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When Sex Feels Out of Control

Beyond Addiction, Shame and Moral Panic in the Treatment of Compulsive Sexual Behaviour Full Info

An online webinar with

Silva Neves

Zoom Webinar
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Times:
6:00 pm – 9:00 pm, London UK
2:00 pm – 5:00 pm, New York, USA

CPD hours: 6

Location: Online streaming only
(all our webinar tickets now include complimentary access to a video recorded version for 1 year or 3 years, depending on the ticket type)

She has already made three promises this month. No pornography. No messaging her ex. No scrolling, "just to look," past midnight. She has broken all three, and she tells you this before she has taken off her coat.

"I need you to fix this," she says. "I need you to make me stop."

The instinct is a reasonable one: identify the behaviour, map its triggers, help her bring it under control. Most therapists in the room will recognise the pull of that instinct, and the relief a client feels when it's offered to them. But the more useful question may be a different one. What if the first thing therapy needs to examine isn't the behaviour — but her certainty about what the problem actually is?
Sexuality is a clinical area in which distress and pathology can be remarkably easy to mistake for each other. A client's urgency pulls the therapist toward an equally urgent response: stop it, reduce it, remove the trigger. Silva Neves asks practitioners to resist that pull — not because distress should be minimised, and not because compulsivity never requires serious clinical attention, but because good formulation starts by finding out what a client is actually suffering from.
Some clients feel entirely out of control while retaining real behavioural choice. Others quietly lose flexibility in a behaviour they insist is nothing to worry about. Others are distressed less by what they do than by what doing it seems to say about who they are. Each needs a different formulation — and a different therapy.

The Addiction Question

Much of the difficulty starts with a borrowed model. "Sex addiction" entered clinical language in the 1980s and has never fully left it, despite the World Health Organization's decision, in ICD-11, to classify Compulsive Sexual Behaviour Disorder as a disorder of impulse control rather than an addiction. The classification matters because it changes the clinical question. Rather than treating sexual frequency or intensity as evidence of addiction, therapists need to assess control, flexibility, consequence, distress and the meaning of the behaviour within the person's wider sexual life.

Silva takes this further. A growing body of research on "moral incongruence" — the gap between sexual behaviour and the values a person believes they should live by — suggests that some experiences of sexual "addiction", particularly around pornography use, may be driven or intensified by conflict between behaviour and belief rather than behavioural dyscontrol alone. The addiction label can be seductive precisely because it resolves that conflict for the client, replacing an uncomfortable moral question with a tidier medical one. At other times, however, there is genuine behavioural dyscontrol: the person's relationship to a sexual behaviour has become increasingly rigid, repetitive and difficult to interrupt. The clinical task is not to decide in advance which client is in front of you. Across two evenings, Silva will help practitioners hold both possibilities steady in the room — behaviour that has genuinely become rigid and hard to interrupt, and behaviour that is being pathologised by the client's own moral framework — without deciding which one they are looking at before the client has finished speaking.

When the Client's Urgency Enters the Room

"I need to stop watching pornography." "I shouldn't want this." "My partner says I'm a sex addict." Statements like these deserve to be taken seriously — not necessarily literally. A client's proposed solution is one theory of their suffering, not a diagnosis.

Before asking how to stop something, Silva explores what it means to ask instead: What function does this behaviour serve? What precisely feels uncontrollable? Where does the distress actually live — in the behaviour, its consequences, or what the client believes it reveals about them? This is the difference between suppressing behaviour and formulating it.

When shame is already organising the client's relationship with their sexuality, agreeing too quickly that a behaviour "has to stop" can intensify self-rejection or concealment before the behaviour itself has been properly understood.

Sexuality Outside the Therapist's Map

Clients also bring erotic lives that sit well outside a therapist's own experience — multiple partners, kink, non-monogamy, pornography, fantasies a therapist may not share or may personally dislike. Clinical neutrality is not achieved simply by deciding to be tolerant. Without sufficient sexological grounding, familiarity quietly becomes the measure of health, and heterosexual, monogamous, conventionally-paced sex becomes the invisible reference point against which everything else is judged — the standard a client is silently measured against even by a therapist who believes they hold none.

Silva asks participants to hold a more demanding position: spacious enough to affirm sexual diversity, and rigorous enough to still recognise when something has genuinely stopped being freely chosen. Consent, flexibility, context and consequence remain the relevant clinical questions; a therapist's own comfort is not one of them.

Assessment and treatment are, in Silva's approach, genuinely different tasks — which is why the training is built across two evenings rather than compressed into one.

Evening One: What "Out of Control" Actually Means

The first evening is assessment and formulation. Silva examines the distinction between feeling out of control and being out of control — and why the source of a client's distress needs to be understood before compulsivity is accepted as its explanation. Particular attention goes to the risk of colluding with despair: when

a client says "this has to stop," agreeing may feel like the most empathic response in the room. It can also entrench the very shame the work needs to examine.

The evening will cover:

- Feeling out of control versus demonstrable loss of flexibility and choice
- Assessing the source of distress before assuming the behaviour is its cause
- What frequency and intensity can — and cannot — tell a clinician
- The functions repetitive sexual behaviour can serve: regulation, avoidance, communication
- Recognising when a behaviour does warrant serious therapeutic attention
- Heteronormative assumptions that quietly shape what looks "healthy"

Evening Two: Working With the Person, Not Just the Behaviour

The second evening moves from assessment into therapy. Once the question stops being only "how do we reduce this," a different territory opens: what does the behaviour do for this client, and what would greater sexual agency — not simply less sexual behaviour — actually look like?
Sexual material also raises the therapist's own countertransference: alarm, curiosity, discomfort, protectiveness, the urge to rescue. None of it tells us what's clinically true about the client. It does tell us the therapist is in the room, and Silva helps participants use that presence — rather than let it quietly become the treatment model, dictating what gets explored, softened or avoided without either party quite noticing it happening.

The evening will cover:

- A humanistic, integrative alternative to purely behavioural treatment models
- Working with distress without reinforcing sexual self-rejection
- Exploring agency and flexibility rather than counting behaviours
- Recognising therapist values and moral positioning as they enter the room
- Using the therapeutic relationship to meet sexuality with curiosity rather than judgement
- Helping clients build a sexual life that feels freely chosen and sustainable

Learning Objectives

By the end of this training, participants will be able to:

- Differentiate a client's subjective sense of sexual loss of control from behavioural evidence of genuinely diminished choice
- Formulate the sources of sexual distress before assuming the sexual behaviour itself is the pathology
- Identify when moral incongruence may be contributing to sexual distress, and distinguish this from — or recognise its coexistence with — compulsive sexual behaviour
- Recognise heteronormative and culturally familiar assumptions that can silently pathologise diverse sexual practice
- Respond to a client's request for immediate abstinence without dismissing their distress or prematurely colluding with it
- Apply a sexology-informed, trauma-informed, sex-positive framework to presentations of sexual compulsivity
- Use their own countertransference to sexual material as clinical information rather than allowing it to become unspoken judgement

Who This Training Is For

Practising psychotherapists, psychologists, counsellors and relationship therapists who encounter concerns about sexual behaviour, desire, pornography or a perceived loss of sexual control — whether or not psychosexual work is their specialism. It is particularly useful for clinicians who meet these presentations occasionally in general practice and find themselves unsure whether they are looking at compulsivity, distress about sexuality, or both — and for those who have simply never been taught how to ask.

Why This Matters Now

Sexuality remains one of the thinnest parts of the CPD landscape — most general clinical training addresses it in passing, if at all, leaving practitioners to improvise a formulation the first time a client brings it into the room. Silva has spent over a decade building the clinical vocabulary this training hands you directly: not a new label to apply, but a sharper set of questions to ask before reaching for one. You will leave better able to slow that moment down: to know what to assess, what not to assume, and what kind of therapeutic response the client actually needs.

Most clinicians will meet a version of the client at the start of this page - the coat still on, the promises already broken. Few will have been trained for the moment, and fewer still will have been trained by someone who has spent this long inside the question rather than reaching for a ready answer to it. This is the training for that moment.

There is no known commercial support for this program.

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