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Deconstruction, disability, and sex addiction: Embracing the narrative perspective

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Abstract

The disease model of addictions has expanded from its original alcoholism base to include many substances and processes. Twelve step groups have flourished in North America. One area that has rapidly grown in the last twenty years is sexual addiction. The use of the disease model privileges the pathology discourse while focusing on deficits of clients, and ignoring context. A hidden discrimination can take place in which the sexuality of a disabled person is pathologized as "sexual addiction." Deconstructing the label of sex addiction and moving to an experience near approach such as narrative therapy can honor the notion that people are veterans of their own lives and respect the personal resources people have. A case study was presented to highlight the recruitment into the identity of a sex addict of a disabled person and the importance of deconstructing this label. The narrative therapy technique of externalizing the problem was used to show how the "sex addict's" story could be re-authored in an experience near way leading to new possibilities and opportunities.

Tom's Dilemma

Tom gathered up his courage as he looked over from his dishwasher and asked the server, "Wanda would you like to go out with me tonight." Wanda laughed nervously and said, "You've got to be joking," and went on her way to serve a table. Tom quietly swore under his breath as he loaded another tray of dishes to put through the restaurant dishwasher.

A simple rejection, perhaps, but what if we were told that the dishwasher was a 47 year old physically disabled person who was a "sex addict." The story of what was happening would change. We will pick up Tom's dilemma of being diagnosed as a "sex addict" later on in this article.

Witnessing The Power of Labels

In my teen years, I witnessed the marginalizing power of labels. I watched my own mother go from a functioning, heart-centered nurse and mother to a "mentally unstable alcoholic" who barely could scratch together a subsistence. She and my dad had divorced but my physician father with his medical connections arranged a psychiatric consultation that established my mother's craziness and unfitness for motherhood. He also arranged for a one-sided split in assets, so my mother left the marriage penniless, crazy, and childless. This all happened in the early 1970's before the feminist movement had hit small town British Columbia. So, for all the years of service my mother had given to the family and dedication to her three sons, she had been totally pathologized. My mother's story left me with a haunting memory of the reality of the power of being marginalized as I saw with my mother how crushing the weight of dominant discourse labels could be.

After a brief and unhappy legal career, I jumped on the humanistic-existential bandwagon in graduate school with heroes like Rogers, Maslow, and Yalom and focused on issues of authenticity and the quest for wholeness. As I started to work with clients, I noticed something was off with my work with a certain sector of my clientele. Certain populations such as those people with intense mental health issues or people from certain culture backgrounds not aligned with the dominant culture, had elements in their stories that I

was not addressing in my focus on individuation and self-actualization. Even after my securing a faculty position in Addictions Counselling, I knew that something was off as my memory of my mother's descent, which ended with brain cancer, still haunted me. I began to suspect that my own position was a reflection of the status quo and in many ways denied the reality of the lived experiences and barriers of people living outside the dominant stories of the status quo.

People sensing my predicament recommended that I needed to check into the work of Michael White. I signed up for a Michael White two-day narrative therapy workshop in Calgary. Michael started the workshop by contrasting experience far expert pathologizing language and experience near client friendly language. I remember laughing at the time at mental health professionals and their DSM-IV language who totally bought into their assessments and objective truths. Ironically though, I did not realize how much experience far language was part of my own game through the new emerging professional field of addictions counselling. I have previously explored my work with narrative therapy in the area of schizophrenia (Nixon, 2000), but now would like to turn my focus to addictions, and in particular, sexual addiction.

The Expanding Turf of Addictions

The addictions profession, like many areas of specialization, is in a turf war. It is an expanding field. Originally, it consisted only of substance abuse but recently it has focused on gambling, the internet, eating disorders and sex. Sexual addiction is one area that has gained attention over the last two decades especially with the highly popular work of Patrick Carnes (1983, 1991). Carnes has written about how the cycle of sex addiction with the fantasies, the rituals, the acting out, and the inevitable despair is a similar cycle to substance abuse. With a focus on the importance of 12 step groups, the disease model of addictions has firmly become entrenched in the area of sexual addiction. A "sex addict" has the disease of addiction that can never be cured but only monitored for the rest of that person's life.

It is amazing the power behind assessing somebody and coming up with the proclamation, "You are an addict." Addictions professionals have a "street-wise" refinement of the truth-telling status of objective health professionals. Typical lines include "You can't con a conner" or "I have already done it all." Thus, any resistance to the proclamation of addict status is merely a sign of denial and an indication of the disease of addiction. Miller and Rollnick (1991) suggested that the attitude of the treatment professionals is that "addicts are liars" so there is no need to hear what they have to say.

Sadly, there is a whole underbelly of this discourse that is missed as White (1995) observed, "This mantle of truth makes it possible for us to avoid reflecting on the implications of our constructions and of our therapeutic interactions in regards to the shaping of people's lives" (p. 115). Thus, as Law (1997) observed, this privileging of disease and pathologizing ignores other descriptions such as those arising from histories of abuse and oppression. Thus, we become blind to the effects of disability, violence, abuse, racism, sexism, heterosexism, class and privilege in our lives.

A Case Study: Tom's Recruitment Into Being a Sex Addict

We will now return to the case of Tom briefly discussed at the start of this article. This case study is presented to show how a shift to a narrative therapy stance can thicken and enrich the counselling process as clients choose preferred stories about themselves. Tom came to counselling, desperate. He announced at the start of our first session that " I need help because I am a sex addict." He was a 47 year old Japanese-Canadian man with a limp caused by polio when he was a child. He had a full-time job at a restaurant as a dishwasher. He lived alone in a bachelor apartment. He had been in counselling previously and had been told he was a "sex addict."

When Tom came to see me that first day I asked him, using an approach articulated by White (1995) and Sanders (1997) in working with adolescents with substance abuse problems, how was he recruited in to this problem based identity of a "sex addict." Tom told me that he had rented some porn videos and gone once to a massage parlor. He also has been very desperate to have a girlfriend and had asked many different females out with disastrous results. He also had an abusive and troubled childhood. This was enough, in his previous counsellor's eyes, for Tom not only to have certain problems in living but to be confirmed as a "sex addict."

Something struck me as odd. Hastings (1997) observed that people with disabilities have

to contend with a somewhat hidden yet "bone-deep" discrimination. For instance, it is strange that people with disabilities are seen to be sexually neutral and "ordinary sexuality is regarded as overcompensation, or trying to 'prove' something" (p.8). Tom's sexual and intimacy forays with his polio induced limp, his intellectual slowness, and his dishwasher socio-economic status were not recognized as Tom's struggle for intimacy but instead given the status of being the works of a "pervert." Cheryl White (1997) asked an important question, "How can we, as non-disabled people, take care not to contribute to a sense that all of a person's identity and life is bound up in their experience of disability while also creating space for the acknowledgement of the real effects of the experience of disability?" (p.44). This seemed an important question as it seemed clear that if this was a non-disabled person, one trip to the massage parlor, and a few videos may indicate problems but would not confirm the person as a "sex addict." Where was the pattern of regular, compulsive, out of control behavior?

The pathologizing of Tom as a "sex addict" gave Tom an explanation as to what was going on for him. But was this a helpful story for Tom to internalize? If he truly were a person with an out-of-control addiction, recognizing that he was an addict would improve the quality of his life. I asked him an important question identified by Sanders (1997), "Does this identity of being a sex addict hold you back from what you desire in life?" Tom immediately responded that it was hard sometimes because what he really wants is a girlfriend, and he gets all weird if he starts thinking that he is a sex addict when he asks a woman out. He gets self-conscious and awkward and ends up stumbling over his words. And then, when his date request gets rejected, he really feels humiliated.

I invited Tom to tell me more about his life in an experience near way. What were his goals and hopes and wants? Tom told me that he gets really lonely and what he really would like is to have a girlfriend. He had found it hard to make social connections in the restaurant as the servers did not really talk to the dishwashers. Sometimes he was very attracted to a server but his attempts to make conversation would be snubbed. This made him mad and angry. Sometimes, he would swear under his breath.

Five years ago, when his counsellor told him he was a sex addict, and needed to go to 12 step meetings, at first he was shocked but then he found he enjoyed the companionship and connections he made at those meetings. He met people that were struggling like him. Ironically, he preferred the co-dependency focused Al-Anon meetings the best rather than the sexual addiction S.A. meeting as the Al-Anon meetings were mostly populated by females, and he could try to make some connections. After a while, he also got the idea that he should join a church and he started going to a progressive one and found he enjoyed the Sunday and Wednesday sermons and post-session teas.

Still Tom's acute sense of things not being right for him did not go away. He still felt frustrated in his attempts to find a girlfriend. He sometimes would go down to a pizza joint and buy a pizza and a beer and if there was a woman alone there he would try to make conversation. Occasionally, he would go to a nightclub, and sit and listen to the band and see whom he could meet. Still, however, he could not shake the sense of feeling rejected and lonely.

To help Tom get a perspective on what the problem was in his life, we decided to look at the problem using the narrative therapy technique of externalizing the problem (Nixon, 2000; Tomm, 1989; White, 1995).

Externalizing The Problem

We used a simplified fourfold approach of naming the problem, mapping the influence of the problem, looking for unique outcomes, and planning for the future (Nixon, 2000; White, 1995). So, firstly, we had to name the real problem. Tom had been told the problem was that he was a sex addict. This was an identity which he had introjected. Instead of this experience far label, I invited Tom to look into his own life, as a veteran, and see if he could put the finger on what the real problem was for him? What had he been struggling with all of these years. He said, "The problem is I am desperate for a girlfriend." We laughed. It was that simple. So, I asked him how he could put that in simple problem terms, "I get desperately lonely," he replied, "that's my huge problem." As for a name than, I suggested, "desperate loneliness." Tom laughed and agreed.

The name caught the situation for Tom. As he looked over the last eight years, he had been very troubled with "desperate loneliness." Next, following the fourfold approach of externalizing the problem, we moved on to the second phase of mapping the effects of this loneliness. How had "desperate loneliness" shown up in Tom's life? Tom had found living alone in a bachelor apartment a life of creeping loneliness. He had worked as a dishwasher and he found that isolating because even though there were lots of people

around he could not connect with the servers on staff and stayed mainly in the dish pit. Even worse, though, he found it hard returning to his apartment. The transition from a busy restaurant to a lonely apartment was always very acute. Sometimes, he would come back to his apartment, and his loneliness was so piercing that he had to get out. So he would go down to the local Boston Pizza and sit there and buy himself a small pizza and a beer. Occasionally, there would also be another single person there, a woman, and he would try to strike up a conversation with her. But he was desperate and he would move to the uptake of asking her out too fast. Inevitably, he would be rejected and feel crushed and order some more beer and just sit in his pain. The pain would get so bad sometimes that he thought the only answer would be to see a prostitute, and after finishing his beers he would walk down to the red light district and peruse the streets for a while before deciding to not go through with it and then he would walk dejectedly back home. By the time he got back home, his desperate loneliness would feel almost unbearable.

Sometimes, he would gather his courage and try to go out with people for coffee after the 12 step meetings but found it was very awkward if he asked a fellow member out as he was breaking the rules of the 12 steps groups and doing a "13 step" maneuver. In the end, it left him feeling hopeless and resigned to his desperate loneliness. His attempts to deal with his "desperate loneliness" seemed to backfire in his face.

Tom had done a nice job of mapping the effects of his "desperate loneliness." We moved on to consider unique outcomes, the third phase of externalizing the problem. When had Tom defeated the problem of "desperate loneliness" in the past? In what situations, had Tom been able to resist the pull of "desperate loneliness." Tom found that going to support meetings had been helpful because he had been able to meet people in a structured environment, with lots of social interaction involved. He had gone to Al-Anon meetings and S.A. meetings and found the relationships talk of the Al-Anon meetings very interesting. After the meetings, they usually went for a coffee and Tom really enjoyed that.

I asked Tom if there were any other groups he enjoyed? He had started going to a growth group on Thursday nights and each week the facilitator would present on a different topic and the group would talk about it. He found the people there that he met really interesting. Tom also said his new church was helpful. He really enjoyed the Sunday and mid-week services. Inevitably, there would be a tea social after each service and it gave Tom a chance to connect with people.

To get away from the preoccupation with possible romantic connections, I asked Tom about what connections he had made with other men. Tom stopped for a minute, perplexed, and then his eyes lit up as he told me about the friendship he had been able to make with an older man at his church. He got rides to the services with him and they would talk about the sermons and human growth. He did not want to take the relationship for granted and sometimes he would give the person gas money. He also really enjoyed connecting with the facilitator of the group he went to as he was very friendly and was open to talking for a few minutes after the group.

I asked Tom to look at the strategies he was using with non-romantic connections such as the two males he just described. Something was different about these connections. They were much more relaxed. "Desperate loneliness" had not taken over. Maybe these unique outcomes could teach us about what would work for Tom as we looked down the road into the future.

We switched our efforts to the fourth phase of externalizing the problem and that is planning for the future. Focusing on the strategies that had worked in his male relationships had given Tom an idea. Perhaps he could more easily defeat "desperate loneliness" if he just focused on making connections. This would take the desperation out of his loneliness. So, just as he had been able to make male friends easily by "going with the flow" with them and being appreciative at the same time, maybe he could start making connections with females the same way. He had just met a singer at a nightclub he went to that had been friendly to him, and he was about to ask her on a date, but maybe instead he could just let the friendship develop. Similarly, after an Al-Anon meeting maybe he could just relax and enjoy the coffee and connections and forget about asking a female out on a date. Likewise, with his church he could just keep going to the sermons and teas, and just try to connect with people and let things develop naturally. Maybe, he could even use this strategy at work with the waitresses and forget about asking them out on a date but just try to be friendly and enjoy a relaxed working relationship.

Tom left that day with an array of strategies that he felt could work for him in defeating "desperate loneliness." He booked an appointment for a month down the road to check-in with how things were going in defeating "desperate loneliness."

A month later, when Tom came to see me, he reported feeling out of the jaws of "desperate loneliness" for the most part. He had just focused in making connections over the last month and this had taken the pressure off. He had gotten closer as a friend to the singer. He continued to enjoy the church and his male friend there, and had been able to make some new connections there. He had enjoyed the coffees after the Al-Anon meetings. The growth group had been going well and he had continued to enjoy his relationship with the facilitator. The biggest change had happened at work however. By not focusing on a possible romantic connection, his relationships with the servers had vastly improved. Work had become more fun. He did report though, he did not have a girlfriend yet, but strangely he was not so desperate about it. With Tom having some momentum in his life, we decided to leave the door open for Tom to check back with me if he desired.

I did not see Tom in counselling again, although I did run into him with a group of people at a coffee shop one evening. He came over and talked with me for a few minutes but then he said he needed to get back to his group. Tom still did not have a girlfriend, but he was spending time with a woman from the kitchen at work from time to time. He told me he still had not totally defeated "desperate loneliness" but was enjoying his social connections and was hopeful for the future.

Embracing The Narrative Perspective

As we saw with Tom's story, a turn to narrative therapy is desperately needed in the addictions field in which so much silencing of the client goes on. Emerging from the social constructionist perspective, narrative therapy emphasizes the historical and cultural aspects of knowledge and rejects the notion that there is an official objective version of the truth (Freedman & Combs, 1996; Gergen, 1994; White & Epston, 1991). The narrative therapy process of collaborating with clients invites a deconstruction of a therapist's expert perspective and "truth-telling" status. As White (1993) observed, "Deconstruction has to do with procedures that subvert taken-for-granted-realities and practices" (p. 34).

In addictions, once a client has been assessed as an "addict," this person is seen to have the disease of addiction for life, and any behaviors are interpreted through the lens of addiction. As we saw with the Tom who received the pronouncement of "sexual addict," the person's life becomes thinly described. Narrative therapy, in contrast, emphasizes a return to client friendly experience near language in which notions of desire, whim, mood, goal, hope, intention, purpose, passion, concern, belief, and other experience near terms are openly embraced and conversed about (White, 1995, 1997). With Tom, a narrative approach allowed us to return to something he knew well, talking and working with his struggle with loneliness and his desire for intimacy.

Rather than experts interpreting people's lives, narrative therapy recognizes that people are veterans of their own lives. The emphasis is on people telling and re-telling preferred stories of their own lives. In this way the unique, contradictory, and personal aspects of a story are engaged. White (1997) observed how thin descriptions exclude the interpretations of those who are in those actions. In our case, Tom was actually excluded from the description of his own life. Moving to a "thicker" narrative description allowed Tom to talk about his struggles, personal resources and community connections he has made in trying to defeat his loneliness. Multiple contextualizations of life can be created that contribute to a richness of narrative resources. Tom did not even realize how many community connections he had made through attending support groups, churches, and counselling groups in his struggle with loneliness and how persistent and resourceful he had been. As White (1997) explained, "These narrative resources contribute significantly to the range of possible meanings that persons might give to their experience of the world, and to the range of options for action in the world" (p.16).

Tragically, as we saw here with Tom, the expert description of the "disease" of sex addiction which is promoted by the addictions counselling industry can produce a dismemberment in which so much of personal and community membership is severed to make way for the thin descriptions of people's lives. Too often, as White (1995) recognized, "persons come to believe that the problem speaks of their identity - so often problems present persons with what they take to be certain truths about their character, nature, purposes, and so on, and these truths have a totalising effect on their lives" (p.22). Tom began to believe that he was truly a "pervert" which made it very awkward for him to ask a woman out on a date. The narrative stance of facilitating clients to move away from internalizing conversations in relation to what they find problematic to externalizing problems and conversations allows people to objectify their problems and "exoticize the domestic" (White, 1993). By having externalizing conversations with the problem as a third party, people no longer identify with the problem as their identity and open up to a multitude of resources in dealing with the problem. In this way, White

(1995) observed, "through externalizing conversations, the problem is to an extent disempowered" (p.23).

We saw in the case study presented here how Tom's externalizing the problem got behind the label of "sex addict" and instead opened up the conversation to the lived experience of his struggling with "desperate loneliness" in which his resources and connections to the community were honored. Tom's story also points to the danger of pathologizing difference in that a disabled person's attempts at starting a romantic relationship are identified as the acting out of a "sexual addict" or "pervert." Rather than being swept away by disconnected expert grand pronouncements, opening up to the narrative perspective allows us to respect the richness and resources of our clients as well as ourselves.

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