

Sex & Relationship Addiction

When connection becomes compulsive - understanding patterns without shaming sexuality or relationships

Sex, intimacy and relationships are normal parts of human life. Having a high sex drive, enjoying sexual activity, dating frequently or wanting closeness does not by itself mean there is an addiction. Concern arises when sexual or relationship-seeking behaviour feels persistently difficult to control, becomes a dominant way of regulating emotions, continues despite significant harm, or repeatedly pulls somebody away from their own values, safety and responsibilities.

A note about the language

“Sex addiction” and “relationship addiction” are widely used everyday terms, but they are not straightforward clinical diagnoses. The World Health Organization recognises **Compulsive Sexual Behaviour Disorder (CSBD)** in ICD-11 as an impulse-control disorder. It involves a persistent failure to control intense, repetitive sexual impulses or urges that lead to repetitive behaviour and marked distress or impairment. Distress based only on moral disapproval is not enough for the diagnosis. “Relationship addiction” is not a formal diagnostic category, but the phrase may describe repetitive, compulsive patterns around attachment, reassurance, pursuit or staying in harmful relationships.

What a compulsive pattern can look like

Sexual behaviour	Relationship / attachment behaviour
Repeated behaviour that feels increasingly difficult to control, despite attempts to reduce or stop.	Feeling unable to tolerate being without a relationship, repeatedly pursuing reassurance or quickly replacing one relationship with another.
Using sexual behaviour repeatedly to escape distress, loneliness, anxiety, shame, boredom or difficult emotions.	Remaining in damaging dynamics because separation, rejection or aloneness feels unbearable.
Increasing time, secrecy or preoccupation, with consequences for sleep, work, finances, health or relationships.	Losing personal boundaries, interests, friendships or identity while organising life around another person's availability or approval.

What this is not

It is important not to pathologise consensual sexuality. Frequency alone does not define a problem. Neither does sexual orientation, kink, masturbation, consensual non-monogamy, a high libido or having more sexual interest than a partner. The focus should be on **control, consequences, distress, consent, safety and whether behaviour is consistent with the person's own values**. Shame can make compulsive patterns worse, so assessment should be curious rather than moralising.

Why the cycle can become powerful

A behaviour can become a rapid route to relief. Anticipation may temporarily lift low mood or create excitement; sexual activity or intense connection may reduce tension; reassurance can quiet fears of rejection. Afterwards there may be guilt, secrecy, exhaustion, conflict or emotional crash. Those uncomfortable feelings can then become triggers for the same behaviour again. Over time the cycle may become less about pleasure and more about regulating distress.

Possible influences underneath the behaviour

There is rarely one explanation. Attachment experiences, trauma, loneliness, rejection sensitivity, anxiety, depression, ADHD-related impulsivity, low self-worth, relationship difficulties, chronic stress and learned coping patterns may all be relevant for some people. None should be assumed. A good formulation explores the individual person's history, current circumstances and what the behaviour is doing for them.

Reflection: what job is the behaviour doing?

Notice what happens immediately before the urge: an argument, boredom, feeling rejected, being alone, stress after work, shame, tiredness or a need for stimulation. Then notice what changes during the behaviour and what happens afterwards. This creates a map of the cycle without reducing the person to the behaviour.

Recognising Harm & Rebuilding Choice

The aim is not to remove sexuality or connection - it is to restore choice, safety and balance

Signs that support may be useful

Consider seeking help when sexual or relationship-seeking behaviour repeatedly interferes with work, sleep, finances, physical health or important relationships; when secrecy is increasing; when attempts to reduce the behaviour repeatedly fail; when the behaviour escalates in time or intensity; when somebody feels driven rather than freely choosing; or when the aftermath regularly includes distress, conflict or significant regret.

Consent and safety remain central

Compulsion never removes responsibility for consent or another person's boundaries. Consent must be freely given and can be withdrawn. If behaviour involves coercion, stalking, non-consensual activity, exploitation, illegal material or risk to a child or vulnerable person, the priority is immediate safety and appropriate specialist or statutory intervention. Therapy should not collude with harmful behaviour, but it can help somebody understand and change the patterns that contribute to risk.

The trigger - urge - action - aftermath cycle

1. Trigger	Loneliness, rejection, stress, conflict, boredom, shame, excitement, opportunity or a reminder of previous experiences.
2. Urge / preoccupation	Attention narrows. Thoughts become repetitive and the anticipated behaviour begins to feel urgent or necessary.
3. Action	Sexual behaviour, seeking contact, reassurance, pursuit, checking, fantasy or another repeated behaviour temporarily changes the emotional state.
4. Aftermath	Relief may be followed by guilt, secrecy, fatigue, financial cost, conflict, emptiness or renewed fear of rejection.
5. Re-entry	The aftermath itself can become the next trigger, reinforcing the cycle unless another response becomes available.

Building a pause between urge and action

A useful early goal is not necessarily "never feel the urge". It is to increase the space in which a choice can happen. That might mean delaying an action, moving away from a triggering device or environment, contacting a safe person, grounding through the body, writing down the emotion underneath the urge, or using a pre-agreed plan created with a therapist. The purpose is to practise tolerating the feeling long enough for automatic behaviour to become less automatic.

Relationships, boundaries and repair

Where trust has been damaged, repair usually requires more than promises. It may involve honesty appropriate to the relationship, agreed boundaries, sexual-health testing where relevant, financial transparency, individual therapy and sometimes couples therapy. A partner is not responsible for policing another person's recovery. Partners may need their own confidential support and space to decide what boundaries they require.

When attachment feels like an addiction

Some people describe feeling "addicted" to a person: repeatedly checking messages, panicking when contact reduces, abandoning boundaries, returning to a harmful relationship or feeling unable to function without reassurance. These experiences may be better understood through attachment, trauma, anxiety, obsessive patterns or dependency rather than a literal substance-style addiction. The label matters less than understanding the cycle and restoring autonomy.

A personal pattern map

Complete four columns for several episodes: **What happened? What did I feel in my body and emotions? What did I do? What did I need?** Look for repeating needs such as reassurance, stimulation, comfort, escape, validation, closeness or relief from shame. Those needs become important treatment targets.

If shame is dominating

Shame often says, "This behaviour proves something terrible about me." Effective therapy separates identity from behaviour: a person can take responsibility for choices and consequences without being reduced to them. This makes honest disclosure, accountability and sustainable change more possible.

Support, Therapy & Moving Forward

Recovery is about developing a relationship with sex, intimacy and connection that contains choice

What therapy may explore

Treatment should be individualised. Depending on the formulation, work may include CBT-style trigger and behaviour mapping, acceptance and commitment approaches, emotion regulation, trauma-informed therapy, attachment-focused work, relapse-prevention planning, self-compassion work, couples therapy, sexual-health support and treatment for co-occurring anxiety, depression, ADHD or other difficulties. Therapy should support consensual, healthy sexuality rather than imposing a therapist's moral values.

Practical recovery foundations

Know the pattern	Track triggers, urges, behaviour, consequences and unmet needs rather than relying on memory after the event.
Reduce secrecy	Choose appropriate professional or trusted support where honesty can occur without humiliation.
Create boundaries	Identify situations, technologies, contact patterns or relationship dynamics that repeatedly remove choice.
Build alternatives	Develop other ways to meet needs for soothing, stimulation, closeness, validation, rest and emotional expression.
Plan for lapses	A lapse is information about the plan, not proof that change is impossible. Review what happened and strengthen the next response.

Where to seek support in the UK

A GP can help with mental health, medication, sexual-health concerns and referral options. NHS sexual-health services can provide confidential testing and advice. For compulsive sexual behaviour, look for a suitably qualified psychotherapist, psychologist or specialist service experienced in sexual behaviour and compulsivity. Relationship counselling may help couples, but individual safety and consent should be considered first where there is coercion or abuse.

Supporting a partner or loved one

You can care about somebody without becoming their monitor. Be clear about what you need to feel safe, what you will and will not accept, and what consequences follow if boundaries are crossed. Avoid taking responsibility for preventing every urge or checking every device. Your wellbeing matters independently of whether the other person chooses treatment.

One book to explore

***Out of the Shadows: Understanding Sexual Addiction* - Patrick Carnes.** This influential book helped bring compulsive sexual behaviour into public discussion and may help some readers recognise cycles of secrecy, escalation and consequences. Its "sex addiction" framework is older than current ICD-11 terminology and should not be treated as the final word on diagnosis. It is best read alongside contemporary, non-shaming clinical understanding of CSBD, consent, attachment and individual differences.

A message from Maggie

Connection is human. Sexuality is human. Wanting to be wanted is human too. The difficulty is when something that once brought closeness, relief or excitement begins to feel as though it is making the decisions for you. Looking at that pattern does not require you to shame yourself or erase your sexuality. It means becoming curious about what happens before the urge, what you are trying to feel - or not feel - and what the behaviour is costing you. Change can begin by creating one small space between the feeling and the action.

Clinical note & source framework

This resource is educational and is not a diagnosis. Compulsive Sexual Behaviour Disorder is recognised in ICD-11 as an impulse-control disorder. "Sex addiction" and "relationship addiction" are not interchangeable with that diagnosis, and relationship addiction is not a formal diagnostic category. Assessment should distinguish high sexual interest from impaired control and clinically significant harm, and should not diagnose distress that arises solely from moral judgement. Clinical framing should be checked against current WHO ICD-11 guidance, NHS sexual-health information and relevant professional standards before publication.