the assessment and treatment of individuals who have sexually abused/offended or are at risk to do so. ATSA also provides referrals to qualified therapists.**
- **The Safer Society Foundation (www.SaferSociety.org): The Safer Society Foundation is dedicated to ending sexual abuse and offending through effective prevention and treatment.**

"Not in my Neighborhood!" Understanding Sexual Offenders

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
www.seekingintegrity.org

@RobWeissMSW on Twitter
lob Weiss MSW on Facebook

SEEKING INTEGRITY

Sex and Relationship Healing

Addiction in the Digital World

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

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@RobWeissMSW on Twitter
Rob Weiss MSW on Facebook

Family Life in the Digital Age

A question to start us off …
Can you be addicted to a cell phone, pad or other digital device?

- You may be addicted to the content such devices deliver: porn, gambling, spending, gaming, but not to the device itself. There is no such thing as cellphone addiction!
- Our culture is struggling with the fact that so many people, our young people in particular, ENJOY spending so much time using a device that offers endless connection, information, relationships, communication and interaction.
- Today, lacking such involvement online, younger people would be unprepared for the world.

Why Does Technological Advance Lead to Behavioral Escalation and Potential Addiction?

1. Increasing access to highly pleasurable content means decreasing inhibitors to impulsive problem behavior.
2. The human brain hungers for any new stimulation that leads to rapid fire dopamine release (pleasure).
3. Increasing accessibility to such content thru digital devices means sexual acting out is more immediate and easier to hide.
4. Those with preexisting social/emotional deficits no longer need to evolve a social skill set in order to be part of a peer group or join into problematic/impulsive behaviors.
5. Certain illegal or negatively consequential behaviors played out online tend to have fewer consequences than IRL.

What types of *pleasure* does the online life offer?

- Hyperstimulation - sex, porn gambling, gaming
- Hyper-satiation - shopping, hoarding
- Social - 24/7 connection to friends, family communities of choice
- Information - 24/7 access to information, imagery and connection
- Interactive/Communal - Gaming, AR, VR
- Dating/Social Relationship

This is *all useful* as it serves the culture of today and is inherently non-pathological (like alcohol, newspapers or cheesecake). Unless your psychological make-up leads you toward fantasy-based emotional self-regulation. Thus, addiction potential in the more vulnerable among us.

Note our naturally occurring triggers for dopamine release (pleasure), which are essentially evolutionary in nature.

- Sex and Orgasm
- Winning/Success/Achievement
- Love and Romantic Attachment
- Parenting and Family Attachments
- Spirituality/Religion/Reflection/Meditation
- Exercise
- Eating
- Sports - Competitive Athletics
- High Risk Behaviors - climbing, auto racing, parachuting
- Violence/Rage
- Running with the Pack (think gaming platforms, highly competitive sports)
- Community Time - (shopping, girl-time, social media, Facebook, etc.)

Now consider pleasure in relationship to the process addictions below:

- Gambling
- Internet Gaming
- Workaholism
- Binge-Eating
- Sex
- Exercise
- Spending
- High-Risk Behavior

Understanding Addiction

Addicts return over and over to pleasurable hyper-stimulation and hyper-satiation for different reasons than healthy people, thus they get stuck.

Over time, for addicts the goal of finding and experiencing hyper-stimulation and hyper-satiation is ultimately ESCAPE, not PLEASURE.
Addicts get hooked on the **secondary gains** brought about by substance abuse and behavioral stimulation (fantasy).

What have been the most profound changes in our relationship to highly stimulating and pleasurable experiences over the past 3 decades?

- OR -
tentially more addictive than an IRL (in re

- Access
- Affordability
- Anonymity

Let's discuss how technology has escalated our easy, inexpensive access to:

Refined Substances:

- High caloric foods and snacks
- Distilled alcohol
- Cocaine, prescription drugs, street drugs

And Refined Experiences (via digital media)

- Gambling and Gaming
- Shopping
- Sex

Pre-1860s, Standard Alcohol Content was 4 - 6%

Present Standard Alcohol Content is 40 to 45%

Note that our cultural norms are ever-changing …

Sexting is fast becoming a cultural norm. In 2015, approximately 30% of all US adults between the ages of 25 and 45 reported having nude pictures on the

Today, being "Big Man on Campus" is determined by how many nude pics y

Clinical Populations to Consider as Potentially Being Negatively Affected by Tech/Social Media?

- Social Phobia
- Agoraphobia
- Aspergers and Spectrum Disorders
- Addiction and Compulsivity (in those vulnerable to this)
- Trauma Survivors (intimacy avoidant)
- Attachment Disordered
- Unhappy marriages!

But for some there also is a silver lining …

Life Online Offers

- community
- communication
- recreation
- social learning
- social bonding
- dating/sex
- education/information

- -All of which can provide a benefit to many of the - - same people with the same problems just listed

- - Online life allows far more reach to help people, increasingly those who might not otherwise find our help. And in far more places than today.

So is it good or bad? Is it addictive or useful?

YES !

To all of the above

But after all that discussion. For us treatment prof

Remember - Humans Plus Tech Always Relates Directly and Indirectly to Human Evolution

The prefrontal lobes (brains) of our children (therefore how they relate, mate, work, etc.) evolve in sync with technology.

Their neurobiological development is already different than ours. What they perceive to be a relationship is evolving in conjunction with the electronic devices we are putting into their hands almost from birth.

Addressing the Role of Digital Technology and Social Media in the Addictions

Dr. Robert Weiss LCSW, CSAT-S
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
www.seekingintegrity.org

@RobWeissMSW on Twitter
Rob Weiss MSW on Facebook

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Rose is adding a tech video here

Addictions in the Digital World

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

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Rob Weiss MSW on Facebook

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Sex and Relationship Healing

The Digital Generation Gap: Technology and Our Changing World

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

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www.seekingintegrity.org

@RobWeissMSW on Twitter
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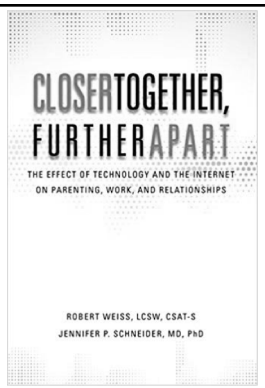

A *new way* to view social media technology as culture and our digital, generational divide.

What is Technology?

Fire
The Wheel
Gas-Powered Engines
Telephones

Note The Escalating Speed of Technological Change

- Radio - took 38 years to reach of 50 million people
- Television - took 13 years to reach 50 million people
- Internet - took 4 years to reach 50 million people
- Social Networking - took 16 months to reach 50 million
- Smartphone apps - took 9 months to reach 50 million

What is yet to come is here before we know it.

Consider the lowly QR Code…

What's your version of reality today? We now seem to have several choices…

In my short lifetime I have experienced:

1. Physical Reality
2. Chemically Altered Reality
3. Broadcast Reality (Radio, TV)
4. Non-Physical Internet Reality (websites, chat rooms, Facebook)
5. Reality-Based Entertainment
6. Augmented Reality - (Pokemon Go)
7. Virtual Reality - World of Warcraft!

Note: How many of these did your parents or your grandparents experience?

Answer the following (shame-based) question: Are you living in the 20th Century or the 21st?

- Door Keys
- Writing Paper
- VCRs and Betamax
- VHS tapes
- Maps
- Hook-up Bars
- Vacuum Tubes
- Transistor Radios
- Film Developers
- Books
- 8mm, 16mm, 35 mm film
- Watches
- Compact Discs
- CB Radio
- Pen or Paper
- Make-Up Mirrors
- Land-line Telephones
- Broadcast Media (TV, Radio)
- Newspapers and Newsstands
- Alarm Clocks
- Magazines
- Paper checks
- XXX Theaters
- Bookstores
- ATM's
- Flashlights
- Encyclopedias / Dictionaries
- Typewriters, Ribbon
- Paper Records
- Pen Pals
- Sony Walkmans
- 8-Track Players and tapes
- Records (LPs and 45s)
- Cassette Players and tapes
- Street Prostitution
- Televisions and CRT monitors
- Photographs
- Scrapbooks
- Postboxes
- Post Offices
- Libraries (in current form)
- Fax Machines
- Paper Money
- Pens, Pencils
- Calculators

devices are still needed, we no longer need the devices t

map/international navigator, phonebook, book/ music player, film player, notebook, radio, address book, compass, blood pressure monitor, calendar, photo album, friend/community finder, camera (video + still), credit card, airline ticket, cash, cash register, gaming platform, ATM, dictionary, flashlight, bank, clock, travel agent, newspaper, magazine and…

Consider this a new GENERATION GAP

Old Gap	New Gap
• Sexual Mores • Rock & Roll • Violence on Television • Recreational Drug Use • Liberalism (Gender, Social & Racial Equality) • Children Seen & Not Heard • Personal Privacy "We won't listen to you!"	• Sexual Mores • Violent Video Games • Rude Interpersonal Communication • Fantasy = Real Life • Social Networking = Ongoing Immediate Interconnectivity • Digital Immigrants vs. Digital Natives • Personal Privacy "Are you there?"

If you already feel dismissive of a client's culture, then how can you truly help them?

Let's talk about culture

What were you taught in graduate school about working with people who live in cultures that are different than your own?

Has it occurred to you that each of the following online worlds are all *Separate* and *Distinct* Cultures? Each with it's own separate populations, languages, norms and values?

Facebook
LinkedIn
Snapchat
World of Warcraft
Instagram
Twitter
and many more

BOOMERS NEGOTIATING THE DIGITAL WORLD

HTTPS://WWW.YOUTUBE.COM/WATCH?V=KAG39JK10LI
FOR EDUCATIONAL PURPOSES

Old Words, Shifting Concepts

So while everything has changed for some of us, it feels the same. For example, what does it mean to you to watch TV today vs. 25 years ago?

Similarly, infidelity can no longer be defined in purely physical terms. Think of it more globally as:

The keeping of secrets in an intimate relationship.

What you consider to be a relationship depends mostly on (you guessed it) how old you are.

In Today's World, Humans + Tech = Human Evolution

The prefrontal lobes (brains) of our children (therefore how they relate, mate, work, etc.) evolve in sync with technology.

Their neurobiological development is already different than ours. What they perceive to be a relationship is evolving in conjunction with the electronic devices we are putting into their hands almost from birth.

Let's Just Get Rid of It!

As we learned with Prohibition, there is no turning back on new technology or its effects. We can only observe with engaged interest not judgment while noting and dealing with related problems as they arise.

AND

That train has left the station.

Place a millennial's guide to baby boomers video here

EMBRACE CHANGE!
It is our sole shared constant.

The Good News!

Treatment and recovery are entering the new digital frontier. Clinicians need to be aware of these options for clients:

- Tele-Meetings and Live Webinars
- Online 12-step Chats
- Online Clinical Support Groups
- Face-to-Face Skype Meetings
- Face-to-Face Video Sponsorship
- Virtual Reality Desensitization Techniques

Our Job Now

To learn as much about modern technology and social media culture as we can.

To learn how to negotiate and understand the world of our young people and highly tech-savvy adults.

To understand tech issues as they present for the client, not how they are presented by the media or peers.

Then we can best help our clients to:

Raise healthy, safe families
Set and negotiate useful tech-related boundaries
Separate *the issues* from *the tech*
Offer our insight - not judgement or fear-based countertransference

Video from a segment of *The Doctors*

The Digital Generation Gap: Technology and Our Changing World

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
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@RobWeissMSW on Twitter
Rob Weiss MSW on Facebook

Kids, Sex and The Internet: A SWOT Analysis

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
www.seekingintegrity.org

@RobWeissMSW on Twitter
Rob Weiss MSW on Facebook

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How analog generations were connected pre-1994 (Gen-X and Boomers)

- In person/face to face
- On the phone
- In snail mail

How digital generations are connected in today's world via texting/social media (Gen-Y, and Millennials)

- 24/7 to:
- everyone
- anyone
- anywhere
- all the time
- anytime

So which generation is more connected?

Not us silly. It's the Millennials, hands down!

Challenges the Internet has brought are related to 3 essential concepts both for adults and kids

- Accessibility
- Affordably
- Anonymity

1992-2007 The Early Public Internet

- Internet user could readily be controlled
- Internet was Accessed from a stable platform – i.e., my room, my classroom, my house, etc.
- A single device or two allowed for monitoring, relatively easy blocking of inappropriate sites

1992–2007
The Early Public Internet

Problems then related to:

- Lack of parental understanding of the web
- Chat rooms, porn
- Fear-mongering on the part of the press (To Catch a Predator, etc.) i.e., incidence of child/adult sexual contact interaction very low despite adult fears
- Moderate Interactive Social Power – website focused
- No universal messages to advise parents how to help their kids
- Kids often knew more than their parents about the technology

2007 – Today
The Internet Today (stage 2)

Problems now related to:

- Lack of parental understanding of social media
- Devices now mobile, can access 24/7 in any place
- Difficult to track and filter, "If tracked, I can just use a friend's phone or pad."
- Internet today is now near impossible to "control"
- Apps and text messages can be deleted without a trail or trace
- High Interactive Power – via Social Media
- Can geographically search and find anything anywhere
- Ubiquitous and fully mobile – can walk down the street and be doing anything

Access to the web: Strengths

- Community building and social maintenance
- Emergency help if ever needed 24/7
- Information when needed 24/7
- Immediate direction, information on any topic, anytime
- Ability to easily find, build and support social support and relationships
- Family and friend contact, relationship building via tech
- Learning increasingly fast ways to multitask – neurobiological development
- Kids can teach parents about tech
- New methods and opportunities for learning
- Rounded and fully accessible education about human sexuality and human development – allows for marginalized or atypical kids to feel less alone
- Helps socially shy or inhibited kids get into social world – with fewer fears

Access to the web: Weaknesses

- Parents less aware, engaged and insightful about Internet life than are their own kids – the generation gap
- Significantly reduces learning opportunities for real life (IRL) socialization and intimacy skills
- No research – no clarity on long term effects of any of it
- No way to (fully) monitor what kids are doing out there
- No way to (fully) protect kids from making bad choices
- A very easy place for kids to find sex, drugs and trouble
- Doesn't encourage kids who are socially unmotivated to develop IRL relationships
- Limits opportunities for IRL social learning (on every level from friendship to romantic intimacy)
- What is seen/viewed/read in the online world may not represent reality – kids may not be able to discern "journalism" from "opinion," or even "intimacy and relationship based connection" from "porn and hook-ups"
- Can introduce kids to negative coping: anorexia, cutting, sexting
- Older generation on the whole does not understand social media or the digital world as do their kids, who tend to dismiss and judge rather than engage – with boundaries

Access to the web: Opportunities

- Educational tool – kids interact with teachers, school, peer groups from home
- Positive, interactive child/parent relationship and connection
- New ways to educate, engage and inspire kids
- Marginalized, impaired or challenged kids – they can access the whole world from their hand – never feel like "the only one"
- Feeling part-of (and connected to) a much larger world
- Normalizes marginalized kids' experiences
- Neurobiological development/evolution – our kids will think, switch, interact faster and more effectively than we do

Access to the web: Threats

- Cyber-bullying – in multiple forms: sex, aggression, gossip, marginalizing, stealing ID, stealing data, gossip
- Prepubescent children exposed to adult pornography
- Post-pubescent children (over) involved with adult pornography
- Teens able to access and engage in adult hook-up culture
- Loss of innocence
- Potential ID theft/TMI sharing via naïve kids
- Porn Induced Erectile Dysfunction (PIED) – viewed not so much as addiction, but more as a conditioned response to hyperstimulation
- Ego and device/platform are fully fused – let's discuss this

Our culture is changing, so know the norms, don't be an "old fogey"

- Don't forget your youth
- Don't forget how you wanted your parents and role models to treat your interests and your exciting world when you were young
- Don't forget your hurt, disappointment, resentment or dismissiveness when your role models "didn't get" your music, friends, lifestyle choices

Protecting kids from unwanted content

- Filters, Blockers and Trackers

Blockers, Filters, and Trackers

Blockers

- These screen out unwanted content, most often by age group, they most often employ browsers set by age and type of content to block – i.e., sex, violence, porn, gaming, etc.
- Blockers are best suited to the youngest kids who you don't want to access broad areas of content.
- And sex offenders

Filters

- These are more specific, filtering out material by terms that the user can install – words like sex, porn, breast, intercourse, gay, etc.
- Filters best suited for pre/post-pubescent teens who may want or need access to sexually related content, but not say – porn or graphic imagery.
- Not good for later teens or sex addicts

Trackers

- These do not block or filter. They report every keystroke and URL visited. Anywhere someone goes on any device, pad, phone, computer will be reported at set intervals to a third party (parent, sponsor, clergy therapist, etc.)
- Trackers are ideally suited for late teens 15-18 in whom you want to install a sense of "observing ego," as they let a child wander where he/she will online and say what he/she will, knowing that an authority figure will read and monitor all his/her communication.
- Also Very Very Useful with sex addicts- helps to 'install' a sense of observing ego.

Online Protection Resources

Effective filtering and accountability software programs at the time of this writing:

- **BSecure Family Safety, www.bsecure.com;**
- **Covenant Eyes, www.covenanteyes.com**
- **McAfee Safe Eyes and McAfee Family Protection, www.mcafee.com/us/**
- **Net Nanny, www.netnanny.com**

All have online reviews from concerned clinicians and parents –
This is a constantly changing arena online and therefore it is best for you to investigate to review the updated 'best recommended' when needed

Kids, Sex and The Internet: A SWOT Analysis

Robert Weiss PhD CSAT
Clinical Sexologist/Author/Educator

rob@seekingintegrity.org

www.sexandrelationshiphealing.com
www.seekingintegrity.org

@RobWeissMSW on Twitter
Rob Weiss MSW on Facebook

SEEKING INTEGRITY

Sex and Relationship Healing

Sex + Tech = Sexnology
Where Sex and Tech Combine

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Sexual Access Timeline
Pre-History - 1860s

- Recreational and Intimate Sexuality
- Cave Drawings and Painted Pornography
- Affairs & Infidelity
- Public Baths and Steam Rooms
- Prostitutes & Harems
- Masturbation

Sexual Access Timeline
1860s - 1970s

All of the above plus ...

- Photographic Porn
- Porn Movies
- Porn Theaters (XXX)
- Adult Bookstores
- Bath-Houses & Strip Clubs

Sexual Content Access 1977 - 1990

All of the above plus ...

- Video = VCR and BETA
- Phone Sex
- Soft-Core on Cable TV - at Home
- "Adult" and "Escort" Sections in Yellow Pages, Magazines and Newspapers

Sexual Content Access 1990 - 2006

All of the above plus ...

- BBS - Online Bulletin Board Systems
- Websites for Porn and Prostitution
- Online Porn and File Transfer Sites
- Chat Rooms
- Online Hook-ups - i.e. Craigslist
- Webcams and Interactive Live Sex

Sexual Content Access 2007 - Present

All of the above plus …

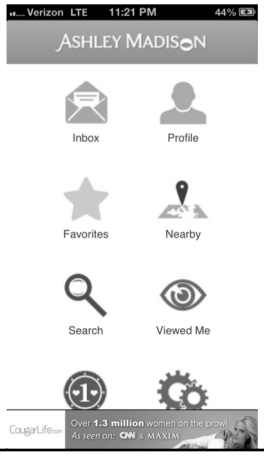
- Sexting and Live Video Streaming from Your Smartphone
- App-based Hook-ups (Tinder, Grinder, Scout, Ashley Madison)
- Social Networks (Facebook, Instagram, Twitter, Snapchat)
- Virtual World Sex (Second Life, Virtual Games, etc.)
- Virtual Sex and Teledildonics
- Selective Searching for Specific Fetishes, Interests

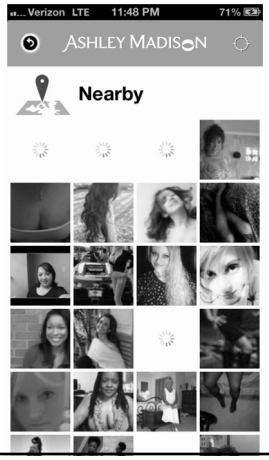
There is also tech for long distance pleasure … and connection

Teledildonics

Also known as cyberdildonics, is technology for remote sex (or, at least, remote mutual masturbation), where tactile sensations are communicated over a data link between the participants. Today, via Bluetooth, "Look ma, no wires!"

And then there are: "Adult Friend Finders" or "Sex Apps"

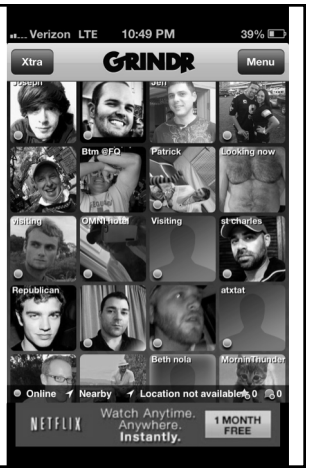


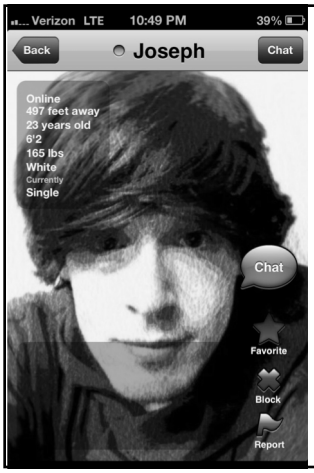


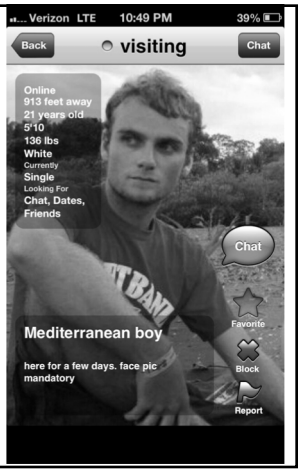
Think about what is being exploited here.

"Don't be a victim of your marriage ... CHEAT!"

The Gay Game Changer







And if you feel badly after … there's an app-based solution for that too!

What is on the way is

… virtual reality. The next tech game changer.

Sex + Tech = Sexnology
Where Sex and Tech Combine

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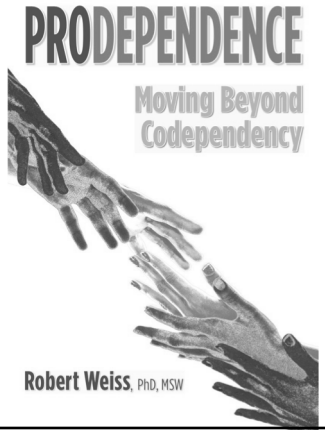
SEEKING INTEGRITY

Sex and Relationship Healing

Prodependence: A New Paradigm

If no one risks new ideas, we stagnate rather than progress. I truly believe that. I also understand that leading with new ideas, especially ideas that may disrupt **existing** norms, is to risk ridicule, derision, and disdain."

— Robert Weiss, *Prodependence: Moving Beyond Codependency*



Codependence: The Old Idea

Codependence is a trauma-based theory of human dependency which, by definition, states that those who partner with an active addict do so as a form of trauma repetition—putting themselves in a relationship where the other person's needs will eventually exceed and overwhelm their own. These caretakers, by definition, demonstrate their trauma-based low self-esteem and desperate desire for approval by seeking out and becoming deeply attached to such troubled people, feeling that they can resolve the addict's problems.

Prodependence: The New Idea

Prodependence is an attachment-based theory of human dependency which, by definition, states that those who partner with an active addict are loving people caught up in circumstances beyond their ability to healthfully cope. Moreover, their desire to help the addict and all related actions toward helping the addict demonstrate nothing more than a normal and healthy attempt to remain connected to a failing loved one while facing extraordinarily difficult circumstances.

Caregiving Scenarios

My spouse of 15 years, with whom I have three children, is diagnosed with cancer:

- I go out of my way to assist her and to care for my family, pushing aside my own needs and desires in the process.
- How do friends, family members, my therapist, and my employer react to this?
- How do they advise me?

Caregiving Scenarios

My spouse of 15 years, with whom I have three children, is addicted to opiates:

- I go out of my way to assist her and to care for my family, pushing aside my own needs and desires in the process.
- How do friends, family members, my therapist, and my employer react to this?
- How do they advise me?

What makes this difference?

1.Addictions are viewed differently than other issues. They are more shameful to both the addict and the addict's family.

2.Back in the 1970s and 80s, we applied systems theory to the disease model of addiction. With that, our thinking shifted from looking at the addict alone to looking at the addict's entire family as a pathological system. Suddenly, everyone in the family was seen as playing a meaningful and pathological role in the formation and maintenance of addiction.

3.From there, we began to apply the trauma-based codependence model to caregiving loved ones of addicts.

How Do You Conceptualize a Codependent Person?

- Enmeshed?
- Enabling?
- Controlling?
- Preventing (either consciously or subconsciously) another person's growth and recovery as a way of maintaining status quo?

Codependence Gone Awry

The codependence movement's progenitors were almost certainly not trying to say that loved ones of addicts provide care based solely on their personal insecurities and neuroses. But that's where we've ended up.

"Like other misunderstood and misused psychological expressions, "codependency" has taken on a life of its own. … Since its introduction in the 1980s, its meaning has devolved to describe a weak, needy, clingy, and even emotionally sick person."

–Ross Rosenberg, author of The Human Magnet Syndrome, on Psychcentral.com

Why Codependence Doesn't Hold Up

As codependence is currently practiced, loved ones of addicts are routinely counseled to accept their own trauma-based weakness, to step away from the dysfunctional relationship, to stop rescuing, to stop enabling, to detach with love, and to "stop being so codependent."

Unfortunately, this approach does not empathetically meet them where they are (anxious, fearful, angry, etc.). Because of that, they often respond negatively to these suggestions, thinking and saying things like, "How can I possibly abandon a person I love, especially in his or her hour of deepest need?"

The Codependence Model

For years, I have listened to therapists and counselors talking about how difficult it is to work with the wives, husbands, and parents of addicts. I consistently hear statements like:

- They don't want to own up to their part in the problem.
- They view the addict as the sole source of the problem, and that makes it hard to help them.
- They don't see how their attempts to be caretakers are making things worse.
- They may be sober, but they're every bit as sick as the addicts, and sometimes sicker.
- They just can't stop rescuing, and that causes more problems than it solves.

Are Caregivers Universally Just Inherently Broken?

- What if loved ones of addicts aren't so difficult to treat? What if "the problem" lies more in how we conceptualize them?
- What if our primary model for treating them has misunderstood and marginalized them in ways that simultaneously confuse them and cause them to feel unnecessarily blamed and shamed?
- What if we prejudge loved ones of addicts as codependent and therefore driving a dysfunctional family system? What if that "diagnosis" pushes them into a reactionary state where they feel they must defend their actions and tell us where the real problem lies, which, in their mind, is with the addict, and we then go round and round with them, playing pin the tail on the pathology?

Prodependence: A New Paradigm

Prodependence is a term I've created to describe relationships that are healthfully interdependent, where one person's strengths fill in the vulnerabilities of the other and vice versa, with this mutual support occurring automatically and without question.

As applied to caregiving loved ones of addicts, prodependence refers to extraordinary, loving attempts to care for and help heal a person to whom one is deeply attached and bonded, even when that person has become chronically dysfunctional because of an addiction or some other equally troubling issue.

The Meaning of Prodependence

- Addictions are not moral failings. Addictions are not weakness. Addictions are not a lack of moral fiber. Addictions are an intimacy disorder.
- Addicts have internalized fear and avoidance, usually early in life through neglect, abuse, and other forms of traumatic experience, to fear and avoid emotional vulnerability. Thus, they distance themselves from others, turning instead to addictive substances and behaviors.

Codependent Traits Reframed as Prodependent Traits

Codependent	Prodependent
1.Enmeshed	1.Deeply involved
2.Externally focused	2.Concerned about the welfare of others
3.Enabling	3.Supporting
4.Fearful	4.Concerned
5.Lacking healthy boundaries	5.Eager to care for a loved one
6.Can't say no	6.Chooses to say yes
7.Obsessed with the addiction	7.Determined to protect the addict
8.Living in denial	8.Unwilling to give up on a loved one
9.Angry	9.Fearful of further loss with no control
10.Controlling	10.Trying to be heard
11.Hypervigilant	11.Anticipating problems

Addiction-Recovery Demands Connection

When addiction is conceptualized an intimacy disorder, it's clear that the best treatment is not the pursuit of sobriety, it's the pursuit of healthy, intimate, ongoing connection.

- This is a fundamental task of addiction treatment. Once we've gotten addicts through their denial and established a modicum of sobriety, we must help them develop and maintain healthy and supportive emotional bonds (which, if they remain sober, will serve as the emotional comfort that their addiction never fully provided).
- It is this approach—not willpower, or baby sitters, or shaming, or threatened consequences— that is most likely to lead to lasting sobriety, emotional healing, and a happier, healthier life.

The Human Rat Pack

Rose- this gets a 3-4 min cut from Johann Hari's TED talk- where he talks about addiction as an intimacy disorder

Addiction Recovery

The most effective way to overcome addiction is for addicts to develop healthy, meaningful, ongoing interpersonal connections. Unquestionably, the most important of those connections are with prodependent loved ones.

The "codependence" fear is that caregiving loved ones might (and sometimes do), as a way of keeping the relationship intact, behave in ways that enable and perpetuate the addiction. Still, the solution is not detachment, where caregivers love the addict but only from afar. The solution is to stay connected and to continue caregiving, but - do that more effectively.

Applied Prodependence

Caregivers need to consistently be safe people to facilitate an addict's recovery, and in the early stages of a family's healing, it's likely that they're not. As such, loved ones often need to take a step back in early recovery, letting the addict rely more on his or her therapist, therapy group, and 12-step program than on family members.

At the same time, loved ones can work to improve the ways in which they care for themselves and the ways in which they relate to, connect with, and care for the addict. Essentially, they can learn to:

- Care for themselves as well as the addict
- Set and maintain better boundaries

Applied Prodependence

Prodependence work may sound a lot like codependence work. And it should because this is the exact same stepping away and engaging in self-care and boundary work that codependence recommends. However, prodependence recommends this work from a different perspective.

- Codependence, as a deficit-based trauma model, tells loved ones they're traumatized and damaged and driving the dysfunction in their family, and, until they step away and make changes, the situation will either stay the same or get worse.
- Prodependence, as a strength-based attachment-driven model, tells loved ones they're doing hero's work, but there are ways they can do that more effectively while also taking better care of themselves.

In the caregiver's mind, that is a huge difference.

Applied Prodependence

Prodependent treatment for loved ones of addicts:

- Assess for any genuine pathology (depression, anxiety, PTSD, mood disorders, and the like).
- Validate and celebrate prior attempts to rescue, save, heal, and otherwise help the addict.
- Educate about the nature of addiction and the stress it can place on loved ones.
- Identify times and situations where a loved one's actions have led to a less than ideal outcome and redirect toward more effective assistance.
- Work to improve the client's efforts at self-care—exercise, recreation, spirituality, creativity, etc.
- If, over time, the client seeks deeper understanding of his or her trauma history, that door can be opened, but only after the crisis stage has passed and the client's life is stabilized.

Applied Prodependence

With prodependence treatment, therapists should avoid attempts to:

- Try to explore at the client's role in the addiction and the family's problems.
- Extensive assessments the client's childhood and family history. Or history with the spouse beyond the acute problem
- Diagnose the client (as codependent, bipolar, borderline, or anything else) as a way of explaining the client's distress.

In the early, crisis stage of treatment, these efforts at "codependence treatment" are not helpful.

Grief Evokes Remorse

People experience any kind of loss are going to feel remorse. Remorse is part of grief. When someone dies, remorse sounds like this:

"I wish I had said this or that. I wish we had done this or that etc.

But when your child or spouse is an active addict, remorse sounds more like this:

"If only I had been this or been that -they would have stopped drinking or using"

Applied Prodependence: Self Care

With prodependence, self-care is about finding a middle ground that is healthy for the caregiver, for the addict, and for the relationship between the caregiver and the addict.

- Living in the extremes—doing too much too often or detaching completely and forcing the addict to struggle without assistance—is not healthy for anyone. Living in one or the other of these extremes perpetuates the addiction, along with insecure attachment, family dysfunction, and an unhappy life.
- Engaging in self-care may feel counterintuitive to caregiving loved ones who are so used to focusing on someone else.

Applied Prodependence: Boundaries

Loved ones of addicts often seem to think that setting boundaries is about putting limits on the addict's behavior. And inevitably they've learned that this does not work. At all. Because other people don't want to be controlled by us any more than we want to be controlled by them. Caregivers must focus on their own behavior, not the addict's.

- Healthy boundaries are about staying in our own hula hoop. The only things we can control or that we should try to control are the items within our immediate space.
- With healthy boundaries we can say, "Not my circus, not my monkeys." If a problem is not of our making, then it's probably not ours to control or fix.

Case Study: Michelle

Michelle is the wife of an active alcoholic. She and her husband, Alex, have three children, ages 11, 14, and 21. For years, Michelle has covered up and attempted to manage Alex's drinking with varying degrees of success. Now her eldest child, Jonathan, is abusing drugs and has dropped out of college. Michelle is worried that Alex will get fired for missing too much work or for showing up at his job while drunk. Meanwhile, Jonathan is living in a crowded two-bedroom apartment with four other dropouts, supporting himself with a part-time, minimum wage job. The younger children seem to be doing OK in school and socially, but Michelle worries they will follow in their older brother's footsteps or worse. Unsure about how she should handle everything that she and her loved ones are going through, Michelle finally seeks therapy and asks for advice for both herself and Alex.

Shame and Blame are Minimized in Prodependence

To treat loved ones of addicts using prodependence, we need not find that something is "wrong with them." We can simply acknowledge the trauma and inherent dysfunction that occurs when living in close relationship with an addict, and then we can address that in the healthiest, least shaming way.

As with codependence, prodependence recognizes that when a caregiver's actions run off the rails and become counterproductive measures can be taken to put the relationship back on track. However, prodependence does not imply that a caregiver's dysfunctional behaviors arise out of any past or present trauma or pathology. Instead, prodependence views these actions as an attempt to maintain or restore healthy attachment.

Applied Prodependence Boundaries

Loved ones of addicts often seem to think that setting boundaries is about putting limits on the *addict's* behavior. And inevitably they've learned that this does not work. At all. Because other people don't want to be controlled by us any more than we want to be controlled by them. Caregivers must focus on their own behavior, not the addict's.

- Healthy boundaries are about staying in our own hula hoop. The only things we can control or that we should try to control are the items within our immediate space.
- With healthy boundaries we can say, "Not my circus, not my monkeys." If a problem is not of our making, then it's probably not ours to control or fix.

Love is Not Pathology Ever!

Under no circumstances does prodependence imply that love is or can become pathological. Instead, prodependence acknowledges that loving an unpredictable, addicted partner who blames, lies, seduces, manipulates, and gaslights loved ones can make pretty much anyone look crazy over time. Because that is the type of behavior that puts people in crisis. And people in crisis can look crazy.

Codependence: How We Advise Loved Ones

Using the codependence model, loved ones are told that their efforts to help are counterproductive and facilitating (maybe even escalating) the problem. They hear:

- They have an unhealthy obsession with the addict and his or her behavior.
- They are enmeshed with the addict.
- They are enabling the addiction.
- They are dysfunctionally trying to control the addict's thinking and behavior.
- They are making the problem worse.

Prodependence: What We Tell Loved Ones

Using the prodependence model, loved ones are told their efforts to help are invaluable and heroic. They hear:

- They can't step away stop caring for the addict any more than they can stop breathing.
- They *can* learn to caretake in ways that are more helpful to the addict, and by extension to themselves.
- They *can* learn to care for themselves as well as the addict.
- They *can* learn to set and enforce realistic boundaries with the addict (and others).

Prodependence: Moving Beyond Codependency

Robert Weiss LCSW CSAT
Sexologist/ Author/ Educator

rob@seekingintegrity.org

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