

Shrink Rap Radio #527  
Sex Addiction as Affect Dysregulation

## Sex Addiction as Affect Dysregulation

Dr. David Van Nuys, Ph.D., AKA “Dr. Dave,” interviews Alexandra Katehakis

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**Introduction:** Today, my guest is marriage and family therapist, Alexandra Katehakis, founder and clinical director of the Los Angeles-based Center for Healthy Sex, and we'll be discussing her work and her 2016 book, *Sex Addiction as Affect Dysregulation: A Neurobiologically Informed Holistic treatment*.

**Dr. Dave:** Alexandra Katehakis, welcome to Shrink Rap Radio.

**Katehakis:** Thank you, David. Thank you for having me today.

**Dr. Dave:** Well I am so happy to have you here. I've got your book here which I've been going through. It's a really thick one [laughs].

**Katehakis:** Yes, it is.

**Dr. Dave:** It's pretty challenging, and I think it's a real tour de force. You know, it's got such a technical-sounding title here: *Sex Addiction as Affect Dysregulation: A Neurobiologically Informed Holistic Treatment*. Holistic is the word I light up to, actually.

**Katehakis:** Mhmm, yeah. Why is that?

**Dr. Dave:** Well because of my own background and affiliation with humanistic psychology.

**Katehakis:** Ah, yeah.

**Dr. Dave:** Yeah, so that to me is the incredible thing, that it's all in here, all the way from very detailed neurobiological material all the way down to what I would consider to be a depth-informed, maybe humanistically-oriented psychotherapy.

**Katehakis:** Right.

**Dr. Dave:** And that is quite a coup –

**Katehakis:** Yeah.

**Dr. Dave:** -- pull all of that off. And Allan Schore, an authority in this area of neurobiology, I agree with his forward that he wrote, and his forward is a whole education in and of itself, and he remarks that you've developed a model that has implications beyond sex addiction, so –

**Katehakis:** Sure.

**Dr. Dave:** Yeah, I think there's a model here that other people will be looking at closely and grabbing hold of. And with all that you've covered here, there's no way that in an hour we can cover it in the depth and detail that you've put in this book, but we can scratch the surface, do our best to do that.

**Katehakis:** Okay.

**Dr. Dave:** So, the place where I start off – maybe even when I first picked up the book – was: sex addiction, is that a real thing?

**Katehakis:** Right. Well everybody asks that question and of course there's a lot of contention about that and there has been, really from the beginning of time. And so, I just want to say, on this end, just to answer that question, is, when I think of sex addiction, I think of it as a syndrome; as a constellation of symptoms that we see in people who come in to treatment, who are radically abusing and destroying their lives with sex. So the pleasure is long gone. It becomes a balm, or an anaesthetic for a deeper trauma. And I do make the distinction in the book between what we call "classic" sex addiction versus "contemporary" sex addiction, meaning that classic sex addiction is really born out of early childhood trauma, and I'm looking at not just what happens from ages four through teenage years, but infancy – early infancy – which is really the work of Dr. Allan Schore, whereas contemporary sex addiction is really pornography addiction. And that's a whole separate problem, and a lot of the symptoms that people experience come as a result of looking at too much pornography, whereas with classic sex addiction, the symptoms pre-date the behaviors. So there's really an inverse to the two of them.

**Dr. Dave:** Well, I have to say that your book has opened me up to what seems to be an ever-expanding set of addictions, so not only sex addiction, love addiction, gambling addiction, Internet addiction –

**Katehakis:** Food.

**Dr. Dave:** -- food addiction and so on. But I think you provide a neurological basis for understanding that, and in fact, that it does make sense to use that model.

**Katehakis:** Well I really looked at the science; there are over 800 citations in this book. That's partially why it's so thick. The last quarter of it is all citations, and the science is there. And if we think about addiction as a strong predilection for something -- that's really the definition of the word -- people start to engage in something, and we are highly adaptive creatures, and our brains are very automatic. And when we do something over and over again and habituation starts to turn into compulsion, these adaptive patterns start to pull us in a particular direction. And with that comes an inability to stop, a constant seeking for the thing over and over again, and compartmentalization: telling ourselves "it's not that bad," or, "I know I'm doing it but I'm not really doing it," which is a feature of dissociation, by the way -- it's one of the criteria for dissociation, is having a highly automatic brain, or automaticity, compartmentalization, and altered states of consciousness. And Dan Hill talks about this in his book called *Affect Regulation Theory*. So these are adaptive patterns, there are attractor states in the brain, we're highly adaptable creatures, and when people start doing something over and over again and it's habituated, they can't stop doing it.

**Dr. Dave:** Yeah, I thought there were a couple of nifty, very short definitions of sex addictions in the book, and I liked the very succinct definition that you quote in the book of: "a pathological relationship with a mood-altering experience."

**Katehakis:** Yeah, that's a simple ear-mark.

**Dr. Dave:** Yeah, I really like it.

**Katehakis:** Another one is: if the behavior is secretive, shaming, or abusive -- if you can come home and tell your partner that you went to a massage parlour today and had a hand job, and your partner says, "Great! Good for you," then there's no problem. But if you're doing that repeatedly and it's secretive, if you start to feel shame about the behaviors, if you're abusing yourself or other people, then you likely have a problem, whether it's with food or alcohol or gambling, or you name it.

**Dr. Dave:** Yeah. Here's another definition, this one from Allan Schore, who defines it as, "a primary chronic disease of brain reward, motivation, memory, and related circuitry."

**Katehakis:** Right, that's actually the definition from the American Society of Addiction Medicine that Allan is probably recapitulating in his introduction. But in 2012, this very conservative organization declared that food, sex, and gambling could also be addictions; it was no longer just chemical or alcoholic problems.

**Dr. Dave:** And you distinguished between two types of people that you work with: sex addicts versus love addicts. And the dynamics – I guess there's some similar dynamics and also some different ones. Give us the thumbnail on the distinction between them.

**Katehakis:** Well, people that identify – and again, these are people that self-identify – because this term can be used as a garbage-can term – and there are extensive self tests that we give people, we put them through a lot of assessment to see whether or not they indeed do have these addictive, pervasive qualities. So I just want to be clear, that if somebody looks at Internet pornography or they have a single incident affair, that does not make them a sex addict.

**Dr. Dave:** Okay.

**Katehakis:** But sex addicts specifically are using sex, and it's the seeking of sex, which is the work of Jaak Panksepp who's done inordinate amounts of research with rats, who share the same architecture to their brains as we do, except they don't have the higher cortical functions. But this reward-seeking is one of the major motivational systems in the brain stem. So it's not the acquisition of the reward, it's the seeking of it that's very activating, it's adrenalizing –

**Dr. Dave:** The thrill of the hunt.

**Katehakis:** Pardon?

**Dr. Dave:** The thrill of the hunt.

**Katehakis:** Yes, it's the thrill of the hunt. It's the dopamine excitatory processes that keep the person seeking, looking, until eventually they acquire and then they're finished. The love addict – so the sex addict is simply only seeking sex, and they're seeking ultimately orgasm in order to change their neurochemistry. Of course, once they have the orgasm, then oftentimes there's a numbing that takes place through compulsive eating or exercising, or sleeping, and then after that people can often fall into despair. But the love addict is really seeking limerence, romance, a love relationship, in order to feel okay about themselves. So they live in fantasy in a way. It has to do with not really seeing the person for who they are. They're seeing an idealized version of them. Because many, many love addicts will tell you that they had a rescue story that goes back to childhood. So if you grow up in a household that is violent or alcoholic or neglectful, it's very easy for children to start to create fantasies about, "someday my prince will come," or "my princess will come," and they live in this longing, which is a narcissistic longing, right? To be seen, to be loved, to be heard and understood, and then in adulthood they seek people for those purposes. So it's not really a two-person relationship, it's a one-person relationship. It's all about what I need, and I don't really see who you are, you're just a warm body that I think can fulfill this fantasy for me.

**Dr. Dave:** I'm wondering if these conditions aren't on something of a continuum, you know, all the way from a little bit to a whole lot –

**Katehakis:** Yes.

**Dr. Dave:** -- to the extremes that drive people into your practice where they're really experiencing a lot of pain and distress.

**Katehakis:** Right.

**Dr. Dave:** And part of what got me wondering about that was, as I was reading the book I was going through a bit of "medical student syndrome," you know, supposedly medical students as they're going through the text, they like to have all the diseases so I was kind of going, "Oh my God, this feels a little close to home."

**Katehakis:** Mmhmm.

**Dr. Dave:** How do people find you anyway? How do they self-present?

**Katehakis:** Well oftentimes they've been caught by their partner, and with the electronics we have today, it's really spectacular the ways in which people get caught and how they think they won't get caught. So somebody who's got a cell phone and a text comes over from, you know, a sex worker or Ashley Madison, a site for married people to hook up and have affairs. Or there's a window open on their computer that shows that they've been looking at escort sites or something of that nature. Or, if it's a female and she's been having, perhaps, serial affairs and lost her job at work because finally her boss fired her because she had sex with a colleague of his. But people often in relationships get caught, and single people will come in because they're in despair because they cannot keep a relationship together. And so, you're right, this is on a continuum and this is where the sexologists argue that sex cannot be an addiction because Kinsey long ago said: "Normal and abnormal are on a continuum, and there's no place for normal and abnormal in science." So this is where we start to split hairs and get into arguments, but when people come to Center for Healthy Sex, they come because they've tried everything, they've tried to stop, and they cannot stop by themselves, and they're in a world of pain and they don't know why. And so it's through a process of really excavating peoples' sexual history that we start to see why the behaviors all make good sense. That person is doing that thing for good reason, not because of a bad reason. But it's become adaptive, and over time it's become an albatross; what started out as fun and games, or sexy, or sexual experimentation has now turned into this monstrous behavior where there are secrets and lies and money being spent and problems in the marriage. And that's when people come to treatment.

**Dr. Dave:** Yeah. Now, you mentioned men and women, and I gather there are gender differences. Can you speak to that a little bit? More men than women, right, suffer from this?

**Katehakis:** Right. Well more men than women come to treatment. I think what we're seeing now as a result of this recent political debacle, there's been a tsunami of females on social media, coming forward, talking about ways in which they've been sexually assaulted, you know, had their genitals grabbed, groped on whether subways or medical offices, or as children or as adults in the workplace. So this goes on all the time for women, and they don't recognize these assaults as being trauma. Some of those women may or may not be promiscuous to the degree where they're sex addicts, but when women are tampered with sexually in an extreme way – which is kind of a funny thing to say – but when it's repeated, they will become sexually compulsive, kind of in the Freudian repetition-compulsion sort of way.

**Dr. Dave:** Mmhmm.

**Katehakis:** Not that they're looking to right the wrong that happened, but from a neurological or neurobiological standpoint we understand that this is an adaptive pattern and an attractor state in the brain, so they can't stop doing what was done to them and they keep doing it over and over again. And sex may be tightly tied to shame and humiliation, because that's what happened to them long ago. So women can be profoundly damaged by sexual abuse, and that can lead into a very serious sex and love addiction for many women, whereas for men, oftentimes it's emotional abuse, physical abuse and neglect. And it's got a more obvious narcissistic quality to it than it may with females. Females may present as looking more borderline but in fact it's more complex trauma.

**Dr. Dave:** Trauma is a word that is key in the model that you developed, so what's the connection between trauma and these behaviors?

**Katehakis:** Well I think first of all, if we're treating addiction today, we're treating trauma. It used to be that the chemical dependency counselors were in the ghetto, they were just counselors over there that wore jeans and ran groups, and it was really the psychodynamic therapist and the psychoanalysts that had the corner on solid psychotherapy. And that's not so today. People that treat addiction know that they're treating trauma and as I said earlier, trauma starts – it can start as early as the third trimester of pregnancy in utero. If you have a mother who is under high levels of stress or duress, through anxiety or depression or circumstantial problems, her neurochemistry is constantly in flux, and that neurochemistry is communicated to the fetus; there's an intersubjectivity between the placenta and the mother's body, and there's lots of science now to corroborate this. So when this infant is born, it's already dysregulated. And then you have a mother who's dysregulated who cannot be present or is not capable enough to attune to this infant in what Dan Siegel calls "contingent

ways.” You’re going to get a central and autonomic nervous system that are set up in ways that are distorted; they’re not optimally being set up. So from the get-go you’ve got a problem with attachment, which really is about regulation.

**Dr. Dave:** Mmhmm, right.

**Katehakis:** That child then grows to fruition and if this problem continues, then you’re going to have neglect, emotional abuse, etcetera, piled on top of that. And then if, God forbid, there’s another trauma, like, you know, the house burned down or the child is raped, or the father’s an alcoholic and beating the kids – sorry to keep saying that dads an alcoholic – but another layer on top of that, you just get layers upon layers, and then you’re really looking at pathological dissociation. And what makes people feel better when they are dead at the core, or they are in despair, are drugs, alcohol, sex, something to pull them out of that pain.

**Dr. Dave:** Mmhmm. And what about the role of shame? That’s another topic that you touch upon. Where does the shame come in?

**Katehakis:** Well shame gets imparted early, early on. Allan Schore talks about this in all of his books, because he’s really expert at early infantile and child development, but when the mother is shaming after, really, the first year – first of all, shame is a pro-social process, it’s a socializing agent. When the mother says to the child, “No, don’t touch that hot burner,” the child has a shame response, which is a bodily-based affective response, and with that we learn, “Oh, that’s dangerous,” or it’s not okay. But when the shame is chronic, it’s unprincipled, the infant child starts to become shame-based. And that is an uncoupling of the autonomic nervous system and between the right brain and the nervous system going down into the body. So there’s a deadness, there’s a shame-based feeling in the body, and sex is heartily shamed in our country, and so if a person feels shame about their sexuality, then they’re going to go act it out in shameful ways. So shame is really the engine; it’s the cause and the effect of sex addiction, as I see it, because it begets itself.

**Dr. Dave:** Okay. Your approach integrates mind, body, and brain, as one of the mantras that runs through the book a little bit, and you integrate it all in such a holistic fashion, but here I’m going to just be touching on this and that – it’s kind of on non-integrated topics – attachment obviously plays a big role in this theory –

**Katehakis:** Right.

**Dr. Dave:** -- and then you’ve referenced it a couple of times and it’s been amazing to me to see how much we have learned about attachment in recent years and how much it’s integrated into our evolving our understanding of the brain, and the neurobiology, neurochemistry, and so one.

**Katehakis:** Right.

**Dr. Dave:** Go ahead.

**Katehakis:** Well again, I mean this is the major contribution, one of them, of Allan Schore's, and I attribute everything I'm saying to him because I've been a student of his for almost ten years now – and what Bowlby, John Bowlby gave us, was attachment theory, which was really more of a behavioral recognition that the mother is creating the secure base to keep the child safe, which was accurate. But when Schore started to really dig into this in the early 90s, what ultimately has transpired is this regulation, this understanding that modern attachment theory is really a theory of regulation. But the mother's job, the primary caregiver's job with the infant, is to attune by way of reciprocity: the musical sound of the voice, eye contact, gesture, touch, all the non-verbal communication that takes place within the mother/infant dyad are in a dance that is non-verbal but highly communicative, wherein she is amplifying joy states and downregulating sympathetic arousal when it's appropriate. And when she does that, she's creating plasticity not just in the central nervous system, but in the autonomic nervous system within the body. So we are a brain-body, they're not separate from one another, therein lies the holistic model.

**Dr. Dave:** Yeah.

**Katehakis:** And so every time the mother – there's a rupture and the mother repairs, you're creating an increase in the capacity for regulation. This is what Dan Siegel called our "window of tolerance" and Pat Ogden later expanded that notion. When you don't have that kind of regulation, that attunement, that contingent communication, you're going to get a system that cannot regulate itself. At the worst you get disorganized attachment, which is borderline personality, and at best you get insecure but organized attachments, like avoidance, dismissive, preoccupied, etc. So it's not just our capacities with other people, it's what's happening in the body. We're a whole neurochemical set here that's taking place, right? So it's our gut, our heart, the whole enteric nervous system; the body, the mind, the brain. The mind is constructed out of what's happening in the body, and in relation to others.

**Dr. Dave:** So when you talk about affect regulation, the affect is referring to how I'm feeling in my body, how I'm feeling emotionally: am I feeling secure, am I feeling joyful, am I feeling at peace versus am I feeling anxious, threatened, fearful...?

**Katehakis:** Correct.

**Dr. Dave:** And there's this kind of dance going on, and what happens in early childhood can – and later too I guess – can really establish some set points that may either be positive or negative.

**Katehakis:** Right. Well, Schore says that it sets the stage for all psychopathology as access one and two: and so when you talk about being secure, that means the child starts to have capacities internally where if it gets scared or anxious, the system readily can down-regulate itself. It's like a rubber band that has a lot of elasticity; you pull it, it snaps back. But if you've got a rubber band that's old, it doesn't snap back, it's not elastic in that way. It takes a long time for that child to down-regulate itself, because the internal capacities were not set up that way. So people can be dominant in a sympathetic way, meaning they're in this highly aroused, anxious state, like a highly revved engine all the time, or they can be dominant in a parasympathetic way, wherein they're more dead internally, dissociated, checked out, dull... Those of course, are the people that are more difficult to treat in psychotherapy, because you've got to get people from deadness to excitation somehow.

**Dr. Dave:** Okay, so this sort of gets us to the title of the book: *Sex Addiction as Affect Dysregulation*.

**Katehakis:** Correct.

**Dr. Dave:** And one of the things that was a little bit surprising to me to read, although it made sense to me, was the idea that the sex addict, the deficit in affect regulation, if I understood it correctly, is that they come to engage in auto-regulation. Instead of it being a socially-based transaction –

**Katehakis:** Right.

**Dr. Dave:** -- between me and my partner, somehow I've learned to manage my brain states on my own.

**Katehakis:** Right, brain and body, yes. I mean Patrick Carnes has these four core beliefs of addicts, and one of them is, "I cannot depend on other people to get my needs met." Now, we see this repeatedly with people, when they tell their stories about typically the households they grew up in, where, they were really on their own, and it doesn't matter if they're super wealthy or super poor, they were left alone to regulate themselves. And so interactive regulation with a secure person comes in the form of, "Ugh, I just got a speeding ticket, I'm going to call my friend and say, 'You can't believe what happened on the way to work, it was awful,'" and your friend says, "That's terrible, do you have time for lunch today?" or "Let's get together over the weekend." So, I'm venting, I'm using another human being to help me regulate and remind me that I'm not a bad person, maybe it was a dumb thing to do, I'm lucky I didn't hurt myself. You know, we talk each other through these things. But if you're not used to relying on other people doing that, what really smart kids figure out is, "I have to do it myself. I'm going to figure it all out myself," so whether I'm sucking my thumb until I'm 13 or I start masturbating and looking at endless pornography to regulate my anxiety, these are all auto-regulatory propositions just as fantasy would be. And many, many men tell me that in

their childhood – this was before Internet – they read comic books; they lived in the Marvel comic books. And there's nothing wrong with comic books, but if that's all you've got and you start to pretend that you're Superman all the time, and you can't function in the world because you want to save everybody but nobody is saving you, those are auto-regulatory channels. So it's through interactive regulation, as I was talking about before, the mother/infant dyad, that we learn self-regulation. I learned that, "Oh, I can breathe in this moment," or I can call a friend and talk to them, or, I can go for a walk or have a cup of tea or call a friend. Calling a friend, of course, is more interactive, but there are self-regulatory things we do all day long to take care of ourselves. But many people that come from deprivation don't even brush their teeth regularly, much less know how to soothe themselves when they're under duress, other than taking a drink or smoking a joint or looking at porn.

**Dr. Dave:** Yeah. So there are some forms of auto-regulation that make sense and we all engage in them –

**Katehakis:** Yes, sure.

**Dr. Dave:** -- but it's possible to go too far, as with everything else in life, right?

**Katehakis:** Well, addiction is about isolation in part, and so when you are auto-regulating to the extent that it's isolative, then you probably are in trouble. Certainly mindfulness practices are auto-regulatory: you close your eyes, you meditate, you're regulating the insular cortex in the brain, which is giving you more hearty connections down into the body; you have a better sense of yourself, you're calmer, your heart rate variability is better. That's all fantastic, but if you live a monastic life and that's your choice, that's okay too, but if somebody only meditates and they don't see anybody, and they have no friends, that can start to go off the rails another way.

**Dr. Dave:** Yeah, right.

**Katehakis:** It's lonely.

**Dr. Dave:** Yeah, yeah. Well this begins to get us off into the area of treatment, and the treatment that you'd developed that you refer to as – you've got an acronym – is it pronounceable? P-A-S-A-T? [Laughs].

**Katehakis:** Well, it's the psycho-biological approach to sex addiction treatment. So we could call it PASAT, I suppose.

**Dr. Dave:** PASAT, okay.

**Katehakis:** That doesn't make any sense to anybody. But the point is that – I learned the Patrick Carnes model, probably in 1997-1994, and it was predominantly a cognitive-

behavioral model that was based on the old Minnesota model for alcoholics. And it came out of the 80s, of: What are you doing? What are you thinking? So, let's stop the behavior, let's look at your thoughts, let's create a plan, a concrete plan, for you so you can stop doing what you're doing. And that's all very well and good, it will help people stop the behavior, but it doesn't get to the underlying cause of what's driving the behavior. Psychodynamic psychotherapists at that time were just doing – I shouldn't say just – but they were using psychotherapy to unlock what was happening in the family of origin in the unconscious. But in the meantime, people were still using the sexual behaviors and hurting themselves. So people would come to see me and they would say, "Yeah I've been to therapy for seven years, and I never talked about my sex addiction," or, "Yeah I just kept acting out during my therapy." So they really understood their family of origin, but they hadn't stopped the behavior. So, this being a holistic model, it's about, from the get-go when people come in for an assessment, the therapist is automatically working these dyadic, regulatory processes. So we're tracking affect, we're tracking gesture, we're tracking our own somatic cues, while we're also asking very pointed questions about: What's your sexual history? What's the presenting problem? What brings you into treatment? And looking at the destruction the person has wrought in their lives and often their families, while we're also in an empathic conversation with them.

**Dr. Dave:** Yeah.

**Katehakis:** So, it requires to be bilingual, let's put it that way.

**Dr. Dave:** Yeah, yeah. Well this is a very multi-lingual approach because it combines cognitive behavioral therapy, 12-step program, and then eventually after some of those initial issues have been worked through, a more long-term relational, depth-oriented kind of therapy. You talk about restoring social, sexual, and spiritual relationality.

**Katehakis:** Right.

**Dr. Dave:** So it's all about getting this person out of auto-mode into relationship mode. And in the book you go into your own experience with trauma, and I'm not going to ask you to go through that whole story here – a very traumatic experience that you suffered early on, and then I believe there's also some generational trauma in your history that you see as another dimension to look at in the work that you do with other people.

**Katehakis:** Well I am my own Petri dish.

**Dr. Dave:** As we all are, right?

**Katehakis:** Right, we all are, right.

**Dr. Dave:** Right, we must be.

**Katehakis:** There's that adage that you can only take your patients as far as you've gone yourself. And so, it was several years ago that it hit me like a ton of bricks that I was carrying the trauma of Hitler's atrocities. Now, I always thought that only Jewish people had that problem because of the concentration camps and what we know about intergenerational transmission of trauma for holocaust survivors and multi-generations after that. But what I forgot, which I always knew, was that my father grew up under the German occupation in Greece. And so – I'm not Jewish, I was baptized Greek Orthodox, I grew up in a Greek family – but my father had untreated trauma, untreated PTSD, really, from the time, probably, he was born, because my grandmother was highly traumatized for a multitude of reasons that I talk about in the book. And so, I grew up with two parents – my mother's parents were both born in Turkish-occupied Greece, so they too had trauma. So these two trauma survivors come together and have children. Which is, you know, it goes on every day of the week, but I realized that my regulatory capacities, my anxiety, was born out of what was transmitted to me through regulatory processes, because I had a nice childhood; my parents were decent people, they were very hard workers, but they had difficulty with intimacy and relationship. And so it wasn't just my psychology, it was my neurobiology that was twisted from these problems that were multi-generational behind me. And so I started to look at that, wow, when we are working with people, whether they're addicts or not, we're looking at deep, deep history that is ancestral, it's intergenerational, it's neurobiological, it's psychological, and... right?

**Dr. Dave:** Yeah, and as you pointed out earlier, these traumas can be cumulative as well, so something like the house burns down, and that's on top of attachment issues and everything else, and in your own case, you as a young woman, you suffered a terrible automobile accident –

**Katehakis:** Right.

**Dr. Dave:** -- and that, I believe, drove you into a long-term therapy –

**Katehakis:** It did.

**Dr. Dave:** -- for yourself to try to heal that.

**Katehakis:** Right. And my therapist at the time – I was 27, he was 65 – and he came from the humanistic movement. Carl Rogers, Maslow, were his teachers, James Bugental was his therapist, and then he became his colleague. And just for a fun story, Jim Bugental married one of this patients, I believe she was a nun. And my therapist became her therapist. It was the 60s, right? [Laughs]

**Dr. Dave:** Let me tell you what a small world this is, because I came to know Jim Bugental – I've been teaching from his books for years and then he retired in my local

area, Santa Rosa, and he started a training clinic called Interlogue and then as he retired he dubbed me as the person who would pick up the mantle –

**Katehakis:** Mm, nice, yeah.

**Dr. Dave:** -- and run that, which I at first accepted, and then realized, wait a second, this is way too big for me to take on. And I had to back out of it. So it's interesting that we've both had that exposure.

**Katehakis:** Yes.

**Dr. Dave:** And so his approach was dubbed, "humanistic existential approach to psychotherapy –"

**Katehakis:** Right.

**Dr. Dave:** -- and it sounds like that had a very big impact on your life.

**Katehakis:** It did because that was the first time that I understood that I had a body that had impulses in it. I had no idea. And my therapist was astute at tracking that, and very much used his own body because he was a transpersonalist and a Buddhist as well. I mean the human potential movement started largely in the 60s. And he was part of that first wave, where everything old is new again. Now we have the neuroscience to back up what the body-oriented psychotherapists and the gestalt therapists were doing.

**Dr. Dave:** Yes. Yes, that's very exciting.

**Katehakis:** I spent a lot of time on that couch with him, and it was through that process that I started to fall in love with the process of psychotherapy, which was really through the transpersonal work.

**Dr. Dave:** And there was another critical influence that you talk about is, you were involved in theater and drama and got involved with some people, an approach – what was it called, walk in their shoes?

**Katehakis:** Walking in your shoes, right.

**Dr. Dave:** Walking in your shoes, which involved kind of an intense practice of empathetic identification with others.

**Katehakis:** Yeah. And this was one of the brainchild's of my therapist, John Cogswell, who paired with an actor named Joseph Culp, and together they sort of put together this protocol where we would sit in a circle and we would practice being one another. So I would stand up, in other words, in the circle, and I would drop the concept of

“Alex,” that would be my intention, and I would say, “I’m now David.” And I would just start to walk in the circle and start to notice the impulses in my body and how that informed how I met the world, how I thought people saw me, what my body – I would follow whatever my body wanted to do, and from that came an inordinate amount of information about others. It was sort of a rapid form of remote viewing. We could never really put our finger on how exactly it worked, but it was extremely powerful at feeling seen and known by others, and it developed high levels of empathy for all of us.

**Dr. Dave:** So this high level of empathy you’ve brought into your own therapeutic work, and so it raised for me, and then I later discovered that you actually address it as I read further – you take risks in terms of really getting into your clients’ experience when they are in this relational therapy with you.

**Katehakis:** Right.

**Dr. Dave:** And sexuality is such a charged thing to begin with.

**Katehakis:** That’s right. [Laughs]

**Dr. Dave:** And then to sort of, get into that world and be so intimately enmeshed, psychically –

**Katehakis:** Mmhmm.

**Dr. Dave:** How do you manage to pull back out? I would think it would be very challenging –

**Katehakis:** Well, it’s messy –

**Dr. Dave:** -- the transference, counter-transference stuff sounds very tricky.

**Katehakis:** It is very tricky and it’s messy. I would say that I slip and slide a lot in that mess, but I feel like I’m always owning what’s going on also and I get a lot of consultation, because it’s a – it can be very dangerous to go in there alone. But when working in the realm of sexuality – I mean, I’m also a certified sex therapist, I’m getting my doctorate right now in clinical sexology, and I work in the world of sex and sexuality, so I often know that I’m entering into these places with people, and I’m going to be impacted and so are they. But it’s in that morass, in that soup, that I think the healing starts to take place, where we’re in it together and we’re feeling what’s happening between the two of us, and being seen and heard sometimes, you know, with people for the very first time in essential ways, and with that comes, I would say, a massive heart opening. Love is in the mix too, which doesn’t get talked about a whole lot. And so, being able to love from a place of love itself, without it being impersonal; I’m not falling in love with my patients, I’m not having sex with them certainly, but to walk on

that edge, I think is essential for these systems that are down in the right brain, because you've got uncoupled systems and in order for them to kindle and to ignite again, they need novelty, they need this kind of human connection. And Philip Bromberg talks about working in an "experience-near way." And so that means very close-in, very intimate, and with that comes, unbelievably, beauty and change, and also pain, and sometimes enactments occur.

**Dr. Dave:** Yeah. Now you have a clinic, and I assume that you have trained other people to do this work –

**Katehakis:** Yes.

**Dr. Dave:** -- because it's so intensive you can't possibly handle it all yourself.

**Katehakis:** No, I can't, and I don't.

**Dr. Dave:** So how in the world do you train other people? I mean, you have such a complex background, a unique background.

**Katehakis:** Right.

**Dr. Dave:** How do you get other people there?

**Katehakis:** Well, I think by slowly educating people. I mean, one of the gifts that Allan Schore has given us is regulation theory, and the point that he's making, if I may speak for him, is that when you understand the theory, there is no formal protocol here. There's a formal theory, but when you understand the theory, clinical intuition, willingness to take risks, knowing what exactly the points are that you're meant to be tracking along the way, allows us to develop these clinical skills where we're in a dyadic relationship with somebody as opposed to the old one-person system where I'm the expert on your life and I'm going to make interpretations to you that make me sound smart and keeps us both in our left brain, and then you really understand what's going on with you but you still feel anxious, depressed, neurotic, etc. So one of the things I champion in my clinicians, is to bring their heart and soul and humanity to the work; to let themselves feel. Because I think therapists burn out by not receiving and by not being human. I think we burn out when we're super bounded or walled-off, and we're bottling up all this transference, and there's no place to go with it. And the counter-transference can be worked through; there's affect disclosure that happens in moments of closeness where you're in tears and I'm in tears, and we're talking about what's happening between the two of us. These are deep, close-in moments that I champion my therapists to risk having.

**Dr. Dave:** Yeah.

**Katehakis:** And with that, I think, comes change. I think therapists become better therapists, and clients get better therapeutic experiences and change.

**Dr. Dave:** Yeah, yeah. Now, there's a whole other level that you get to towards the end of the book, which is the whole social, cultural, political contributions to sex and love addiction.

**Katehakis:** Right.

**Dr. Dave:** And so let's get into that some. You've made some passing references to pornography and that is such a potent force now, culturally, I mean it's so widespread and...

**Katehakis:** Readily available.

**Dr. Dave:** Readily available, and escalating in terms of the, you know, the awfulness [laughs].

**Katehakis:** Yeah.

**Dr. Dave:** Escalating... de-escalating [laughs]. Going down the escalator into the worst of the Freudian unconscious.

**Katehakis:** Well first of all I think we're in a major social and sexual revolution right now, one that leaves the 60s in the dust. And pornography, Internet pornography, has been a double-edged sword. On the one hand it's opened us up to ideas about sex and sexuality and given us permission to experiment with sex and sexuality in ways we never have before, and that's the good news, because even recently a colleague of mine wrote an article saying that missionary-style sex is now a sexual minority, that more and more people are having oral sex, they're experimenting with anal sex, they're experimenting with opening their relationships that ever before. And we have to keep in mind that there is a 50 to 75% divorce rate in this country – California touts 75% because we lead the charge in everything.

**Dr. Dave:** Wow.

**Katehakis:** So people are really struggling with intimacy, sexuality, what works for them. And so it's kind of the Wild West right now where that's concerned, and it's forcing us to look at the lack of sex education in our schools. We do not educate our children about healthy sexuality, we just don't talk about it. We say, "Don't do it, don't get pregnant and don't get HIV," and that's really the extent of it. Meanwhile every child has access to digital pornography as soon as they can pick up an electronic device. And so therein lies the problem. So I believe in free speech, I'm a big proponent of free speech, and pornography is a speech issue, but I do think we need to consider, how do

we protect our children? How do we regulate these things in ways that create safety and sanity? And these are big political questions now. And so I really think we need opt-in, opt-out mechanisms on our devices so that we can protect our children from seeing porn if we want to. One of the things we've been seeing at my clinic, Center for Healthy Sex for the last, I would say, five years now, are these young men coming into treatment, and I'm talking about 20 years old, that have been looking at digitized pornography since they were six, seven, eight years old, and by the time they're 21, 24, they cannot get an erection with a real live human being. And so this is a result of their brains wiring up to the Internet pornography, and there's tons of science on this now. And in fact there are large grassroots movements now, one of which is called "Reboot Nation," of young men that just gather in these online forums and talk about erectile dysfunction due to too much porn use.

**Dr. Dave:** Yeah, yeah.

**Katehakis:** They don't call it sex addiction, because it's not. It's pornography addiction, and what they're finding is that the earlier a male starts looking at Internet pornography, the longer it will take him on the back end to restore his erection. So for a lot of these young men it can take four or five months of a porn diet; no pornography, before they start to get erections again, which is pretty scary. If you take somebody who's older, a male let's say in his 40's, 50's, 60's, who looks at pornography, and then video pornography, but really grew up on print pornography, if he's having a problem with Internet porn, it would probably only take him two or three months to restore his erection.

**Dr. Dave:** Hmm, that's interesting.

**Katehakis:** Because the brain hasn't gotten as tenaciously wired with the digital stuff.

**Dr. Dave:** Yeah, yeah. I'm blocking on his name now, but I interviewed a guy about this very topic, who, you would probably recognize this name, he's done a –

**Katehakis:** Gary Wilson, maybe?

**Dr. Dave:** Yeah, Gary Wilson, thank you. Yep.

**Katehakis:** Yeah, he's got a website called "Your Brain on Porn."

**Dr. Dave:** Right, right. And so, yeah he kind of – I don't know if he was the first person to open up that area?

**Katehakis:** Yeah he is a major player on the Internet pornography scene and he has looked very closely at the science and there are a lot of forces arguing that it's junk science or it's not real, or there's no such thing, but I think that you kind of have to

follow the money on that one, because pornography now is a \$97 billion a year money-maker in the world over.

**Dr. Dave:** Yeah, it's also played a huge role in the development of technology.

**Katehakis:** Yes.

**Dr. Dave:** This technology that we're using right now –

**Katehakis:** That's right, yeah.

**Dr. Dave:** -- a lot of porn money went into [laughs] developing –

**Katehakis:** That's right, developing it.

**Dr. Dave:** -- this kind of capability. I'm particularly concerned about what's coming in terms of virtual reality.

**Katehakis:** Oh boy, yeah.

**Dr. Dave:** I think that's going to be a whole storm of trouble coming our way.

**Katehakis:** Right, and it's already on and it's already available now. And you know, we have our secure attachment in this country has been dropping since the 1970s pretty radically. I mean I think we're at 53 to 58% secure attachment now. It used to be 75% in the 70s. And so we have more avoidance than ever before and with the advent of teledildonics, and with virtual and sexual practices people won't ever have to touch each other again if they don't want to. And I don't know what that says about us evolutionarily or where we're headed, but it does have a bit of a chilling effect.

**Dr. Dave:** Right.

**Katehakis:** I mean there are now sex dolls that you can buy that are life-like for thousands of dollars. I mean, it's a whole new world now.

**Dr. Dave:** Yeah, yeah. Well [laughs], what a note for us to close on, as we wind down here. Is there anything more that you'd like to say, or any final thoughts you'd like to leave our audience with?

**Katehakis:** Yeah. I think I'm really passionate about right now is how important it is for us to start to advocate and teach and help mothers start to attach to their babies in secure ways, so that we as psychotherapists don't have to be the mop-up crew, because that's what we are. And that we can start to teach healthy sexuality in kindergarten: what does it mean to like someone, to hold their hand? What are your body parts? How do

we teach children that their body parts are theirs? How do we raise sexually intelligent children to become sexually intelligent adults so that we can have healthy, happy, celebratory sexuality, instead of using it as a weapon against ourselves?

**Dr. Dave:** Those are real concerns and you're just the person to lead the charge.

**Katehakis:** Thank you.

**Dr. Dave:** Alexandra Katehakis, I want to thank you for being my guest today on Shrink Rap Radio. It's been delightful to meet you.

**Katehakis:** Thank you David. Nice to meet you as well.