

Barriers to female sex addiction treatment in the UK

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Background: Over the last 20 years, behavioral addictions (e.g., addictions to gambling, playing video games, work, etc.) have become more accepted among both public and scientific communities. Addiction to sex is arguably a more controversial issue, but this does not take away from the fact that some individuals seek professional help for problematic excessive sex, irrespective of how the behavior is conceptualized. Empirical evidence suggests that among treatment seekers, men are more likely than women to seek help for sex addiction (SA). **Methods:** Using the behavioral addiction literature and the authors' own expertise in researching female SA, this paper examines potential barriers to the treatment for female sex addicts. **Results:** Four main types of barriers for female sex addicts not seeking treatment were identified. These comprised (a) individual barriers, (b) social barriers, (c) research barriers, and (d) treatment barriers. **Conclusions:** Further research is needed to either confirm or disconfirm the identified barriers that female sex addicts face when seeking treatment, and if conformation is found, interested stakeholders should provide better awareness and/or see ways in which such barriers can be overcome to aid better uptake of SA services.

Keywords: sex addiction, female sexuality, female sex addiction, hypersexual disorder, addiction treatment, barriers to treatment

INTRODUCTION

As behavioral addictions have become more widely accepted into mainstream society (e.g., gambling, video gaming, workaholism, etc.), as well as legitimacy among the psychiatric community following the reconceptualization of gambling disorder from a disorder of impulse control to a behavioral addiction in the latest (fifth) edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5; American Psychiatric Association (APA), 2013], it has become essential to understand and develop provisions of treatment for such disorders (Dhuffar & Griffiths 2015a; Griffiths & Dhuffar, 2014). One (arguably controversial) behavioral addiction that has received increasing research interest is sex addiction (SA) (Griffiths, 2010). Since there is no universal agreement on how SA and/or hypersexual disorder (HD) are defined, it is more difficult for clinicians outside of the field to conceptualize, assess, and diagnose the disorder (Kafka, 2009). However, scholars and treatment specialists (e.g., Goodman, 1992; Schneider, 2000; Weiss, 2013) have continually argued that the disorder is the same, irrespective of what it is called and whether or not it is included in the DSM-5 (APA, 2013) or ICD-10 (World Health Organization, 1992).

The prevalence rate of out-of-control sexual behavior and its consequences among females in the UK and elsewhere is unknown at this time (Hall, 2013). In order to increase awareness, provide treatment options for such groups, and,

for SA to officially be recognized as a clinical reality, an indication of how many people experience it as a problem is of significance. Although some researchers in the field have estimated that 3–6% of the general population in the US may be sexually addicted (e.g., Carnes et al., 2012), no nationally representative published studies have been carried out to support this statistic (Reid, 2013). For example, Coleman (1992) estimated 5% of the population met criteria for “sexual compulsivity” and Carnes (1991) estimated a figure of 3–6% in the population of the US suffer from SA. Exactly how these estimates were reached is not clear. Kuzma and Black (2008) pointed out the difficulty in obtaining proper data. For instance, problematic sexual behavior is obviously of a private nature and continues to be stigmatized. Underreporting is highly likely and may also be due to a lack of knowledge or denial of the problem (Kuzma & Black, 2008), but empirical studies in this regard are lacking (Ragan & Martin, 2000).

Griffiths and Dhuffar (2014) investigated what treatment services were available within the British National Health

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Service (NHS) using Freedom of Information requests sent to all 58 Mental Health Trusts (MHTs) in the UK. Results showed that 53 of the 58 MHTs (91%) did not provide any service for treating those with SA or HD (but this may be a reflection that individuals do not seek treatment for such disorders). There was also some evidence to suggest that the NHS may potentially treat SA or HD as a secondary disorder that is intrinsic and/or comorbid with other mental health disorders (e.g., depression and substance abuse disorder). Of the MHTs that provided data on treating the disorder, almost all the individuals treated were male. The results suggest that there may be potential barriers as to why females do not seek treatment and are the focus of this paper.

In order to increase help-seeking behaviors among females in the UK, it is important to identify the barriers that may influence treatment access among British individuals. While there are residential SA clinics in the US that exclusively treat female SA, treatment for such behaviors within the British health system remains limited. The identification of such barriers can potentially inform tailor-made treatment interventions among health services and may also help clinicians to understand the contemporary ways in which treatment can perhaps be implemented for such behaviors. Consequently, the aim of this paper is to address the potential barriers to SA treatment access among women. The paper draws on other literatures (particularly from problem gambling literature) for a number of reasons: (a) treatment barriers specifically relating to SA in the UK are yet to be formally identified; (b) there are similarities in the DSM-5 diagnostic criteria for gambling disorder (APA, 2013) and the proposed criteria for HD (Kafka, 2009); (c) there are similarities in the consequences of the two disorders (including suicidal ideation); (d) although awareness for gambling addictions is growing in the British population, treatment provisions for some types of gamblers (e.g., problem adolescent gamblers) – as with treatment for hypersexuality – are arguably minimal.

In the gambling studies field, Griffiths (2001) and Chevalier and Griffiths (2004) outlined many reasons as to why young people may not seek help for a gambling problem. Many of these reasons can also be applied to the field of SA and HD among both men and women. This paper borrows from (and in many places expands upon) barriers to seeking treatment in the youth gambling field and applies this literature (where appropriate) to the barriers for women seeking treatment for SA. More specifically, this paper examines (a) individual barriers, (b) social barriers, (c) research and screening tool barriers, and (d) treatment barriers.

The present authors concur with the view that characteristics of SA (both online and offline) remain the same regardless of what it is called. For the purpose of the paper, the term “sex addiction” will be used for the sake of simplicity but can also refer to terms used elsewhere in the literature (e.g., HD). In the absence of empirical evidence, many of the barriers outlined are admittedly speculative and/or based on what is known about other behavioral addictions (in particular gambling disorder). Consequently, many of the barriers outlined can also be applied to SA among males and/or behavioral addictions more generally. This issue will be returned to in the conclusion.

Individual barriers

This section examines potential innate barriers to seeking treatment for SA. Such barriers are operationally defined as those that are directly linked to the non-treatment seeking motivations of women themselves.

Denial of SA. Women with SA may fail or refuse to acknowledge that they have a problem concerning their sexual behaviors, especially if they feel that they have gained control through a period of abstinence from all sexual-related activity. Carnes (1997) suggested that SA lies at one end of the spectrum and the other end being characterized by the lack of any form of sexual activity or involvement. Carnes considers this as a form of sexual “self-starvation,” and the term “sexual anorexia” has been used to describe the phenomenon and refers to an obsessive state in which physical, mental, and emotional task of avoiding sex dominates one’s life (Carnes, 1997). In this, the feelings of disconnection, rejection, and fear of intimacy are significantly more apparent.

Deliberately not wanting to seek treatment for SA. Some women may know that their sexual behaviors are spiraling out-of-control but may knowingly choose not to seek treatment for it. Ferree (2001) highlighted that women are more inclined to experience ambivalence toward treatment seeking due to strong feelings of guilt, shame, and religious restrictions that portray sex as sinful or dirty.

Occurrence of spontaneous remission and/or natural recovery from SA. It may be that some women have SA but are able to overcome their problem without the need to resort to professional help (Shaffer, 2007) either through spontaneous remission and/or natural recovery.

Committing suicide prior to seeking treatment for SA. Some women may commit suicide because of the shame associated with their sexual behaviors before they are able to seek treatment. Hall (in an unpublished survey reported in her 2013 book) conducted a survey of 350 sex addicts and it was found that 19.4% reported had a serious desire to commit suicide. However, actual suicide rate as a consequence of sexual behaviors remains unknown.

Excess in youth is commonplace and excessive sex may not be pathologized. Youth is a time of general risk and/or excess (Arnett, 1992), and young people may not view such excessive sexual behavior as problematic. Consequently, excessive sexual behaviors may not be perceived as warranting treatment given the social norms during this developmental period.

Seeking other forms of mental health treatment before getting treatment for SA. It may be that women are more likely to seek help for common mental health problems (i.e., depression, anxiety, and trauma) that are “socially acceptable” before seeking treatment for SA.

Treatment of other underlying problems that indirectly diminish SA. Given that women are more likely to seek help for an underlying mental health problem that maintains their SA, such a treatment could indirectly help diminish their problematic sexual behaviors. However, treatment for another problem (e.g., depression) may help diminish hypersexual behaviors if the sexual behavior is used as a coping strategy [therefore, the potential of SA being an Axis I disorder rather than an Axis II disorder as described by Kafka and Prentky (1992)].

Negative consequences that are not unique to SA. The negative consequences of a number of sexual behaviors share similar consequences that can arise from SA (e.g., sexually transmitted infections, unwanted pregnancies, relationship break-up, etc.). Therefore, SA may not be treated as an underlying factor in problem behavior especially among young people (see Cohen, 2008).

Social barriers

This section examines potential social barriers to seeking treatment for SA. Such barriers are operationally defined as those that directly impact the individual on a micro-level (e.g., interpersonal environment, family, and friends), meso-level (i.e., organizations and community), and macro-system (i.e., public policy) level [as outlined by Bronfenbrenner (1993)].

Family bailout. Turner and Liu (1999) highlighted that young people are most likely to seek help when the consequences of their behavior are most severe. However, if family is supportive and willing to financially assist with an unwanted pregnancy or having an abortion, then help is less likely to be sought for what might be the primary problem (i.e., SA).

Parents. According to Griffin-Shelley (2002), the main obstacle for young people seeking treatment is the parent. First, most carry shame about sexual, relational, and cultural issues. Second, parents may fear being seen as “bad parents” and also apprehensive to look at their own behaviors that may have potentially influenced the behaviors of their child (Griffin-Shelley, 2002).

Social undesirability. In women, a lack of engaging in sexual behavior (particularly outside of committed relationships) is often viewed as desirable. Casual sex (even when it is not problematic) is associated with shame in cultural minorities, and therefore, the woman might be less inclined to seek treatment for SA in such cultures (Ferree, 2001, 2002).

Peers. Griffin-Shelley (2002) asserted that peers could be a barrier to seeking help and/or treatment because of their own shame, embarrassment, judgment, or lack of understanding about love and/or SA (i.e., peers’ lack of exposure to the concept in comparison to substance-related addictions). Griffin-Shelley (2002) claims that peers’ lack of knowledge could result in ridicule and bullying of the person preventing them from seeking treatment. In support, Wisdom and Agnor (2007) asserted that adolescents (in particular girls) are concerned about their peers’ responses to their mental health that could perhaps influence their decisions to forgo treatment in this case, treatment for SA.

Research barriers

Research barriers are those that are directly linked to the assessment of female SA. These barriers may minimize SA treatment services being offered in the first place.

Lack of universal agreement as to what constitutes “sex addiction”. The absence of diagnostic criteria within the DSM-5 and ICD-10 as to how “sex addiction” should be defined and diagnosed presents difficulties for medical and clinical professionals. This has been reported consistently

within the literature (e.g., Carnes, 1983; Kafka, 2009; Reid & Kafka, 2014). If “sex addiction” does not officially exist, it might prevent some with the disorder (including women) seeking help in the first place.

Lack of research into female SA and SA treatment. Given that SA has only recently become a topic of interest in mainstream society (see Dhuffar, 2015), empirical research on both female SA and SA treatment remains limited. Recent reviews have highlighted the paucity of rigorous studies examining addiction treatment (e.g., Dhuffar & Griffiths, 2015a; Hook, Reid, Penberthy, Davis, & Jennings, 2014) and randomized control trials, and outcome studies have yet to be conducted.

Lying or distortion on self-report measures because of the sexual double standard. The sexual double standard (i.e., different rules and standards of sexual behavior for men and women; Bordini & Sperb, 2013) suggests that women are judged more harshly than men if they engage in promiscuous sex. Consequently, women (particularly young women) may be malingering and/or minimizing the effect of symptoms and consequences of their sexual behavior to avoid being judged by others (Adetunji, Basil, Mathews, & Osinowo, 2006) including scholars carrying out research into SA.

Invalid screening instruments for assessing SA in women. Another reason for skewed prevalence rates may be the tools used to assess SA. Such instruments may be underestimating the number of female sex addicts. However, it should be noted that some self-report measures are gender-specific (i.e., Sexual Addiction Screening Test; Carnes, 1991) but these tend not to be used by researchers as they tend to study populations as a whole and use instruments that can be administered to both males and females.

Misinterpretation of questions. The overuse of formal language and information about SA may lead some women to endorse items they should not and perhaps doing so because they do not fully understand the question being asked. This may also have an effect on reported prevalence rates of female SA.

Screening instruments for SA being used incorrectly. The inconsistency in methodology, definitions, measures, and cut-off points for SA may also account for the inconsistency of prevalence rates for female SA.

Exaggeration of SA by professionals to enhance career needs. Chevalier and Griffiths (2004) highlighted that one possible explanation for the reported high rates of adolescent gambling may be that researchers who rely on funding in this area may be overstating such rates for personal career gains. This does not appear to be the case with SA in the UK, as research funding in the area of SA is almost non-existent in the UK at present. Given the relatively large numbers of private sex therapists in the US who treat sex addicts, it is in their (financial) interest to maximize the problem as they need such clients for their career to survive.

Lack of funding for SA research and treatment. As SA does not appear in the DSM-5 or the ICD-10, this has arguably resulted in lack of rigorous SA research studies (either epidemiologically or clinically based). To date, most SA treatment studies have been small scale and methodologically weak using self-selected samples (see Dhuffar & Griffiths, 2015a; Hook et al., 2014).

Treatment barriers

This section examines specific treatment barriers to seeking psychological treatment for SA. Such barriers include the lack of clinical treatments and/or psychotherapies currently available and that may potentially demotivate women to seek treatment within the NHS or within the private sector in the UK.

SA may not be viewed as a “clinical reality”. As noted above, SA as a clinical concept is not listed within any current psychiatric diagnostic manuals (e.g., DSM-5); therefore, it is not only a challenge to diagnose, but also treatment is generally not funded in the UK by the Department of Health nor does it appear in the National Institute for Health and Care Excellence guidelines, whereby treatment seekers could potentially receive psychotherapy under the NHS (see Griffiths & Dhuffar, 2014).

Lack of trained professionals who can treat SA. Only a small number of therapists in the UK are trained to treat SA and a majority of them are in private practice. While organizations such as *Relate* (a national UK relationship counseling service) offer psychosexual counseling, it is often specific to the “lack” of sexual intimacy within a relationship rather than for the breakdown of relationships caused by a partner’s SA.

SA treatment requires a specialist service. The misconception that SA services are specialist services was a significant finding in the study by Griffiths and Dhuffar (2014) highlighted earlier. Therefore, this may lead a treatment seeker to consider going to a more established SA treatment location in another country (e.g., US), but the cost might be prohibitively expensive.

SA therapists may lack knowledge of online SA. Where treatment is accessible and available, the SA therapist or counselor may have limited understanding of some of the online behaviors that are involved within online SA (Weiss, 2013). Dhuffar and Griffiths (2015b) found that there was a significant difference in acting-out behaviors among women who were considered “traditional” sex addicts (engaging with sexual activity offline) compared with “contemporary” sex addicts (where online sex was a central part in meeting potential sex partners offline).

Lack of women-only SA treatment programs. The lack of availability of treatment services for female SA is reflected in the small number of those who seek help for their problem. For example, there are currently only two private residential clinics in the UK that specifically deal with the treatment of SA (governed by the *Association for the Treatment of Sexual Addiction and Compulsivity*). Among these clinics, 98% of those in treatment are men (Hall, 2013).

SA treatment programs being unsuitable. The treatment programs that are available for SA may cover other aspects of sexuality (i.e., hyposexual disorder and/or other mental health disorders, whereby SA is a secondary disorder). Treatment programs may also concentrate on other paraphilic and/or fetishistic aspects of sexual behavior, aspects that are much less common among females.

Fear of relapse inhibiting individuals seeking SA treatment. The potential fear of relapsing may prevent a sex addict from seeking treatment in the first place. The prevalence rates of “failure neurosis” [coined by Laforge (1941)] among females have been documented in psychodynamic

literature (i.e., Freud, 1957; Kanefield, 1985), whereby women would rather experience low self-esteem and perceive themselves as worthless than seek treatment.

Ambivalence in client–therapist relationship. A therapist can only work with what the client brings to therapy sessions. Clients may themselves create a barrier by concealing specific behaviors they typically engage in out of the therapy sessions (Miller & Rollnick, 1991) particularly if it involves a behavior that they are ashamed of (such as SA).

Lack of engagement when in treatment. Although women tend to seek therapeutic treatment in mental health or primary care settings, they are less likely to engage in specialist treatment programs (Green, 2006) that may include SA treatment.

Stigma toward treatment seeking. While all addictions encompass an element of stigma, stigma appears to be more prevalent in SA than other addictions (Adams & Robinson, 2001; Carnes, 1983). This may lead women to attend self-help groups with other individuals suffering the same thing (e.g., Sex Addicts Anonymous, Sex and Love Addicts Anonymous, etc.) because the shame and stigma would be less of an issue among such individuals. However, Hall (2013) noted that such groups are typically facilitated without the presence of a qualified therapist meaning that female sex addicts do not get the professional help they need.

Length of referral process to get treated for SA. The length of time between initial referral, initial contact, and the beginning of regular sessions for SA may impact on therapy adherence (e.g., the longer the time period between an initial referral and the onset of treatment, the worse the adherence; Godden & Pollock, 2007).

SA therapists not knowing about religious and/or cultural beliefs of their sex addict clients. Some therapists and counselors may have little understanding of sexual “norms” in other religions and cultural minorities and may result in a female sex addict dropping out of treatment. Such examples were illustrated in Dhuffar and Griffiths’ (2015b) study, where female sex addicts reported the discomfort that they experienced from mental health professionals when they disclosed their sexually problematic behaviors.

CONCLUSIONS

This paper sought to address some of the potential (and admittedly speculative) barriers that potentially prevent women in seeking treatment for SA. As noted above, many of these barriers are equally applicable to male SA and/or behavioral addictions more generally. Therefore, stakeholders in the addiction field (e.g., researchers, treatment providers, funders, policymakers, etc.) may also be able to consider these barriers more generally in relation to their own day-to-day practices in the behavioral addiction field (i.e., outside of female SA treatment).

In terms of the individual barriers outlined, all of them are applicable to both male SA and those suffering from other behavioral addictions. The only aspect that is unique to females is in relation to negative consequences that are not unique to SA, in particular the female’s family helping out financially to pay for an abortion (this is also true for family bailouts under the category of social barriers).

In relation to social barriers, most of the barriers listed could feasibly be found among male sex addicts and others suffering from behavioral addictions, but the consequences for female sex addicts concerning their peers and social undesirability appear to be far more pronounced (particularly because of the sexual double standard). In relation to the research barriers, some of these could apply to male SA (e.g., lack of universal agreement as to what constitutes as “sex addiction,” misinterpreting questions on SA scales, lack of funding for SA research, etc.), but some are more relevant to female SA research compared with male SA research because most research on SA has been carried out on males and most screening instruments used are not gender-specific. In relation to treatment barriers, many of the reasons outlined are also applicable to both male SA and behavioral addiction more generally. However, some of the barriers appear to be more pronounced for female SA (e.g., lack of dedicated female-only treatment programs, lack of engagement in treatment, and fear of relapse).

While there are some clear research gaps [e.g., the true prevalence rates of SA among males and females and that the knowledge based on female SA is limited to very small samples and clinical case reports (e.g., Dhuffar & Griffiths, 2014, 2015b; Dhuffar, Pontes, & Griffiths, 2015)], such barriers remain mostly speculative and they provide only limited information about many of the possible causes of non-treatment seeking among female sex addicts. Further research is needed to either confirm or disconfirm the identified barriers that female sex addicts face when seeking treatment, and if conformation is found, interested stakeholders (researchers in the SA field, practitioners who treat SA, addiction service providers, etc.) provide better awareness and/or see ways in which such barriers can be overcome to aid better uptake of SA services. The list of possible reasons for female sex addicts not seeking treatment may not be exhaustive but hopefully includes the major possible reasons based on the relevant literatures of other behavioral addictions and the informed thoughts of the present authors who have carried out research into female SA.

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