Middlesex University and Metanoia Institute

A Relational Model of Therapists' Experience of Affect Regulation in Psychological Therapy with Female Sex Addiction

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1. Abstract

This study investigated how therapists work with female sex addicts on affect regulation from a relational perspective in psychotherapy. I used a grounded theory approach, embedded in a social constructionist epistemology, and implemented a relativist constructionist methodology (Bryant & Charmaz, 2010). A total of twelve experienced psychotherapists and psychologists who worked in the sex addiction field participated in conversational, semi-structured interviews. Analysis revealed seventeen central properties, which organized five reciprocal, interactive categories. Four of these – namely, Forming Relationship, The Therapist's Edge, Managing Risk and Safe Surprises and Finding a Shared Frequency – are cohered by the fifth category, The Multiversal Space. Findings demonstrated affect regulation as a therapeutic method with female sex addicts to be inextricably bound up with the therapist's subjective response as well as their capacity for conceptualization, and theory of mind. Central to the work is an attendance by the therapist to both the implicit unconscious and somatic communication and explicit, cognitive and narrative aspects, as these were shown to influence the quality of relationship and the therapeutic action of change (Boston Change Process Study Group, 2010). The contribution of this research added to that of the small number of empirical studies considering female sex addiction. The originality of the study concerned the conceptualization of psychological therapy with female sex addicts as a two-person endeavour, thus positioning it in the field of relational and counselling psychology.

Timeline of Key Empirical and Conceptual Literature for Female Sex Addiction

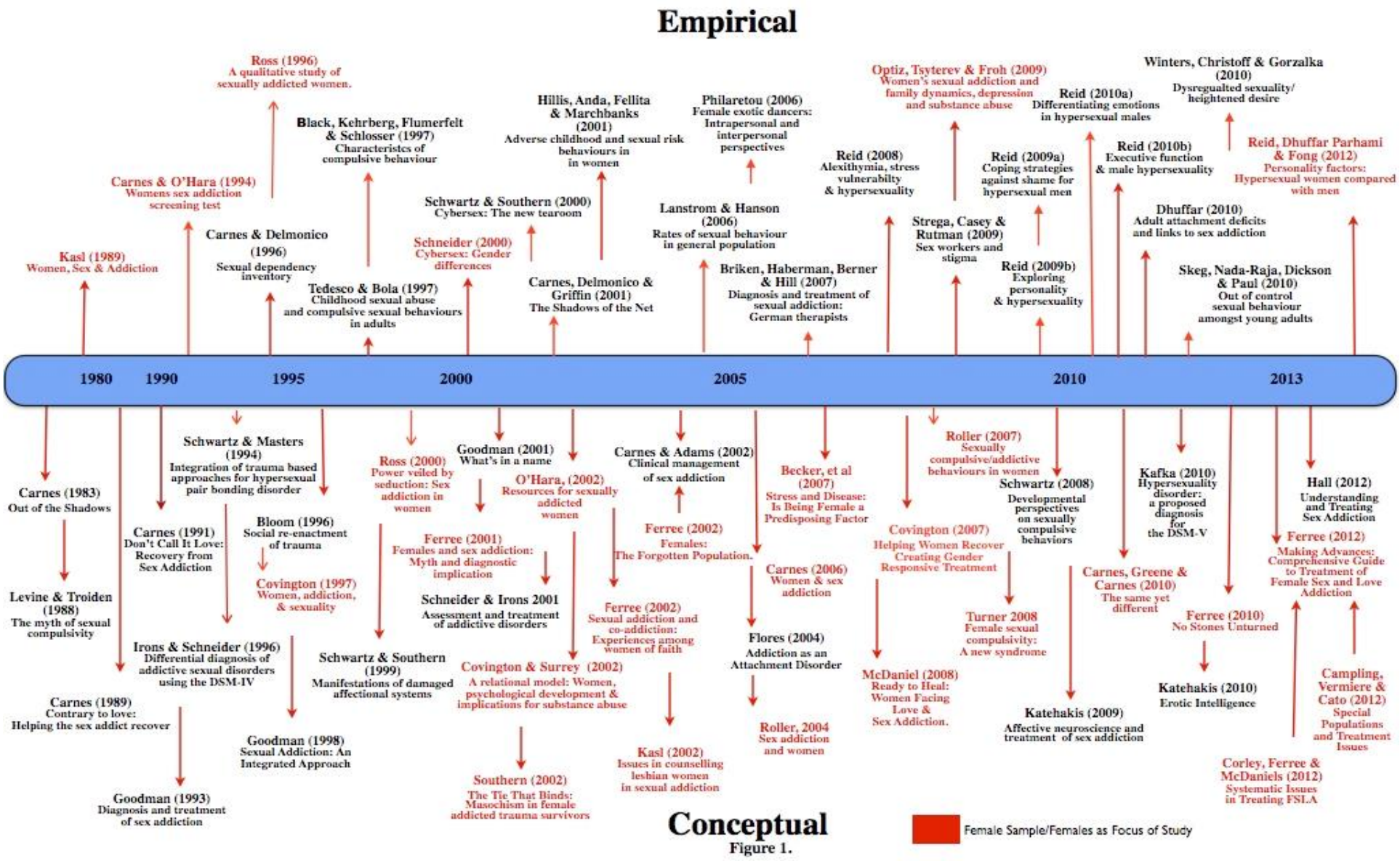

Figure 1.

2. Introduction

Attachment theory (Bowlby, 1969, 1973, 1980, 1988) is considered in the literature to be one of 'the most useful and generative frameworks for understanding both normative and individual differences in the process of affect regulation' (Mikulincer, Shaver & Pereg, 2003). There has been a growth in the literature describing the attachment relationship as an affect regulatory system involving processes of self and other regulation (Beebe & Lachmann, 2002; Schore, 1994, 2002, 2003). Influenced by current advances in explorations of neuroscience, psychotherapy research has perhaps shifted the significance of emotion regulation from peripheral position to centre stage as it is increasingly understood to influence 'change' in the treatment and therapy of a number of psychological conditions and psychopathologies (Boston Change Process Study Group, [BCPSG} 2010; Schore, 2012; Fonagy, Gergely, Jurist & Target, 2002). Even those from a more cognitive behavioural perspective appear to integrate emotional regulation in task-focused models (Berking Wupperman, Richardt, Pejc, Dippel & Znoj, 2008; Linehan, 1993a; Linehan, Dimeff & Sayrs, 2008), provide treatment manuals for clinicians (Greenberger & Padesky, 1995; Linehan, 1993b) and produce diagnostic assessment tools, like the Difficulty in Emotional Regulation Scale (DERS) (Gratz & Roemer, 2004).

Many studies in the wider field of psychological research have demonstrated early attachment history to shape factors of personality (Shaver, 1992), adult relationship dynamics (Feeney, 1999; Hazan & Ziefman, 1999) and sexual patterns (Birnbaum, 2007; Hazan, Zeifman & Middleton, 1994). Recently, others have conceptualized the primary function of the attachment relationship to be an affect-regulating system (Schore, 1994, 2003, 2012) and in particular see early developmental attachment disruption as being a central component in the development of psychopathology (Bradley, 2000; Dozier, Stovall & Albus, 1999). Gross and Munoz (1995) see emotion and affect regulation as a unifying factor in a variety of symptoms and maladaptive behaviours. Panskepp (1998) states that 'all subfields of psychology must begin to integrate this new and strange landscape into their thinking if they want to stay on the forefront of scientific inquiry' (p.11). Many authors see this thinking as marking a paradigmatic shift in terms of 'therapeutic action of change' in psychological therapy (Schore, 2012, 2003; BCPSG, 2010) and this as signifying a move from a 'talking cure' to an 'affect communicating cure' (Ogden, 2008).

2.1 Autobiographical Influences

My clinical work at a treatment centre for addictive disorders ignited my interest in issues of sexual addiction amongst women and highlighted the complexities for both the client and

clinician. In private practice I noticed female addicts, abstinent from alcohol, drugs, bulimia and anorexia nervosa, were presenting for therapy struggling with emotional-disequilibrium-perpetuated interpersonal difficulties and patterns of addictive sexual acting out. In my view, there was scant attention paid to emotional regulation and self-soothing and what was implemented was limited to formulaic, task-focused cognitive and behavioural interventions. During my counselling psychology and psychotherapy training I came to understand both the complexity and pervasiveness of affective dysregulation as a derailed relational process, particularly in the context of psychopathology and mental health. This, combined with the paucity of empirical attention to affect regulation as a therapeutic method in the context of clinical work with addiction, located my area of study.

2.2 Literature Review

This literature review begins by addressing the debates surrounding the etiology and conceptualization of sex addiction. It then leads into a consideration of the conceptual and empirical papers addressing the social and cultural perspectives, prevalence and presentation of female sexual addicts. I review the contribution of the attachment literature as it contextualizes early relational derailment and sexually addictive adult behaviours, particularly in the context of female sex addiction and hypersexuality.

2.2.1 Etiology and Definition: Is Sex Addiction a Disorder?

Out of control sexual behaviour was documented as early as the 3rd century by St Augustine and later from the mid-18th century by medical pioneers such as Benjamin Rush (1745–1813) and sexologist Richard von Krafft-Ebing (1840–1902). Krafft-Ebing observed one patient suffering:

> *To such an extent that permeates all his thoughts and feelings, allowing no other aims in life, tumultuously, and in a rut-like fashion demanding gratification and resolving itself into an impulsive, insatiable succession of sexual enjoyments. This pathological sexuality is a dreadful scourge for its victim, for he is in constant danger of violating the laws of the state and of morality, of losing his honor, his freedom, and even his life.* (Krafft-Ebing, 1886)

In the last two decades many authors and researchers have focused on attempts to establish a consensus of definition and etiological understanding of excessive, 'out of control' and maladaptive sexual behaviour (Kafka, 2010). Despite the use of terms such as Don Juanism (Stoller, 1975) or satyrism for men (Allen, 1969) and nymphomania for women (Ellis & Sagarin, 1965), these non-paraphilic, appetitive sexual behaviours are still acknowledged in

the literature to represent a 'conceptual quagmire' (Schwartz, 2008:p.1). In reviewing the literature, it is seen that one of the central debates surrounding definition asks whether or not excessive sexual behaviour can be classified as a behavioural addiction and indeed whether or not *sex addiction* is an appropriate diagnostic term (Carnes, 1983; Goodman, 1998, 2001). Could the classification of an obsessive-compulsive disorder and the term *sexual compulsivity* (Black, 1998; Coleman, 1987), or perhaps an impulsivity spectrum disorder, Impulse Control Disorder (Hollander & Rosen, 2000; Mick & Hollander, 2006), be a more appropriate fit? The field is fraught with debate, complexity and plurality and worthy of further review.

Diagnostic Classification

Kafka (2010) observed that while there was no classification in the *Diagnostic Statistical Manual* DSM-II (APA, 1968) for excessive sexual behaviours other than those mentioned in the context of personality disorders, the DSM-III (APA, 1980) included paraphilic conditions as psychosexual pathologies, or psychosexual disorders (APA, 1980). The revised version of the DSM-III-R (APA, 1987) classified *sexual addiction* under sexual dysfunction not otherwise specified as 'Non-Paraphilic Sexual Addiction' which was later removed due to lack of empirical evidence (Wise & Schmidt, 1997). Both the DSM-IV (APA, 1994) and the revised DSM-IV-TR (APA, 2000) reintroduced the character of the earlier DSM-III (APA, 1980) concept and included Sexual Disorders Not Otherwise Specified (302.9). Both texts include this as 'a condition involving distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used' (2000:p.582). On the other hand, while the *International Classification of Diseases* 2010-Version (WHO, 2010) includes a condition reflecting 'excessive sexual drive' (Diagnostic Code F52.7), unlike the DSM-IV-TR (APA, 2000) it further specifies gender differences stating nymphomania (for females) and satyriasis (for males).

DSM-V and Hypersexual Disorder

Many researchers (Kafka, 2010; Kingston & Firestone, 2008; Reid, Carpenter, Spackman & Willies 2008) addressed issues of diagnostic viability pertaining to the inclusion of Hypersexual Disorder in the DSM-V (APA, 2012). In arguing the case for this new classification (see Appendix I, p.141), Kafka and colleagues deliberately included two aspects already 'well-established' in the DSM-IV-TR (APA, 2000), including Hypoactive Desire Disorder and the Paraphilias. While the term *hypersexuality* has been more frequently used to establish a differentiation from hyposexuality this classification should not be confused with more historical conceptualizations of the term, which see excessive sexual activity as being propelled by an inability to achieve sexual satiation. Kafka (2010) considered this current term as describing excessive sexual activity, which is specifically attributed to a condition

involving the progressively increasing intensity and frequency of normophilic, sexual behaviours associated with significant adverse consequences and failed attempts to reduce use despite negative consequences (Kafka, 2010; Barth & Kinder, 1987; Coleman, 1987; Orford, 1978; Quadland, 1985).

Of interest here, perhaps, are the significant overlaps between the criteria for hypersexual disorder and the criteria for sexual addiction (Carnes, 1991; Goodman, 1998), including repetitive use of sexual fantasies, urges, planning strategies and engagement in sexual behaviour independent of the physiological influence of any extrogenous substances or co-occurring medical conditions or manic episodes. Like sex addiction, hypersexuality is conceptualized as a response to dysphoric mood states such as depression, boredom and irritability as well as a response to stressful life events. What this proposed classification also shares with the diagnostic criteria for sex addiction (Carnes, 1989, Goodman, 1998) is the repetitive unsuccessful attempts of the individual to control or reduce the behaviour and the continuation of sexually addictive patterns despite negative consequences, particularly disregard for risk of physical and emotional harm to self and to others. At the time of writing this review, despite hopes for its inclusion in Section III, Conditions For Further Study of the DSM-V (APA, 2013), the proposal to include hypersexual disorder in the DSM-V (APA, 2012) has been 'outrightly' rejected on the grounds of insufficient evidence. In response to this exclusion the *Society for the Advancement of Sexual Health* (SASH) published a special edition of the journal *Sexual Addiction & Compulsivity*, in which Samenow (2013) asserts that sex addiction as a field may have further to go but, increasingly, 'the similarities between the constructs and the research continue to outweigh the differences' (p.1).

While the diagnostic classification of psychiatric illness contributes to both our organization and understanding of psychiatric conditions and symptomology, it is also useful to draw understanding from elsewhere in order to better account for the more subtle nuances and complexities of the human condition that the reductionism of the Diagnostic Statistical Manual could not possibly include. There is significant argument in the literature questioning the viability of the translation of this classification system into clinical practice. Clinical authors (Vanheule, 2012) suggest that over the last thirty years the clinical application of these diagnostic classifications has become increasingly 'unworkable'. This is due in part to the movement toward seeing 'symptoms and complaints' as neurological process, which is a position 'not compatible with the referent that psychotherapeutic theories use' (2012:p.128). Vanhueule (2012) goes on to draw out the debates and tensions between diagnostic classification and clinical application while arguing the case for subjective and contextual criteria and the importance of case formulation. This has particularly relevant clinical

implications for women and highlights the importance of cultural, social and individual autobiographical information in the context of assessment, diagnoses and case formulation (Covington, 1997, 2002).

Sexual Compulsivity

Coleman (1986, 1987, 1991) and others (Black, Kehrberg, Flumerfelt & Schlosser, 1997) argue an obsessive-compulsive model for sexually excessive behaviours and understand non-paraphilic and paraphilic patterns to be obsessive compulsive disorder and thus worthy of the term *sexual compulsivity.* While there are certainly clinical cases that warrant this diagnosis, Irons and Schneider (1996) argue that 'an individual who engages in compulsive behaviours such as hand washing, does so in an attempt to suppress obsessive thoughts and impulses and to reduce anxiety not, as in addiction, to pursue pleasure and gratification' (p.19).

Impulsive Control Disorder

Impulse control disorder, not otherwise specified (APA, 1994) describes the 'failure of an individual to resist an impulse, drive or temptation to perform an act that is harmful to the person or to others' (p.609) and also is suggested to explain sexually excessive behaviour (Bart & Kinder, 1987; Hollander & Rosen, 2000; Mick & Hollander, 2006). Irons and Schneider (1996) accept that out of control sexual activity can occasionally be attributed to this diagnosis but argue that more often than not this is misdiagnosed sexual addiction. Like Goodman (2001, 1998, 1993) they highlight the overlaps between the diagnostic criteria of impulse control disorder (APA, 2000) and those of pathological gambling and substance abuse (APA, 2000). Goodman concurs and asserts that if sexually out of control behaviour can be considered an impulse-control disorder, surely the criteria for an impulse control disorder can 'characterize substance dependency equally well' (Goodman, 2001:p.192). It is therefore plausible he argues that just as substance dependence is widely acknowledged to be an addictive disorder, sexual impulsivity 'cannot be precluded from being identified as an addictive disorder as well' (Goodman, 2001:p.194).

Sexual Addiction

Many of the sex addiction theoreticians acknowledge the avenues of differential diagnoses yet firmly argue that the addiction model conceptualizes a condition with distinct characteristics (Carnes, 1983, 1989, 1991a; Goodman, 1998) (see Appendix II, p.142 and Appendix III, p. 143). They assert that 'sexual disorders which do not fit into standard DSM-IV TR (APA, 2000) categories can be best diagnosed using an adaptation of the DSM-IV criteria for substance dependence' (Goodman, 1998; Irons & Schneider, 1996:p.7) (see Appendix IV, p.144) and that these diagnostic criteria are interchangeable with other addictive substances

and behaviours including drugs sex, limerence, food and gambling (Carnes, 1991a; Goodman, 1998; Shaffer *et al.*, 2004, 2012). A central debate, however, considers whether or not behavioural processes can be considered as addictions. Shaffer's research at Harvard has long pushed the case that addiction is a syndrome involving multiple expressions, with a common etiology. While some authors consider the lack of empirical data to cast doubt on this notion an increasing number concur with Shaffer *et al.* (2004, 2012) and see addiction as being defined by a complex set of genetic, neurological, psychological and social conditions, creating in the individual a predisposition to a pathological reliance on substances and behaviours (Carnes, 1989, 1991a; Goodman, 1998; Robertson, 1990). Robertson (1990) particularly supports the position of Shaffer *et al* (2004, 2012) and sees the addictive reliance on a behaviour-induced chemical 'buzz' as resulting from the neurochemical stimulation created by the individual's level of excitation rather than use of chemical 'mood altering' substances. More recently Hilton and Watts (2011) have claimed that scientific studies evidence neurochemical changes in sexually addicted individuals. While it seems credible that sex addiction, like pathological gambling (Griffiths, 2004) and cocaine addiction (Volkow, Fowler, Wolf & Hitzemann, 1991), is located in neurological pathways, Reid (2011b) vehemently argues that no such data is currently reliable (see Appendix V, p.145).

Carnes's (1983) seminal book *Out of the Shadows: Understanding Sexual Addiction* (1983) was the first to coin the term s*ex addiction*. Since then the term has become both popularized and contentious (Carnes, 1989, 1991a; Carnes & Adams, 2002) with 'little consensus about its defining characteristics' (Gold & Heffner, 1998:p.368). Carnes (1991a) argues that sex addiction is differentiated from other conditions such as impulse disorders and compulsivity because it is characterized by an uncontrolled and 'pathological relationship with mood altering behaviours' (Carnes, 1983:p.4). He specifies these as including repeated and unsuccessful attempts to reduce or control stress and dysphoria, an increasing tolerance for frequency of use and risk-taking despite negative and harmful physical, psychological, social and financial consequences, and symptoms of withdrawal following cessation (1983, 1989). Carnes organizes his model into four iterative and cyclical, behavioural dimensions, i.e., precoccupation, ii) ritualization, iii) compulsive sexual acting out, and iv) despair, and proposes that these occur in one or more of ten domains of sexual acting out behaviour (1991a) (see VI). Aspects of these dimensions are perhaps consistent with some of the classification criteria for paraphilic disorders in the DSM-V (APA, 2013) – namely, voyeurism, exhibitionism, sadomasochism and the pain exchange in sadistic sex. Three dimensions – namely, paedophilia, fetishism and transvestitism – are not included by Carnes. Carnes includes a sexual anorexia component, which accounts for a compulsive avoidance of and aversion to sex, and mentions this as being more prevalent in female groups than male

groups (Carnes, Nonemaker & Skilling, 1991). This hyposexual presentation is also conceptualized as part of a sexual binge/purge pattern (Ferree, 2001). The sex addict's avoidance and rigid abstinence from sexual contact is understood to be an acting-in attempt to manage and self-correct the out of control 'acting out' sexual patterns.

Goodman (1998), influenced by his psychiatric and psychoanalytic background, sees sex addiction as resting on underlying psychological and neurological pathways and, given this, his integrative approach strongly argues the case that all forms of addiction share a common etiology. As such, he considers substance abuse, eating disorders, pathological gambling and sex addiction as underpinned by a common biological, psychological and developmental substrate. While Goodman (1998) concurs with Shaffer *et al.* (2004, 2012) and Carnes (1983, 1989, 1991a) and sees sexual addiction as existing co-morbidly with one or multiple addictions, he considers that sexual addiction can also be an independent stand-alone condition and independent from other expressions of addictive disorder. Goodman (1998) uses the substance abuse criteria of the DSM-IV-TR (APA, 2000) to formulate the *Diagnostic Criteria for Addictive Disorders* (see Appendix VII, p.147) and proposes that any addictive process, including sexual behaviour, fits this diagnostic classification. He also argues that when the words *substance abuse* (APA, 2000) are substituted for *sex addiction*, all the criteria in the DSM-IV-TR (APA, 2000) could correspondingly be observed in individuals with sexually addictive behaviours. While Goodman (1998) shares the central tenets of Carnes's (1983, 1989) sex addiction model he elaborately extends this in his book *Sex Addiction: An Integrated Approach* (1998) and draws together ideas from neurobiology, psychoanalysis, self psychology and object relations to construct a sophisticated, multifaceted conceptualization of sex addiction. While the limitations of Carnes' model are perhaps addressed by Goodman, he also reviews the arguments for *sexual compulsivity, dependency and addiction* and presents a thorough and clear case that in his view these out of control and excessive sexual behaviours are indeed consistent with the definition of an addictive disorder (Gold & Heffner, 1998).

Levine and Troiden (1988) challenge this position from a sociological perspective of symbolic interactionism and argue sexual addiction to be an 'invention of culturally induced perceptions' (p.361). They consider this disease concept to 'threaten the civil liberties of sexually variant people' (p.361) and to reflect a 'stigmatism and a condemnation of particularly overt sexual behaviours' (Gold & Heffner, 1998:p.368). Levine and Troiden (1988) see sex addicts 'not to have characteristics that set them apart from non-addicts' and propose 'sex addicts to differ only in external behavior and not in internal make up' (p.361). While this notion challenges the disease argument for sexual addiction it also highlights the need for caution with sociopolitically driven tendencies towards over-diagnosis. Aligning too

hastily with Levine and Troiden's (1988) view that sexual addiction is a mere social construct designed to stigmatize promiscuity would perhaps risk overlooking the subtle complexities of the issue in question and thus risk prematurely rejecting an opportunity to treat women with viable diagnoses of sexual addiction. In support of this view, Coleman (1992) contends that 'sexual addiction is more than just excessive sexual behavior' (p.323) and clarifies that what differentiates this clinical group from others is high levels of underlying distress, depression, anxiety and obsessive thinking which are not 'often found in promiscuity alone' (p.323).

While this review considers the tensions surrounding the validity of terms such as hypersexuality, sexual compulsivity, impulsivity and sexual addiction, the complexities inherent in seeking a definition for out of control sexual behaviours are at times more semantically confusing than diagnostically helpful. In the literature these terms are used interchangeably and, while the presenting diagnostic criteria and symptomology are perhaps more similar than different, it is the etiology that is contended. Reid and Carpenter (2009b) reflect that 'although some ambiguity and indecision exists about the advantages and disadvantages of these alternate conceptualizations, each label does seem to carry with it implications for how the indicated problems might be perceived and therefore treated' (p.295). Goodman also comments on the semantics of the debates and concludes that:

> *Sexual addiction is thus not a bizarre aberration, nor a new fad, not even a unique disease. It is simply the addictive process being expressed through sex, the compulsive dependence on some form of sexual behavior* as a means of regulating one's feelings and sense of self.* (Goodman, 1993:p.312)

2.2.2. Women, Sex and Addiction

While these authors have contributed to the diagnostic endeavour and moved toward a viable case for sexual addiction, none of them have adequately addressed how sexual addiction impacts women. While the DSM-IV-TR (APA, 2000) stipulated four categories of sexual dysfunction that are generalizable for both men and women, the DSM-V (APA, 2013) classifies gender-specific sexual conditions, with only one applicable across gender. Carnes * only incorporated female-orientated dimensions in his twenty-five-item, Sex Addiction Screening Test (Carnes, 1991b) as an afterthought, to create a twenty-five-item Women's Sex Addiction Screening Test (Carnes & O'Hara, 1998). He did revisit this later on to reflect further inclusion of sexual orientation and gender differences (Carnes, Greene & Carnes, 2010). Goodman barely makes reference to female sex addiction and it takes Kafka (2010) only one small paragraph to review the totality of the population-based empirical studies. He summarizes that, in the six studies implementing a mixed gender sample, males outnumber

females with women constituting between 6.8 and 43% with a mean of 18.6 % (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Briken, Habermann, Berner & Hill, 2007; Carnes & Delmonico, 1996; Lanstrom & Hansen, 2006; Schneider, 2000; Reid, Dhuffar, Parnhami & Fong, 2012; Winters, Christoff & Gorsalka, 2010). Kasl (1989), Ross (1996) and Opitz, Tsytarev and Froh (2009) are the only researchers in the last three decades to implement a study using a homogenous female sample.

Certainly this paucity of attention to female sex addiction reflects the complexity and contention surrounding the viability of the term sex addiction as a clinical diagnosis for women. While some authors argue it to be a socially constructed phenomenon and to reduce the subjectivity of female sexuality to suit a male-dominated system of clinical classification others express concern that male-orientated diagnostic manuals are inadequate classifications for women. This tension certainly raises curiosity about the clinical usefulness of using the term when working with women presenting for therapy with excessive and problematic sexual behaviour.

Female Socialization: A Sociocultural Perspective

The feminist perspective views sexual addiction and female hypersexuality as a social construct 'depicted by males, and as such sees it to present a fundamental barrier to understanding women's sexuality' (Dhuffar, 2010). Historical perspectives see excessive forms of sexual behaviours for women in negative terms, like *nymphomania*, compared with more socially celebrated male forms like s*atyriasis* (Griffiths, 2004). Female sexuality has been contextualized in derogative ways and in the past was also seen to underpin mental health problems such as alcoholism. Until the 1950s these distorted ideas justified abhorrent psychiatric treatment interventions involving the de-sexualization and sterilization of female alcoholics with the removal of their uterus and ovaries (White, 1998). The disparity between men and women in the context of social roles, position and power is reflected by Jellinek (1941) cited Covington, 1997) who quotes Kant's perception of female drunkenness:

When using quotes from American sources spelling will reflect this, i.e., 'behavior' etc.

> *Women should avoid drunkenness because their privileged place in society was ensured only if they adhered to a higher moral code of behavior than men* (p.2)

Covington (1997) sees little as having changed from the days of Chaucer (translated by Coghill, 1951), when it was believed women who drank invited sexual assault:

A woman in her cups has no defence. As lechers know from long experience. (p.2)

Women who seem to be 'out of control' and intoxicated are perceived to be more eager for sex, more vulnerable to seduction, and less selective about partners (George, Skinner & Marlatt, 1986; George, Gournic & McAfee, 1988). This surely is a comment on their vulnerability to the projections of observing males as well as perhaps the disinhibited sexual and erotic behaviour that can be 'out of control' during intoxication. In light of this, Covington (1997) highlights the sociopolitical stigma surrounding addicted women and sees this in sexual terms in the branding of women as promiscuous, loose, or 'looking for it'. While derogatory sexual terms are rarely used to describe addicted men, unlike drunken men, drunken women can never be perceived as just spending a pleasant night out on the town with 'the boys' (1997). Despite twenty years of debate and 'an increase in the flexibility of the parameters' about what is acceptable and appropriate male/female behaviour in the area of human sexuality, these socialized attitudes are at their least flexible and are at the 'nub of inter-gender dynamics where the complexities and nuances can be best observed' (Covington & Becket 1988).

> *Men are taught to act knowledgeable about sex, comfortable with their bodies, and to unselfconsciously touch themselves and their genitals*. (Covington, 1997:p.2)

Whereas:

> *Many women can't even speak about the sexual parts of their bodies without using euphemisms such as 'down there,' and many more have never even looked at themselves. Traditionally, the value of a virgin has been her inexperience and her trust in her husband to awaken her sexually. Whereas a sexually uninformed male may be ridiculed by his peers, a sexually experienced woman is at risk of being considered 'wild' by hers.* (Covington, 1997:p.2)

Shaffer (1981) asserts that women are:

> *Discouraged from learning about sex, touching or thinking about their genitals, or being sexually assertive.* (cited in Covington, 1997:p.2)

Oppression and Power

Covington and Surrey (2000) argue that women are 'socialized toward passivity in intimate relationships' and they see these social attitudes and constructs as contributing to women's

already elevated levels of shame and isolation in both the context of addiction and healthy excessive hunger for sexual activity (Covington, 1997). While women are idealized as sexually disciplined, restrained and chaste, they are also represented and 'desired' as sexually provocative and seductive (Ferree, 2002a). Hyposexuality is expected for women but hypersexuality is not. Hypersexual men are often thought of as 'being male', with social attitudes reinforcing men with this disorder as being almost a cause for celebration, to have a certain prowess and desirable masculinity. However, women with this disorder attract criticism and derogatory terms such as 'slut', and 'whore' (Ferree, 2002a). This double standard is reflected in the literature and echoes the familiar Madonna/Whore split:

> *It's as if the cultural message of the 'good' passive woman and the 'loose, wanton, and whorish' sexual woman is still operating on a deep level.* (Covington, 1997)

There is a view that female sexual addiction is a response to socio-patriarchal oppression in which women seek to gain a sense of internal and interpersonal and control using sex (Kasl, 1989, 2002; Ross, 1996, 2000; Turner, 2008). It is speculated that oppression contributes to the conditions that 'trigger the creation of sexually addictive patterns as a release from this oppression in fostering rigid thinking and a sin/redemption mind set' (2008:p.713). These ideas challenge the more traditional view of women as the victims of male sexual aggression and perpetration (Herman, 1990; Hudson Allez, 2009; Marshall, 1993) and perhaps explain the growing number of studies showing female sex offending toward children to be on the increase (Davin, 1999). Emerging trends also reflect young females (including teens and young adults) presenting for sex addiction treatment 'more frequently now than before and exhibiting more typically male acting out behaviours' (Carnes, 2006; Welch, 2011). This includes a more overt pursuit of power through a sense of sexual conquest and a belief that excessive sex and multiple partners represent an accolade.

Prevalence

While the absence of any large study using a generalizable, random sample makes accurate estimates of prevalence rates impossible (Skeg, Nada-Raja, Dickson & Paul, 2010), some writers have speculated that for sexually addictive women these could be between 3% and 12% (Carnes, Nonemaker & Skilling, 1991; Skeg, Nada-Raja, Dickson & Paul, 2010; Schwartz & Southern, 2000). One study of cybersex addiction suggested that, of the estimated 1% of the population that have serious problems with internet sex, 40% of this number were female (Carnes, Delmonico & Griffin, 2001). Of interest is the review of eighteen female inpatients at a residential treatment centre in the United States, revealing the demographics of the group to include three teachers, one college professor and two business owners, with the

remainder being either physicians or prostitutes (Philaretou, 2006). In one study women were shown as more likely to suffer from problems associated with promiscuity than men and less likely to experience compulsive masturbation or pornography dependence (Briken, Haberman, Berner, & Hill, 2007)

Both research and clinical issues in this area seem to be male dominated and driven by patriarchal approaches to assessment, diagnosis and treatment (Ferree, 2002a). In combination with clinicians' personal values and bias toward female sex addiction, these factors create obstacles to knowledge about the condition (Hagedorn & Juhnke, 2005; Roller, 2004), which hamper appropriate and adequate diagnoses and treatment. The irony is that despite the more serious health implications for sexually addicted women than for men (Barth & Kinder, 1997; Coleman, 1992; Carnes, 1983, 1989; Kasl, 1989), the female sex addict's shame-based defence frequently thwarts sufficient disclosure of the problem and thus creates a block to treatment (Ferree, 2002a). Women tend to present for treatment only when the consequences of their out-of-control, sexually addictive behaviour have escalated to create chronic and acute health issues including recurrent sexually transmitted infections, unwanted pregnancies, abortions and suicide attempts (Ferree, 2001; Hall, 2013; Roller, 2007).

Presentation

Prior to 2000, female sex addiction resembled alcoholism in women thirty years ago – i.e., largely ignored (Ferree, 2002a). However, in the last twelve years a few published articles have considered conceptual ideas of female sex addiction. These include a chapter in the *Handbook of Clinical Management of Sex Addiction* (Carnes & Adams, 2002) entitled '*Females: The Forgotten Sexual Addicts',* which is located in the section named '*Special Populations*'. Other articles include a provision of resources (O'Hara, 2002), ideas addressing treatment, assessment and diagnosis (Ferree, 2001; Roller, 2004, 2007; Turner, 2008), issues of female sex addiction in a Christian context (Ferree, 2002b), lesbian issues (Campling, Vermiere & Cato, 2012; Kasl, 2002), female sex offenders and sex workers (Campling, Vermiere & Cato, 2012; Strega, Casey & Rutman, 2009), an object relations approach to treatment (Valenti, 2002) and the impact on family and partners (Corley, Ferree & McDaniel, 2012). The majority of the literature seems to be written by female clinicians who provide self-help publications in the form of autobiographical disclosures of sexual addiction recovery, workbooks and task-focused manuals for clients and clinicians (McDaniel, 2010), including one for the Christian community (Ferree, 2010). There is however a notable dearth of academic, empirical studies.

Despite several theoretical articles and conceptual publications considering female sexual addiction the literature search only located three empirical studies implementing a homogenous female sample (Kasl, 1989; Ross, 1996; Optiz, Tsytarev & Froh, 2009). These authors were primarily concerned with identifying characteristics of sexual addiction amongst females (Kasl, 1989; Ross, 1996) by exploring clients' subjective experiences of the condition and the influence of early paternal experience (Opitz, Tsytarev & Froh, 2009). Kasl's (1989) seminal book *Women, Sex and Addiction* extended her PhD and was the first to address, if not define, female sexual addiction. Since then very little has been done to extend her work. She studied the experience of ninety women, childhood abuse survivors who presented with sexually addictive and compulsive behaviours. These women actively sought connection without knowing how to create and sustain an intimate and healthy interpersonal bond. In terms of definition, Kasl (1989) sees sexual addiction for women as being organized on a continuum ranging from sexual addiction to sexual codependency (Corley, Ferree & McDaniel, 2012:p.17). Sexual codependency is characterized by more passive, submissive and acquiescing sexual behaviours, including seducing sexual attention and manipulating sexual encounters. Women use these to regulate their abandonment anxiety and fears of physical safety (Kasl, 1989). The female sex addict exhibited more stereotypically male characteristics such as sexual aggression, becoming addicted to the hunt, and the pursuit of sexual conquest. These women reported using sex as a form of power to create a temporary escape from feelings of worthlessness, shame and inner feelings of emotional distress and intense negative affect. In conclusion, Kasl's (1989) study indicated that female sexual addiction was motivated by feelings of emotional pain, fear, loneliness and desperation.

Ross's (1996) research extended Kasl's (1989) findings and further explored the characteristics of sexual 'acting out' behaviours amongst eighteen women who met the criteria for sexual addiction. Using the 100-item, Sexual Dependency Screening questionnaire and a qualitative approach to analysis, Ross (1996) found women to be as sexually compulsive as men but to present with a set of 'victim-based' behaviours rather than those of 'perpetrator'. However, she also reported women as exhibiting more passive perpetration by seducing, manipulating and objectifying sexual partners. Behaviours included visual stimulation (voyeurism), masturbation with objects to the point of pain, displaying underwear or their body in public or at home (exhibitionism), casual sex, anonymous sex and one-night stands with strangers and acquaintances, cruising bars and group sex, seductive role play, trading sex and pain exchange. Additionally, Ross (1996) reported that these women were not in fact looking for a relationship as an outcome of the behaviour and sought only the gratification of the sexual encounter.

Ferree (2001) draws together the results of these two studies with existing theoretical ideas in the literature (Kasl, 1989; Carnes, 1983, 1989, 1991a; Ross, 1996) to identify four dimensions of female sex addiction. These include i) love and relationship addiction, ii) cybersex, iii) sex addiction, and iv) sexual anorexia. The question arising here asks whether relationship addiction is really an insecure and preoccupied attachment disorder. Certainly processes currently defined as *love addiction* could be considered consistent with Tennov's (1979) ideas of limerence, which are set out in her book *Love and Limerence: The Experience of Being in Love*. Tennov describes the phenomenon of *being in love* as the 'involuntary state of mind that results from a romantic attraction to another person, combined with an overwhelming and obsessive need to have one's feelings reciprocated' (1979). Fisher (1997) and Fisher, Aran, Mashek and Brown (2002) contribute to the dialogue with evidence from a neurological perspective that the human drive for mutual and passionate attraction, i.e., the state of *being in love*, is simply a brain state mediated by neurotransmitters including dopamine, serotonin and noradrenaline. I recognize the neurological implications here in terms of overlaps between sexual attraction and addiction; however, due to word count restrictions I cannot include this in the current review.

Predictors of Sexual Addiction for Women

Paternal Influence

While there are ample references to the links between sexual addiction and the developmental influences of the mother/son relationship, there are considerably fewer addressing the notion that a woman's relationship with her father has a direct influence on her physio-sexual development and sense of sexual self. Until recently, the links to female sexual addiction have been limited to theoretical ideas (Kasl, 1989). Optiz, Tsytarev and Froh (2009), however, explored the father/daughter dynamic as a determinant of female sexual addiction using a multiple regression analysis and showed female sex addicts to experience their fathers as 'less caring, warm, affectionate and nurturing' as well as 'overprotective, controlling and intrusive' (p.334). They demonstrated an absence of family cohesion bonding and attachment and rigid 'black and white' thinking to predict female sexual addiction, and also found significant correlations between early sexual abuse, drug and alcohol use and depression. Depression for women was found to mediate childhood abuse and sexually addictive/compulsive behaviour (2009), thus linking early abuse and mood dysregulation to sexual addiction amongst women.

Consistency is found in other studies investigating the influence of paternal bonding on female alcohol and drug use (Bernardi, Jones & Tennant, 1989), a well as indicating the quality of a woman's relationship with her father to influence the onset age of puberty and menarche (Ellis, McFadyen, Dodge, Pettit, & Bates, 1999). While lower levels of paternal

attentiveness, affection and availability have been linked to the earlier onset of menarche and pubescent development, early menarche has been linked to poor body image, depression, anxiety, alcohol misuse and sexual promiscuity (Mendle, Turkheimer & Emery, 2007).

Trauma and Risk

Hughes (2010) reflects that while sex addiction is similar to other addictions it is 'distinctly different' (p.1) because of the connection to childhood trauma and difficulty with intimacy. In his landmark study, Patrick Carnes' (1991a) results found that 82% of the sexually addicted sample group were sexually abused in childhood, 72% were physically abused and 91% were emotionally abused. While some research has reported similar links between childhood sexual trauma and sexual addiction in a homogenous male sample (Anderson & Coleman, 1991), others using a mixed gender sample found female sex addicts to report higher levels of childhood sexual abuse and severity (Tedesco & Bola, 1997). Schwartz and Southern (2000) found 76.2% of a female clinical sample in a study of cybersex abusers to indicate a history of sexual abuse and, of these, 52.4% exhibited markers of post-traumatic stress disorder (PTSD). While there is a suggestion that these figures represent an underestimation of the prevalence of trauma for female sex addiction, a recent UK-based study found even lower measures and different data, with only 38% of a mixed gender sample reporting emotional abuse, 17% sexual abuse and 16% physical abuse (Hall, 2013). Hall (2013) suggests that the lower figures were based on early self-reports of clients entering treatment programs when 'denial' is high; they might also reflect a cultural difference with most other studies conducted in the United States. The high level of early trauma supports the idea that sexually addictive behaviour is a re-enactment of a life trauma, which, as an expression of post-traumatic stress disorder (PTSD), often involves sadomasochism (Bloom, 1996; Schwartz, 1992, 1996; Schwartz & Masters, 1994; Southern, 2002). As many as two thirds of women in prostitution met the diagnostic criteria for post-traumatic stress disorder and reported traumatic experiences of physical or sexual abuse in childhood rather than occurring in prostitution (Young, Boyd & Hubble, 2000). Writers speculate that this high number might reflect a woman's attempt to create an experience of being in control, unlike the experience of powerlessness experienced in the original trauma (Schwartz, 2008; Stoller, 1975). Hall (2013) hypothesizes that the 'sex industry is perfect hiding place for female sex addiction and posits that not only can she get her unconscious needs met through sex but can also get paid for it' (p.23). Covington (2010) observes that while she has treated women presenting with female sex addiction they also have untreated trauma and that working with the trauma has been more effective in her work than focusing on the sexual addiction (see Appendix VIII, p.148).

The literature certainly points to the relationship between high-risk sexual behaviours in adult women and exposure to adverse sexual experience in childhood (Hillis, Anda, Fellita & Marchbanks, 2001). Individuals who sustained negative childhood experiences exhibited risky sexual behaviour in order to achieve intimate interpersonal connections. Deficits in self-care and self-protection when combined with deficits in healthy experiences of interpersonal intimacy were seen for women to create underestimation of risk exposure in sexual encounters. The implications for women's public health were highlighted by results of the retrospective screening of the same sample of the five thousand and sixty women, revealing greater occurrences of cervical cancer, vaginal cancer, infertility, ectopic pregnancy, chronic pelvic pain, stillbirth, spontaneous abortions, hypertension, ulcers, and violence-related trauma and death (Hillis, Anda, Fellita & Marchbanks, 2001).

2.2.3 An Attachment Perspective

The literature review revealed that articles theoretically linking affect regulation and sex addiction draw on psychoanalytic and attachment ideas. While these share a common view that sexual addiction is underpinned by early developmental disruption, they diverge in their thinking about the specific intra-psychic and inter-psychic dynamics. While Khantzian (1990) and Goodman (1998) are influenced by the more Kohutian ideas of self-regulation (Kohut, 1977a, 1977b) and object relations theorists like Margaret Mahler (1975), others have focused more on ideas of dyadic, intersubjective approaches based on attachment theory, developmental psychology and neuroscience (Creedon, 2004; Hudson Allez, 2009; Katehakis, 2009, 2012).

Insecure Attachment, Women and Sexuality

Leedes (1999) estimates that 95% of sexual addicts are unable to form close attachments yet very little research exists in terms of supporting empirical investigation. Certainly in the field of personality and social psychology, attachment-focused research suggests that dimensions of attachment insecurity shape personality and sexual patterns both for women (Birnbaum, 2007; Birnbaum, Reis, Mikulincer, Gillath & Orpaz, 2006) and the population in general (Hazan & Diamond, 2000; Hazan, Zeifman & Middleton, 1994; Mikulincer & Shaver, 2007). Hazan, Zeifman and Middleton (1994) identified three sexual styles specifically associated with insecure adult attachment patterns. While secure individuals were less likely to engage in one-night stands or have sex outside the primary relationship, avoidant individuals reported seeking sexual activity without psychological intimacy, such as one-night stands and sex without love. Most significant, though, were indications that ambivalent females tended to engage in exhibitionism, voyeurism, and domination and bondage. Certainly, with the overlaps between attachment styles, sexual and sexually addictive patterns, there are grounds

for speculation that for women attachment disruption significantly contributes to acting out behaviours.

Schwartz (2008) also observed that characteristics of sex addicts' acting out patterns varied consistent with characteristics of their attachment style. He reported preoccupied individuals 'starving for love but confusing genital sexuality with feelings of loneliness and disconnection' as engaging in anonymous sex with multiple partners in one evening without 'feeling sated' (p.573). The avoidant individual on the other hand, while 'dismissing the need for attachment and any available connection', will engage in 'mechanical sex without affection and emotional connection' (p.573). While earlier empirical studies addressed questions of adult attachment style and sex addiction using homogenous male samples (Leedes 1999; Zapf, Greiner & Carroll, 2008), Dhuffar's (2010) unpublished MSc dissertation represents the first study to implement a mixed gender sample to explore the relationship between gender, attachment style and sex addiction. While Dhuffar (2010) found no significant differences in attachment styles for male and female sex addicts, her study reported sexual addicts to be 60% less likely than non-addicted men and women to relate to their partners in a securely attached style. Interestingly, results showed a significant correlation between sexually addicted males and females and anxious and avoidant subscales, indicating that sexually addicted males and females exhibit characteristics of a fearful–avoidant style of attachment. Dhuffar's (2010) study reported 71.8% of men and women to have high scores on both the avoidance and anxiety subscales, compared to 12.5% in the preoccupied attachment style (high anxiety and low avoidance).

Disorganized Attachment and Sexuality

Contributions by contemporary psychoanalytic writers are brought together in a collection of papers in *Attachment and Sexuality* (Diamond, Blatt & Lichtenberg, 2007). This volume consolidates a spectrum of contemporary analytic views 'elucidating different configurations of the relationship between attachment and sexuality' (p.1). The editors drew on a diverse group of authors in order to 'provide a paradigm of relatedness that forms a scaffold for the development of unfolding sexuality in all its manifestations: infantile and adult, masturbatory and mutual, normative and perverse' (p.1). In his chapter *Sense and Sensuality*, Jeremy Holmes (2007) presents a case study entitled *Severe Disorganisation: Sex as a Perverse Route to Attachment* in which he conceptualizes severe borderline personality disorder to have a precursory attachment disorganization leading to 'major disturbance in the individuals' sexual lives' (p.155). Holmes (2007 makes reference to Fonagy *et al.* (2002) to clearly argue the case that severe attachment disorganization creates a sexually orientated set of 'dissociative responses to stress which can be seen as attempts to create some sort of coherent

strategy for self-soothing' (p.155). In his view, these regulating strategies involve high-risk, shame-inducing debased and unpleasurable sexual behaviours (p.154), which are understood as follows: the individual is resorting to dominance/submission rather than mutuality; a routine is preferable to a sense of total chaos; bringing together sex and aggression means the sufferer's pain is an escape dissociation; having a defined role he says, even as a victim is preferable to non-identity and brings some sense of protection even if it is at the expense of pleasure or self-respect; and the shame of vulnerable neediness is re-enacted through degraded sex in a repetitive way, that gives the subject an illusion of mastery (Holmes, 2007). Holmes (2007) like Rickards & Laaser (1999, 2002) positions excessive and compulsive self-debasing sexual activity and borderline personality organization in the context of early relational trauma and disorganized attachment patterns.

Sexual Working Models

These ideas have built on Bowlby's (1969, 1973, 1980) view that attachment and sexual patterns are embedded in discrete and yet reciprocal systems (Birnbaum, *et al,* 2006; Birnbaum, 2007; Mikulincer & Shaver, 2007) that interplay with the internal working model to shape interpersonal and sexual behaviours (Buss & Kenrick, 1998; Money, 1986). Buss and Kenrick (1998) originally conceptualized these sexual working models as psychic structures which organize erotic-sexual representations, in addition to the internal working models of self and other. However, it was Money's (1986) pioneering idea that attachment and early trauma influenced the development of these erotic-sexual systems and saw early *affective* autobiographical experiences, such as those involving 'illicitness, conquest, fear, intimidation, love and challenge' (Schwartz & Southern, 1999:p.166), as shaping the developing sexual and erotic systems of an individual. Money (1986) proposed this early experience as becoming cemented in the individual's psychic structures during puberty and adolescence and as configuring the expectations of proceptive activity in adulthood. This, he says, includes expectations of a partner's characteristics, which lead to sexual arousal, genital and physiological responses and perceptions of self as attractive and sexually desirable (1986). In addition to Schwartz and Southern's (1999) view that an individual's internalized, *affective* attitude to gender and erotic-sexual patterns are partly those directly transmuted from parents, they also see this as including unresolved parental rage, which is absorbed in childhood at an implicit, affective level to become part of an embedded, sexual/relational model of self and other in the child. In adulthood this affective-erotic-sexual material is considered by Money (1986) to configure beliefs such as 'I hate men' and 'sex is dirty'.

2.2.4 Self and 'Self/Other' Regulation

'Damaged Affectional Bonds'

Schwartz and Southern (1999) conceptualize maternal deprivation as influencing gender-based differences in adult proceptive behaviours (those leading to mating, copulation and conception). While females suffering maternal deprivation have a tendency to engage in self-injurious behaviours, males display aggression towards partners. An earlier study (Schwartz & Brasted, 1985) cites Becklin's (1975) scientific investigation demonstrating that:

> *With experimentally induced developmental deprivation an animal can copulate, but approaching a mate is associated with fear and ambivalence. The male monkey appears to translate this inhibition into violent and aggressive behaviors whereas the female will bite her own body and cower.* (p.165)

The significance of Schwartz and Southern's (1999) ideas is in how they link the emerging concept of attachment injury as a derailment of affect regulation to the causality of sexually addictive patterns in adulthood. They posited sexually addictive behaviour as an attachment injury and more specifically suggested it as a 'way of coping with a myriad of dysphoric emotions and a lack of internal self cohesion' (p.171). This was quite groundbreaking in its subjective observation that sex addiction was a mechanism to 'mediate shifts in internal states' and either calmed down over-activated and overwhelming affect, or stimulated a release from the numbness caused by dissociation. Another central tenet of their paper is that the individual relies on sexual addictive patterns to simulate a sense of self-cohesion and integration, by temporarily restoring emotional homeostasis and felt safety. She therefore develops a pathological bonding to the addictive object as a means of seeking a sense of self, and internal regulation including managing shifting self and affective states. There were others at this time contributing to the threads of thinking that further buttress these ideas. They are perhaps best explored in a review of the psychoanalytic (Khantzian, 1991, 1995, 1999, 2001, 2003) and integrative (Goodman, 1998) theories considering self and dyadic regulation.

Sex as 'Self-Object' Regulation

The idea that addictive processes are maladaptive regulating strategies designed to manage intra-psychic deficits in an individual's self-function is not new (Khantzian, Mack & Schatzberg, 1974; Khantzian, Halliday & McAuliffe, 1990; Krystal, 1988; McDougall, 1984; Wursmer, 1974). Khantzian's (1974, 1991, 2001) *Self Medication Model* conceptualizes the addict as seeking many forms of affect-regulating substances and behaviours and these as involving complex, interrelated, poly-drug use specifically organized to manage emotional homeostasis by heightening and calming inner affective states. While Khantzian's (1991) hypothesis strengthens the argument that affect dysregulation is a central organizing

motivation for addictive acting out, he does not explore the addictive use of sex other than as one of the many interrelated expressions of the addictive condition. Goodman (1998), on the other hand, locates sex addiction as a figural, stand-alone condition and argues that not all individuals with a predisposition to addiction become sex addicts. While he agrees that sex addiction, like other addictions, shares a neurological vulnerability, he also understands it to represent an *impairment of the self-regulation system* (in particular a deficit in self-governance and self-function) and to involve an inappropriate, sexualized experience in early life. Goodman (1998) sees this predisposition, lack of self-function and early trauma as creating a pathological reliance on sex and sexual partners, which serves as an externalized 'self-object'regulatory mechanism. The individual 'depends on external actions to regulate their subjective states and cope with the subjective consequences of internal dysregulation' Goodman, 1998:p175). He states:

> *The addictive processes originate in an impairment of the self regulation system, the internal psychobiological system that regulates one's own subjectivity (sensory, cognitive and emotional) states and behaviour states. Impaired internal regulation of the subjective states leads individuals to depend on external actions to regulate their subjective states and regulate the consequences of internal dysregulation.* (p.175)

In summary, affective experience 'can become conditioned to particular craving sensations or can become a discriminative stimulus for particular addictive-behavioural response'; thus, for the sex addict, affective experience can become experienced only as sexual arousal and excitation (Goodman, 1998).

Khantzian (1991) began to move psychoanalytic theories of addiction away from the more classical drive theory toward relational models (Fairburn, 1952; Guntrip, 1992), and draws on Kohut's (1977a) ideas of self-function and self-regulation; while both he and Goodman drew on Kohutian influences and object relations theory regarding intra-psychic development, they see the mother/child relationship as involving more of a mother 'doing to' rather than 'doing with' the infant. While Goodman's (1998) and Khantzian's (1991, 1995, 2001) theories clearly position affect regulation as a central underlying factor in addiction and sex addiction they do not unpack in any great detail the nature of affect dysregulation and addiction. While they are both influential in the evolution of thinking in the field their positions are that early dyadic regulatory failure sets up a self-regulatory impairment: this is conceptualized as an intra-psychic deficit with no mention of attachment theory. Phillip Flores (2004), on the other hand, published his seminal book *Addiction as an Attachment Disorder*, in which he presents an integrated model of addiction from an attachment perspective. While Flores (2004) does at least address the relationship between attachment and addiction in detail, he only briefly (on

three pages) describes the role of affect regulation. Sex is referred to almost 'in passing' and in the context of a list of addictive 'acting out' behaviours, alongside alcohol, drugs and gambling. Katehakis (2009) and Hudson Allez (2009) however push the edge of the sex addiction field further into the realms of a relational psychology with theoretical attention to treatment as a two-person, inter-psychic approach based on the reparative nature of the regulatory relationship as a process of mutual and reciprocal influence and attachment repair.

Two Person 'Self/Other' Regulation

Katehakis's (2009) paper significantly extends the sex addiction literature by integrating contemporary ideas from developmental theory (Beebe & Lachmann, 2002; Stern, 1985), affective neuroscience (Panskepp, 1998; Schore, 1994, 2002; Siegal, 1999) and trauma (van der Kolk & Fisler, 1994). She sees the regulation of affect to be an inter-psychic, dyadic, relational process involving interactive and implicit right-hemisphere-to-right-hemisphere mechanisms. Her work highlights the value of 'self/other' regulation and presents affective neuroscience as the basis for 'affective, cognitive and behavioural development of sexual addiction' (Katehakis, 2009:p.1072). While this has significant implications for therapeutic intervention it also marks a shift away from a more traditional Carnes model (1983; 1989; 1991a) with its focus on 'cognitive behavioural protocols to engage sex addicts' prefrontal cortices in order to repair childhood damage to brain functions' (Katehakis, 2009:p.1073). Katehakis (2009) argues that clinicians and researchers in the sex addiction field need to 'enrich these procedures with expanded knowledge about the developmental role of affect and its reparative power in clinical interventions' (p.1073). Katehakis is strongly influenced by her participation in Allan Schore's monthly study group and recently facilitated a significant endorsement of affect regulation as a central component of sex addiction by organizing the attendance of Allan Schore as keynote speaker at the International Institute of Trauma and Sex Addiction Professional (IITSAP) in February 2012. Schore articulated his view that there is a relationship between early attachment trauma and affect dysregulation as the result of affective state maturational-dependent attunements and misattunements between mother and infant (1994, 2002, 2003) and that any approach to the therapeutic treatment of sexual addiction must involve repair to these early and implicit relational mechanisms. (2012b).

Implicit Relational Processes

The Boston Change Process Study Group (2010) contributes to this thinking and conceptualizes a dynamic and mutually influencing 'implicit relational knowing' as being the basic structure shaping each interpersonal relationship and these intra- and inter-psychic patterns of relatedness as shaping a person's 'affectively rich way-of-being-with' self and other. They view this implicit communication as relying on projective identification,

transferences, countertransference and enactment and this as articulating the unconscious relational dynamics between therapist and client. While they understand enactment as not being primarily language-driven or even 'translated into symbolic form' (The Boston Change Process Study Group, 2008:p.127), they do see it as 'one way that particularly dramatic or problematic ways of proceeding in relationships become clearer in the treatment' (Boston Change Process Study Group, 2010:p.189). Lyons-Ruth (2005) suggests that as these 'implicit and powerful, affect-laden schemas are played out in therapy, and disruption and repair are negotiated, a person's implicit enactive representations' are revised (p.316). She sees psychological shifts as resulting from the mutually co-ordinated reorganization of the implicit 'ways-of-being-with' in therapy and sees this as involving 'a new "opening" of the working-out of new relational possibilities' for both the client and the therapist (p.316).

Gerson (2004) also conceptualizes enactment as an integral part of the implicit communication between client and therapist and as being embedded in their shared and co-created 'relational unconscious' (p.63). He conceptualizes this 'relational unconscious' (p.63) as the 'fundamental structuring property' (p.63) of interpersonal interaction and, consistent with previously mentioned authors, sees this as being at the core of the dyadic therapeutic process, permitting as well as constraining 'modes of engagement specific to that dyad and as influencing the individual's subjective experience within it' (p.63). Gerson (2004) also sees these unconscious, mutually responsive, 'reciprocal and reverberating influences of [client and therapist] upon each other to have found most use in the concept of enactment' (p.63). Like the Boston Change Process Study Group (2010), Gerson (2004) sees the reorganization of the structure of the relational unconscious that binds both client and therapist as creating a change action in therapy and this is often expressed as enactment.

Director (2002, 2005) and Burton (2005) have argued fervently that the emphasis on working with implicit processes and enactments advocated by relational theorists is ideally suited to working with addicted clients (p.588). Burton (2005) understands the addicted client as struggling to integrate multiple, affect-laden 'self-states' and suggests that these 'important pockets of the client's [dissociated and split off] experience are often missed in the treatment' (p.588) unless they are effectively worked with in therapy. While Burton's (2005) relational perspective sees enactment as being unavoidable in therapeutic work with addiction, Director (2002) echoes Gerson (2004) and Lyons-Ruth, 2005) and sees enactments as inevitably 'holding promise as the means by which an addict may reproduce an unresolved relational dynamic in therapeutic form' (Director, 2002:p.598), thus affording the opportunity of awareness, knowledge and change. Director (2002) suggests that both in 'theory and approach, the relational model provides the basis for the desired course of treatment' for

addiction (p.554) and argues that it is 'by placing enactment at the heart of [this] analytic work, relational practitioners can open the door of psychoanalysis to addicted clients' (Director, 2002:p.554).

David Mann, in a personal communication to Valerie Cunningham (2009) described enactment as the 'trauma enacted in the therapeutic relationship whereby both client and therapist are caught in the unconscious process as though the trauma is revisited or enacted in the therapy itself – the enactment is [however] a re-edition of the past not an exact replica' (p.32). While Mann (1997, 1999, 2009) brings issues of the therapists' material, in the context of both their own trauma and their erotic subjectivity, to the fore in the literature, he sees 'the therapist as caught up in the same cauldron of passions as the patient' (1999:p.75). He urges that the therapist be thought of as a 'sexual subject' not a 'sexual object' and, in these terms, sees him/her as being drawn into the erotic unconscious dynamic with the client where 'the unconscious incestuous and murderous desires of one individual meet the incestuous and murderous desires of another' (p.76). Mann emphasizes both the challenge and the value for therapists in recognizing their erotic countertransference in the therapeutic process and sees the terrain of this erotic subjectivity as being the most difficult they are likely to face regardless of experience (Renn, 2009). On the one hand, Mann (1999) sees the erotic subjectivity of the therapist as serving as a way of providing the *good enough* erotic experience for the client in the therapy, yet, on the other, sees that without sufficient awareness on the part of the therapist this holds potential for 'displacement or projection onto the patient' or 'acting out with the patient' (Renn, 2009:p.2) in iatrogenic ways.

I would like to echo Renn's (2009) view that, while the literature addresses the issue of erotic subjectivity of the client and the erotic subjectivity of the therapist in therapy, there is very little consideration of a two-person perspective conceptualizing how the shared relational processes of erotic reciprocal influence manifest in this relational therapeutic domain. This paucity is reflected to a greater degree in sexual addiction literature, with its scant consideration of issues involving eroticized and sexualized transference and countertransference (Katehakis, 2009; 2012). It is marginally better addressed by the psychoanalytic literature reviewed and integrated by Goodman (1998), who reflects across only two pages on the influence of the therapist's personal history in shaping their responses to the sexually addictive pathology brought by the patient. Outside of this there is very little that addresses the challenges of countertransference for the therapist in working with female sexual addiction or indeed the use of the shared erotic subjectivity inevitable in clinical practice.

2.2.6 Affect Regulation – A Therapeutic Method

Affect as a Mechanism of Change

The literature search revealed a handful of studies exploring affect regulation in the context of the psychotherapy process and outcomes. In particular these demonstrated links between the clients' affect regulation deficits and measures of the therapeutic alliance (Nightingale, 2002; Safran & Muran, 2002) and the quality of their in-session processing and the measured outcomes in short-term therapy (Watson, McCullen, Prosse & Bedard, 2011). Interestingly, an earlier study based on emotion-focused therapy found clients' increased depth of capacity for emotional experiencing to more robustly predict therapy outcome than factors of the therapeutic alliance. What is significant about these findings is that the clients' competence with affect regulation is also shown to predict outcomes at the end of therapy independent of the working alliance (Goldman, Greenberg & Pos, 2005). This invites us to speculate that affect regulation is perhaps an integral part of the therapeutic alliance, as well as a discrete, central factor in psychotherapy and worthy of exploration in its own right.

Affect Dysregulation. The literature differentiates between *affect dysregulation* and *negative affect*. Affect regulation describes an individual's implicit and explicit strategies to maximize positive affect and minimize negative mood (Westen, 1994). This involves mechanisms that identify the significance of emotional stimuli and produce an affective experience in response, as well as the ability to regulate the affective state (Phillips, Drevets & Rauch, 2003a, 2003b). The literature seems to organize affect dysregulation on a continuum ranging from an over-regulated, hypo-aroused style like alexithymia (Taylor, Bagby & Parker, 1997) to an under-regulated, over-activated, hyper-aroused regulatory style. Dysregulation and disorganized affective responses do not necessarily describe an absence of affective experience. On the contrary, they describe an unpredictability involving an excessive or diminished affective responsiveness (Sarkar & Adshead, 2006). Central characteristics involve the individual's inability to soothe themselves and return to a baseline of affective experiencing (van der Kolk & Fisler, 1994) as well as a capacity to stimulate a feeling of aliveness. Both adapted styles often lead the individual to seek an external regulation in the form of excessive risk-taking, self-harm, eating disorders, substance abuse and sex, and are often expressed as a personality disorder and post-traumatic stress disorder diagnoses.

Negative Affect on the other hand is considered to be a discrete construct (Conklin, Bradley & Westen, 2007), which describes an individual's experience of anxious, dysphoric, angry and shame-based affective states (Watson & Clarke, 1992). While distinguishing between negative affective experience as a *trait* and extreme experiences of dysregulation as a *state* is reportedly difficult, it is an important distinction to consider. While there are calls for a

clearer definition this remains conceptually unclear (Kassel, 2007). Certainly the research demonstrates mechanisms of dissociation to exist in response to negative emotions in psychotherapy, which suggests that this reduces the efficacy of treatment (Spitzer, Wilert, Grabe, Rizos & Freyberger, 2007). An individual's attempt to 'avoid, minimize or convert' intolerable negative affect is thought to express the 'bottom-line defense' of dissociation (Fosha, 2009:p.127; Bromberg, 1998), which interrupts the 'emotional-motivational aspects of the change process in psychotherapy' (Schore, 2007). This is highlighted particularly in work with 'early forming and more severe pathologies' (Fosha, 2009:p.127). While Berking *et al.* (2008) demonstrated the importance of implementing emotion regulation skills 'as a treatment target in [cognitive behavioural] psychotherapeutic interventions' (p.1230) they also speculated that there might be *automatic* processes involved in managing negative affect. They conclude that more implicit levels of emotional processing exist, giving rise to speculation that cognitive behavioural interventions may be inadequate and that interventions addressing implicit and unconscious, intra-psychic regulating mechanisms are perhaps necessary (BCPSG, 2010; Schore, 2002, 2003).

While the research investigating the links between affect and sex addiction is scant there are a handful of studies that have explored the relationship between hypersexuality, negative affect, stress and affect dysregulation. The majority of them used a quantitative methodology and a homogenous male sample to investigate a range of areas including problems of self-concept amongst hypersexual men with attention deficit disorder (Reid, Carpenter, Gillian, 2011a), emotions in hypersexual men (Reid, 2010a), executive function and hypersexual behaviours (Reid, Karim, McRory & Carpenter, 2010b) and shame and neuroticism in hypersexuality (Reid, Harper & Anderson, 2009a). A further three studies, however, used a mixed gender sample to explore the relationship between psychopathology, personality and hypersexuality using the MMPI-2 (Reid & Carpenter, 2009b), alexithymia, emotional stability and vulnerability to stress (Reid, Carpenter, Spackman & Willes, 2008), and one in particular compared personality factors between hypersexual women and men (Reid, Dhuffar, Parhami & Fong, 2012). These studies evidence hypersexuality as an expression of affect dysregulation, negative affect and stress vulnerability and empirically support the hypothesis that hypersexual men and hypersexual women are more likely to experience deficits in affect regulation and negative affect than a non-addicted group.

Temperament and Affect Dysregulation.

Factors of temperament have been empirically linked to an individual's vulnerability to sexually addictive and compulsive behaviours (Cloninger, Bayon & Svakic, 1998) and personality traits associated with negative affect, mood states and hypo-regulation such as

alexithymia, shame and loneliness have been observed in correlation studies of hypersexual clients (Reid, Carpenter, Spackman & Willies, 2008). In a study exploring their emotional coping strategies, measures of overall distress including depression, anxiety, difficulties managing thoughts and social alienation were reported to be elevated in a group of hypersexual men compared to the non-hypersexual group. While results reflect a struggle with affect regulation, this group also reported a tendency toward feelings of demoralization and generalized vulnerability to emotional distress with over 40% of the hypersexual group indicating experiences of insecurity, low self-worth, lack of self-confidence, social alienation, guilt, and sadness (Reid, Harper and Anderson 2009a:p.304). The following year Reid (2010a) extended these findings to investigate which emotional experiences were predominant amongst hypersexual males. He found greater levels of shame, which perpetuated self-directed hostility, than guilt, and also identified experiences of fear, disgust, anger and shyness. In addition men exhibited impoverished positive emotions in a lack of joy and happiness. Reid (2010a) concluded that hypersexual males had higher measures of *clusters* of negative rather than positive affects and that these 'constellations of negative emotions require attention, particular clarity in psychotherapy' (Reid, 2010a:p.213).

Women, Stress Vulnerability and Sex Addiction.

While Reid's studies have certainly shown modest but significant results supporting the hypothesis that individuals who manifest symptoms of hypersexual behaviour are more likely to experience deficits in affect regulation and have greater levels of negative affect including alexithymia and depression, and that severity of hypersexuality is linked proportionately to levels of emotional instability and stress vulnerability, the studies up to this point did not account for any gender difference. Becker and colleagues (2007) hypothesize that women are more vulnerable than males to developing disease, mood disorders and addictions due to a greater neurophysiological vulnerability to emotional stress. Incorporating Becker *et al'*s (2007) idea, Reid, Duhuffar, Parhami and Fong (2012) explored whether Reid *et al*'s (2008) previous research could be replicated to account for predictive factors of female hypersexuality. Their study represents the first to compare 'factors of personality across genders in a treatment seeking sample of hypersexual patients' (2012:p.263). The findings demonstrated high levels of emotional dysregulation, including stress vulnerability and interpersonal sensitivity for both men and women compared with normative groups, with no significant difference in these levels between genders. Reid and colleagues (2012) concluded that stress vulnerability was a generalized, perpetuating risk factor for sexual addiction that men and women share. However, there are some notable and interesting variations between genders. Women reported having a much higher measure of excitement-seeking than men and exhibited greater difficulty trusting others and processing emotions, particularly anger and

resentment. Of particular relevance in light of Becker *et al*'s (2007) article was that 61% of hypersexual women, compared with 32% of men, indicated they have difficulty coping with stress. Reid *et al.*'s (2012) concluding thoughts indicate that treatment approaches for hypersexual women must centralize affect-regulating interventions and strategies for coping with stress, as well as an approach accounting for interpersonal sensitivity. While the lack of demonstrable gender difference in the findings is perhaps more problematic than helpful, these writers do also contribute by raising concerns about the paucity of attention to women with this condition. Reid *et al.* (2012) reflect that any therapeutic endeavour treating sexually addicted women must cultivate an experience of relational security through which they can address issues of interpersonal trust, self-confidence and affect regulation, particularly addressing the experience and expression of suppressed and unformulated feelings (2012).

Affect Regulating Interventions with Specific Clinical Presentations

The literature search located a few studies that specifically address the efficacy of affect regulating interventions with a homogenous female sample. While none of these studies specifically explore female sex addiction they do address clinical issues, which often overlap and co-occur with female hypersexuality. These include binge eating (Telch, 1997), episodic bulimia (Burton, Stice, Bearman & Rhode, 2007), deliberate self-harm (Gratz, 2007), post-traumatic stress disorder (Cloitre *et al*, 2004, 2008, 2010) and borderline personality disorder (Yen, Ziontnick & Costello, 2002).

Deliberate Self-Injury has been conceptualized as a compensatory strategy for emotional dysregulation and is understood to manage persistent and painful dysregulated affect (Gratz, 2007). Empirical evidence demonstrates benefits to treating deliberate self-injury using interventions specifically focused on the reduction of negative affect (Gratz & Roemer, 2004). This efficacy of affect-regulation-orientated/motivated interventions was reported in a study of hospitalized adolescents diagnosed with addictive aspects of repetitive self-harm incidents (Nixon, Cloutier & Aggarwal, 2002), with findings showing decreased levels of daily urges to self-harm, particularly in cases where the behaviour was reported to create release from unbearable tension and feelings of depression (Slee, Spinhoven, Garnefski & Arnesman, 2008). We might speculate that interventions designed to target specific emotional regulation difficulties as opposed to symptomatic criteria specific to psychological disorders could be more effective in a client group presenting with repetitive, compulsive behaviours (Slee *et al.*, 2008).

Cloitre, Stovall-McClough, Zorbas & Charuvastra (2008) highlighted 'attachment theory as a useful understanding of the myriad of psychiatric outcomes associated with childhood

maltreatment and, in particular, the focal role that emotion regulation and interpersonal expectations may play ' (p.282). Previously, Cloitre and colleagues (2002) empirically demonstrated the efficacy of implementing Skills Training in Affect Regulation (STAIR) with conditions such as post-traumatic stress disorder (PTSD) in a sample of women. By introducing an initial treatment phase involving interpersonal and emotional regulation skill-building to their two-phase treatment approach, their findings showed an increase in therapeutic benefits. These included fewer adverse effects in therapeutic trauma work with women surviving childhood abuse. The indications points to a reciprocity between client treatment retention and outcome and levels of emotional and interpersonal regulation, which in this study also protected against post-traumatic stress disorder (PTSD) symptoms worsening.

These studies highlight the efficacy of affect-regulation-oriented interventions for women presenting with psychological and psychiatric conditions involving symptoms of repetitive and compulsive, out of control behaviours which are designed to manage unbearable consequences of the disequilibrium of affect. While measures of clients' difficulty managing affect are highest for females presenting in therapy with post-traumatic stress disorder (Tull, Barrett, McMillen & Roemer, 2007) and borderline personality disorder (Gratz & Gunderson, 2006) this has not been replicated in the addiction field. At the time of writing this review, researchers at the Institute of Addiction Research in New York are exploring affect as a central change mechanism in the treatment of alcohol addiction (Stasiewicz, Bradizza, Coffy & Guliver, 2011) and hypothesize that 'profiles will emerge that are associated with little improvement in alcohol involvement when negative affect is relatively high throughout treatment' (Stasiewicz, Bradizza & Schlauch, 2012). It is not difficult to speculate about the importance of affect regulation as a central therapeutic method in therapy for the female sex addict given the reported likelihood of co-morbidity with these other diagnoses.

2.3 Concluding Thoughts

To sum up, the literature review revealed complexity and ambiguity in the debates and dialogues concerning female sexual addiction and highlighted the tensions around definition and etiology, issues of sociopolitical gender bias and paucity of empirical studies and theoretical papers. There are certainly 'crucial considerations here concerning female sex addicts that have broad diagnostic implications. For many clinicians, and especially the public at large, a paradigm shift will be necessary that will require looking outside the box of a male-dominated understanding about sexual addiction' (Ferree, 2001:p.288). While female sex addiction clearly represents a contentious and narrow area of addiction and psychological therapy, it also clearly emerges as a condition rooted in persistent and dysregulated affect,

positioning it well within an attachment framework and relational psychotherapy perspective. While this is notably in line with the wider and shifting field in terms of acknowledging affect as a change mechanism in psychological therapy, any recognition of female sex addiction has largely remained at a theoretical and conceptual level and has not been addressed with any empirical consideration in the context of clinical practice. In light of this emerging understanding of affect as a central action of therapeutic change and the existing quantitative studies, it is notable that there are no qualitative studies exploring the underlying therapeutic processes involved in implementing this as a therapeutic method. In particular there are none at all exploring these processes in the psychotherapeutic encounter with female sex addicts. I propose to explore and uncover the experience embedded in this therapeutic work, with a particular focus on generating a theoretical understanding as it emerges and is constructed from clinicians' *lived* therapeutic experience.

The current study is therefore positioned in an emerging paradigm of relational psychology, positioning affect regulation as a central therapeutic method and situating itself, in a contemporary way, as going beyond description in data and, rather, seeking to get underneath and go beyond measurement and quantification. It sets out to explore what sorts of processes are involved at ground level between therapist and female sex addict and not to adhere too closely to symptoms, as this would interfere with the construction of a theory. What this study aims to explore is the rich complexity within the layers of lived experience in the relational therapeutic encounter with this clinical group.

2.4 Aim of the Study

The aim of this study is therefore to explore how therapists work from a relational perspective with affect regulation in psychotherapy with female sex addicts.

3. Doing the Study: Methodology

Rather than describe my methodological decisions as a vindication of my choices, I set out to tell the story of this research process in the hope that it might offer the reader 'a better understanding of how [this] particular study unfolded and progressed through the major analytic decisions and moves' (Locke, 2001:p.129).

3.1 Early Exploration: The Pilot Interview

I conducted a semi-structured interview with a female therapist at her office that was two hours in length. While the process was guided by the initial interview question protocol (see Appendix IX, p.149), it was more a conversational dialogue based around three main areas of concern. These were, broadly: therapists' understanding of female sex addiction, how affect dysregulation contributes to the problem, and how this is experienced in the process of relational psychological therapy. The interview was digitally recorded, transcribed and explored for emerging themes, patterns and insights. The interview in the main confirmed a richness of data and the potential for breadth and depth of material. A noted limitation was a shared tendency to drift into considerations of work with male sex addicts rather than females. This highlighted the need to manage this in future interviews. The pilot study raised my awareness of how deeply entwined the affective, erotic and sexual material becomes both for the therapist and client, and inevitably for the researcher and participant in the intersubjective field.

The pilot interview also brought into view the need for a specific sensitivity to the inevitable subjective and intersubjective tensions in the context of ensuring the participants' well-being (see Ethical Considerations). It revealed my personal assumptions, attitudes and beliefs (see

Reflexivity: Use of Subjectivity in Credibility, Reliability and Trustworthiness). Throughout the interview and analysis I felt drawn into a shared experience of *sisterhood* and alerted to the potential risk of assuming a feminist bias. I would need to be mindful of the unique and implicit enactments and tensions that are co-created in each research dyad. This prompted the inclusion of particular self-care and support during the process (see Ethical Considerations and Credibility, Reliability and Trustworthiness) as a way of mitigating unnecessary risk to data analysis and the integrity of the study.

In terms of methodological considerations, I noticed an inclination to 'immerse' in the data and understood this subjective pull as inevitable for the *embodied researcher* (see Embodied Researcher). I also understood the notion of acting *with* (Charmaz, 2006) rather than acting *on* the data (Glaser & Strauss, 1967; Glaser, 1992; Strauss, 1987). I was able to consider the intricacies of the relationship with the participant and saw how the data would be co-constructed and dynamic. I had a deep and visceral sense that the participant and I would be socially and relationally embedded in the process (Kaskett, 2011) and recognized that as the researcher I needed to have capacity for immersion and reflexivity. My role would be neither inert nor speculative but participatory and dynamic throughout the process.

3.2 Thinking About the Method: My Philosophy

As a counselling psychologist and integrative psychotherapist I located myself in a pluralist epistemological position and held an open and curious attitude to all possible research approaches. I considered 'divergent research methodologies to be equally valid in exploring important research questions' (McAteer, 2010). I had no prior allegiance to a particular methodological approach and would not identify myself as either a 'grounded theorist' or a 'quantitative researcher'. Replete with paradox and diversity, I believe each research experience to be a unique representation of 'a contextual truth', and considered the 'best fit' between research question and methodological approach. While I understood this to be shaped in part by my philosophical assumptions, I adhered to the belief that the selection of an appropriate methodology is led by the research question and not by the methodological preferences of the researcher.

However, in considering what approach to use with the current study it seemed appropriate to adopt a philosophical position consistent with the inherent requirements implicit in the question. This called for a position in line with Vico's (1668–1743) notion that 'the norm of the truth is to have made it' (Fabiani, 2009). I saw understanding as emerging from interaction with another and meaning-making as a co-created action of participation, not speculation (Kierkegaard, 1846). I considered experience to be co-constructed and as such to

be shaped by the complexities and ambiguities embedded in the relational experience. I believe intersubjectivity to be a central philosophical value in the construction of knowledge, instead of a more positivist objectivity. I saw my participation and reflexivity to be central to the philosophical underpinnings of my current approach to research. I understood this to 'facilitate understanding' through a 'subjectively guided process' (Rogers, cited in Kirschenbaum & Henderson, 1996:p.268).

3.3 Choosing Grounded Theory

In considering the most appropriate design methodology for this study I considered several qualitative approaches. A phenomenological design would certainly have revealed the richness of therapists' lived experience but would have required a focus on description of these experiences rather than an exploration of the underlying processes of action. I considered the research question to require investigation behind the specific phenomenon and not to merely produce 'a thematic description of the pre-given essences and structures of lived experience' (Starks & Trinidad, 2007:p.1373). Implementing a single-case-study approach, while interesting and certainly acquiring depth, would have involved the loss of potential for rich variance in the data.

Interpretative Phenomenological Analysis (IPA), with its epistemology located in a contextualist and hermeneutic phenomenology, focuses on the interpretation of the experienced world of participants and the contextual organization of data around connectivity of themes. However, with a focus on *what is being said* rather than *what are the processes behind what is being said*, this might only have allowed for a descriptive interpretation. Part of this process involved getting together with a research peer group using Interpretative Phenomenological Analysis to explore how this approach might fit the current question. They described how they make meaning of the client's meaning of her phenomenological experience. A metaphor might be that while grounded theory sees the 'participant as a vessel containing precious liquor in which the researchers will immerse themselves' (Mills, Bonner & Francis, 2006:p.4), IPA involves to a greater degree examining how participants make sense of the label and the cork.

My personal resonance with IPA in terms of the question did not have the same 'grab' as grounded theory, which seemed to involve more of a getting into and underneath the experienced phenomenon and behind the participants' experience. My aim in this study was to explore and conceptualize the subjective and objective processes underlying the phenomenon being explored rather than seek to present an interpretation of the perceptions of the participants. Glaser and Strauss's (1967) contribution to the epistemological dialogue

established ‘practical guidelines for action’ (Charmaz, 2006:p.5) and endeavoured to ‘construct abstract theoretical explanations of social processes’ (p.5). Integrating pragmatic and positivistic traditions within a symbolic interactionist perspective, their qualitative inquiry moved beyond ‘descriptive studies into the realms of explanatory conceptual frameworks, thereby providing abstract conceptual understandings of the studied phenomena’ (Charmaz,2006:p.6). It was considered important that the research design included the construction of a theory, not the describing, interpreting or testing of one.

Charmaz (2006) observed that qualitative methods outside grounded theory ‘rarely if ever lead to new theory construction’ (p.5) and, as a central concern was the absence of substantial theoretical and empirical literature in the substantive field, a grounded theory approach was considered the best design fit. It would provide a method of conceptualizing an understanding of how therapists in the addiction field work with affect regulation with female sex addicts building on a *bottom up* method of data collection and analysis. The objective was to ‘discover a theory that not only had grab, but would fit the data, and would work in the real world’ (Glaser & Strauss, 1967).

3.4 Focusing on a Relativist Constructionist Approach

Mills, Bonner and Francis (2006) stated that ‘all variations of grounded theory exist on a methodological spiral’ which reflect each researcher’s epistemological underpinnings. ‘The variety of epistemological positions that grounded theorists adopt can be located at various points on this spiral and are reflective of their underlying ontology’ (Charmaz, 2006:p.1). Whilst grounded theorists share the use of common characteristics within their strategy – i.e., theoretical sensitivity, theoretical sampling, treatment of the literature, constant comparative methods, coding, the meaning of verification, identifying the core category, memos and diagramming, and employing a measure of rigour (McCann & Clark, 2003) – there are central differences, not in whether there is a need for each technique but more in how these processes and techniques are carried out. So, while the current approach ‘applies the strategies of the more traditional grounded theory approaches it does so within a constructionist paradigm thus rejecting notions of emergence and objectivity’ (Annells, 1997c, cited in Mills, Bonner & Francis, 2006:p.6).

The ontological perspective of the current study takes a relativist constructionist epistemological position (Bryant & Charmaz, 2010) and as such really emphasizes the subjective interrelationship between the researcher and participant in the co-construction of meaning from my interactions with both the participant and with the data (Hayes & Oppenheim, 1997; Pidgeon & Henwood, 1997). While I understood this to be a more

contemporary and *relational* approach to grounded theory I also saw it as building on the 'pragmatist heritage' of the post-positivist philosophy of Glaser (1969) and the 'social interactionism' integrated by Strauss (1987), and as such considered the underlying assumptions and values of a constructionist approach to best answer the current research question.

This approach diverges from the classical Glaserian approach and moves away from seeking to unveil 'the' pre-existing theory in the field of enquiry, and rather sets out to co-construct 'a' conceptual understanding of the experienced phenomenon. Unlike the more classic grounded theory, a relativist, co-constructionist approach (Bryant & Charmaz, 2010; Charmaz, 2006) does not aim to discover *the* pre-existent theory as if it were separate from me and divisible from the part of the world I am studying and of the data I am collecting. In this grounded theory process I sought to 'actively construct a version of reality based on my past and present involvements and interactions with people, perspectives, and research practices' (Charmaz, 2006:p.10), and how this interacted with the data and shaped the analysis.

My consideration of Strauss and Corbin's (1994, 1990) ideas, which set out to organize the complexity of the data into fixed categories and matrices, led me to concur with Glaser's critique that to include axial coding would be to *force* the data rather than allow it to *emerge*. Like Helen Scott I considered Strauss and Corbin's (1990) method, 'with its dependence on a single theoretical coding structure, as unable to handle the complexity of multiple structural conditions having such diverse dimensions, that (other) grounded theory handles so elegantly' (Scott, 2007b:p.35). While Strauss and Corbin (1990) integrate ideas of social interactionism, Charmaz extends this to centralize the subjective experience of the researcher in the co-construction of meaning and understanding. I considered my role as researcher to be figural to the process and understood the co-construction of a conceptualized understanding of the data to be enhanced by centralizing my reflexivity.

3.5 Reflexivity

Unlike the objectivist grounded theory, which springs from a positivist philosophy (Charmaz, 2000), constructivist grounded theory is embedded in interpretative roots, and as such centralizes the 'data and analysis as created from shared experience and relationship' (Charmaz, 2006: p.130) between researcher, participant and the data, thus stressing the importance of researcher subjectivity in the research process. This approach involves 'acknowledging or even embracing [the researcher's] subjectivity' as a 'standard of quality and credibility' (Patton, 2002) and involves consideration of how it is shaped and influenced

by the researcher who inevitably 'cannot stand outside of it' (Charmaz, 2006:p.330). I understand the use of the researcher's subjectivity as a vital methodological tool and as **'**providing an opportunity to understand how experience and understanding of the world affects the research process' (Morrow, 2005:p.253). Given this, I see use of my subjectivity in the context of the current study as encouraging, understanding and providing a 'frame of reference' to the enquiry (Tufford & Newman, 2010:p.83). Processes are described as *bracketing*, *monitoring of self* (Peshkin, 1988 cited in Morrow, 2005:p.254) or *being rigorously subjective* (Jackson 1990, cited in Morrow, 2005:p.254). The use of one's subjectivity involves a consideration of the terms bracketing and reflexivity as they differ in meaning, value and applicability, both as a research concept and as an influence on the agency of the researcher.

Bracketing: Husserl's (1931) phenomenological reduction conceptualizes identifying and setting aside one's presuppositions and views in order to mitigate any undue influence on the research process. Heidegger (1962) rejects this notion in favour of the idea that 'lived experience was, in essence, an interpretative process and that bracketing out preconceptions was neither possible not desirable' (Tufford & Newman, 2010). I take the view that in reality one cannot ever totally know everything and that, as in therapy, there will always be a presence and an influence in the research process that remains out of awareness. I came to understand that the proper and rigorous use of my subjectivity was dependent on my skills of reflexivity rather than the more idealistic position of bracketing. While I acknowledge the philosophical debate and enduring tensions as to whether bracketing is a viable concept or not, in the context of the current study I took the position that *bracketing,* while interesting in the theoretical context, is perhaps less realistic in practice.

Reflexivity: Influenced by Heidegger (1962), I see my position as researcher in the context of this grounded theory as 'centering on engagement as a means of knowing' (Tufford & Newman, 2010:p.83) and as 'being in the world, where contextual interpretation and meaning are sought and valued' (p.83). I understand this to position the researcher as a 'self-conscious, critical and participatory analyst engaged with but still distinct from participants' (Fine, 1992:p.220) and reflexivity as involving the complex relationships between 'how we know what we know and who we are' (Etherington, 2004:p.34). This requires more than just an acknowledgment by the researcher of her presuppositions but also a transparency about how this is applied in practice (see Credibility, Reliability and Trustworthiness). Reflexivity is described by Rennie (2004) as 'self awareness and agency within self awareness' (p.183) and as creating an agency 'within and between ourselves and our participants' (Etherington, 2004:p.34). This challenged the researcher to develop a heightened awareness of her

ideologies and cultural beliefs as well as those of the participants. I understood it as allowing for transparency in the research process and for increased awareness, not just of information on what is known, but of how it is known, and as allowing for and opening up of the space between objectivity and subjectivity 'where the distinction between process and content can become blurred' (Etherington, 2004). Reflexivity recommends 'an inquiry into the very possibilities of our unreflective knowledge and practices' (Macbeth, 2001:p.36) and, as such, as drawing on multiple levels simultaneously in order to understand the origin of my implicit and explicit responses to interviewee, data and analysis (see Credibility, Reliability and Trustworthiness and Reflections on Implementing Grounded Theory).

I see the researcher and participant as being engaged in the mutual exploration of the phenomenon and as collaboratively constructing the data (Colaizzi, 1978). As such, I did not see myself as a *tabula rasa* or blank slate (Clarke, 2005) but valued my own and the participant's reflexivity in the co-construction of a theory from the shared experience of this data. Whilst I understand that the Glaserian approach aims legitimately to develop a theoretical sensitivity (Glaser, 1978), it does seem to expect an *emergence* or *unveiling* of the theory and assumes it to be embedded in the data. I understand a constructionist grounded theory to be a dynamic, iterative unfolding process and, although I see it as important to hold an idea of logic and structure in the process, I endeavoured to avoid too rigid an adherence to prescriptive methods of analysis. Consistent with Charmaz's (2006) relativist constructionist approach I saw my use of reflexivity as a key methodological tool and, given this, I held a personal attitude of openness and curiosity, as well as placing value on my capacity for fluidity and flexibility (Bryant & Charmaz, 2010) and tolerance for uncertainty, ambiguity and complexity.

3.6 An Insider/Outsider Researcher

My position as the reflexive researcher embodied an inevitable tension in the complexities of the 'insider/outsider' practitioner/researcher. I saw it as a key responsibility to develop my 'awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining "outside of" one's subject matter while conducting research' (Nightingale & Cromby, 1999, p.228).

I am a forty-nine-year-old female. My position as a counselling psychologist-in-training created an experience of difference in the interview process. I observed this in participants' tendency to simplify their descriptions of clinically complex processes and often avoid elaboration altogether, assuming, perhaps, a limitation to my understanding as a novice therapeutic psychologist. This also felt like a tutor/tutee experience with many participants

preferring to *educate* and teach me about sex addiction. In another respect, co-researchers' perception of me as a doctoral candidate created in some a feeling that I held more authority or knowledge than they did. With others there was a felt equality with a shared experience of addiction treatment centre work. Certainly my gender positioned me as more of an 'insider' with female co-researchers than with male co-researchers. I felt at times I identified more with the female client than with the male co-researchers. A possible difficulty was perhaps my insider experience as a client of various forms of addiction treatment and therapy, which had the potential to create unhelpful insider processes. I believe with this awareness I was able to navigate and manage this if and when it arose. I believe my clinical experience in the addiction field and my beliefs in the centrality of affect regulation in the process of sex addiction positioned me well as a robust 'insider' and 'outsider' researcher.

3.7 The Grounded Theory Procedure and Analysis

3.7.1 Selecting the Sample

I gave thorough consideration to the 'appropriateness and reliability of (my) data sources' (Phillips & Pugh, 2000) and selected my sample using clearly defined inclusion parameters from the substantive population within the substantive area of exploration. These included fully accredited psychotherapy training working with a relational approach, experience and knowledge of working in the addiction field, specifically with female sex addicts, and inclusion of affect regulation as a therapeutic method in therapeutic practice with sex addiction.

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3.7.2 Recruiting Participants

I recruited twelve appropriate participants for the current study using two recruitment strategies. The first involved sending an invitation letter by email (see Appendix X, p.151) to members of the United Kingdom Council for Psychotherapy (UKCP), who are also listed on

the Psychoanalytic and Psychodynamic Psychotherapy, Analytical Psychology, Family, Couple, Sexual, Systemic Psychotherapy and Humanistic and Integrative Psychotherapy register. I sent a total of two hundred and fifty emails in the first of two cohorts. Responses were minimal and of the five therapists who responded only one met the criteria for inclusion in the study. Some respondents, while having clinical experience working as psychotherapists and psychologists with sex addiction, had no experience working with female sex addicts, affect regulation as a clinical method or a relational approach and therefore were not considered viable as participants. I considered it possible that the term *sex addiction* might deter participants who worked with this phenomenon but who used the term *sexual compulsivity.* I included the term *sexual compulsivity* in the second cohort of recruitment email invitations. This revision made little difference to the number or the quality of responses with no viable participants yielded from this stage. A third cohort of recruitment invitations was sent by email to the members of the United Kingdom Council for Psychotherapy (UKCP) who were listed as members of the British Association of Relationship and Sexual Therapists (BARST; now the College of Sexual and Relationship Therapists – COSRT). I reworded the invitation again at this point as I felt the first version may not have been 'catchy' or engaging enough and I wanted to increase response numbers (see Appendix X). While fourteen therapists responded, it seemed they were motivated more by curiosity than suitability or willingness to participate. All of these respondents said they had *'experience of male clients and sex addiction but none with females*'. This recruitment process, using an invitation strategy, yielded a total number of nineteen respondents and, of those, only one respondent met the inclusion criteria and qualified as a viable participant in the study.

Finding therapists who had an understanding of working with affect regulation, sex addiction and females was beginning to feel like the needle in the research haystack. I considered reverting to the British Psychological Society (BPS) directory in order to recruit counselling psychologists directly, but felt there was a greater contribution to be made by recruiting a sample located from inside the addiction field. I felt the sample was perhaps better drawn from within itself and thus the recruitment strategy focused on approaching clinicians who were specifically located within the addiction field who had experience of working with sex addiction. I chose a *snowball* strategy to source these participants. I initially approached a female therapist, who was suggested by a respondent from the invitation strategy and was clinical director at an addiction treatment centre in Surrey. Following this interview I asked her to suggest another therapist and possible participant. From this I found the second participant. The third participant was from the initial mailshot to the UKCP. The fourth was based at an outpatient centre in London and was located by me directly, the fifth was

suggested by the fourth participant and the sixth was suggested by the third participant. I approached the seventh directly who then suggested the eighth. The remaining participants in the sample were selected using a similar strategy. In order to minimize any loss of diversity in the sample, or risk of premature saturation, where possible I asked each participant to suggest another counselling psychologist or psychotherapist they considered as holding dissimilar characteristics to themselves. This *snowball* strategy yielded a sample pool of fourteen therapists, of which twelve were suitable and met the inclusion criteria for the study.

While I had no preconception of the sample size required for saturation, I held Morse's (2000) view in mind that the ability, experience or knowledge of a researcher determines the size of the sample. While my level of skill and experience might have reflected the need for a larger sample size, my training as a psychotherapist provided a strong skill set useful in inviting participants to reveal significantly deeper and richer data, and thus I believed a smaller sample size might prove to be adequate (Morse, 2000; Strauss & Corbin, 1990/1998). While some researchers report saturation as occurring within the first twelve interviews, others indicated that the basic elements of the focused codes and categories were already present as early as interview six (Guest, Bunce & Johnson, 2006). This implied that although the idea of saturation is conceptually helpful it is not indicated by sample size. I remained open and, although I used a sample size of twelve, I was satisfied with the emergent data and considered no further themes to emerge by interview eight. I selected the remaining four participants to *flesh out* and enrich the categories and to achieve greater robustness within and between dimensions (see Theoretical Sampling). The recruitment process was influenced by the patterns, categories and dimensions emerging from the data and determined specific selection of participants who would provide deeper insights into the emerging concepts as well as confirming or disconfirming emerging lines of enquiry.

3.7.3 Participants' Demographics

In locating the sample by looking into the field itself, I was able to select participants who reflected the multiplicity and diversity of psychotherapists and psychologists working within this substantive area which allowed for a sample comprising characteristics typical of the field at that time. This was reflected in the variety of training modalities, including Psychoanalytic, Transpersonal, Existential, Clinical Psychology and Analytic Psychology, and approaches to therapy, as well as a breadth of accrediting organizations. Although participants had trained in different institutes, all had been trained to a minimum of masters level and had each a minimum of ten years' clinical experience. All had knowledge of the Twelve Step approach to addiction work. At the time of doing the study all participants were accredited psychotherapists or psychologists who worked in private practice with female sex addicts and identified themselves as using a relational therapeutic approach. Five participants

worked part-time as therapists at residential addiction treatment centres in the United Kingdom and three further participants were clinical directors at addiction treatment centres in London and Surrey. Six participants were accredited by the British Association of Counselling and Psychotherapy (BACP), five by the United Kingdom Council for Psychotherapy (UKCP) and one by the British Psychological Society (BPS). Two of the participants were United States citizens and qualified as licensed marriage and family therapists in the United States prior to transferring to the United Kingdom. Two held post-qualification trainings in Somatic Experiencing (SE), six were Certified Sex Addiction Therapists (CSAT), three were trained in Eye Movement Desensitization and Reprocessing (EMDR) and three were accredited by the British Association for Sexual and Relationship Therapy (BASRT; now COSRT). Eight are qualified and practising supervisors. There were six female and six male participants, six heterosexual women, four heterosexual men and two gay men. They ranged in age from thirty-eight to sixty-three. All participants are white in ethnicity with nine co-researchers being British in nationality, one being Canadian and two being citizens of the United States. Eleven had a family history of addiction and mental illness.

The sample pool did not include counselling psychologists and as such reflected the demographic characteristics of clinicians working within the addiction field with female sex addicts. I considered this sample to reflect both the breadth and diversity of clinicians in the field and the dearth of counselling psychologists working in this area. The table below illustrates the demographic information of each participant.

Table 1 Participant Demographics

Participant	Gender	Age at Interview	Training Orientation, Highest Qualification Post Qualification & Accreditation	Length of Time and Clinical Practice Setting

P1	Female	56	Psychoanalytic MSc, LSW CSAT, SE, EMDR LMFT BACP	Clinical Director Residential Addiction Treatment Centre/Private Practice Supervisor
P2	Male	61	Attachment MSc CSAT LMFT BACP	Senior Psychotherapist Residential Addiction Treatment Centre/ Private Practice Supervisor
P3	Female	51	Existential Psychosexual MSc BASRT (COSRT) UKCP	Private Practice Supervisor
P4	Female	38	Psychodynamic, Psychosexual MSc UKCP BASRT (COSRT) BACP	Clinical Director Outpatient Addiction Treatment Centre/Private Practice Supervisor
P5	Male	49	Humanistic MSc CSAT BACP	Senior Psychotherapist Residential Secondary Addiction Treatment Centre/ Private Practice
P6	Female	60	Integrative/Psychosexual PhD Psychology BPS, UKCP	Private Practice Supervisor

P7	Female	63	Transpersonal, PsyD Psychotherapy CSAT BASRT (COSORT) BACP	Psychotherapist Outpatient Sex Addiction Treatment Centre/Private Practice
P8	Male	55	CBT PsyD Psychotherapy CSAT UKCP	Clinical Director Outpatient Sex Addiction Treatment Facility/ Private Practice Supervisor
P9	Male	48	Psychoanalytic Psychotherapy MSc UKCP	Private Practice
P10	Male	51	Psychoanalytic Psychotherapy MSc EMDR BACP	Private Practice Supervisor
P11	Male	45	Analytic Psychotherapy (Jungian) MA (Hons) BACP	Senior Psychotherapist Outpatient Addiction Treatment Centre/Private Practice
P12	Female	59	PhD Medical Anthropology, CSAT, SE EMDR UKCP	Private Practice Supervisor

Certified Sex Addiction Therapist (CSAT). Somatic Experiencing (SE). Doctorate in Psychotherapy (PsyD).

3.7.4 Interview Procedure

Interviews took place in either participants' consulting rooms or in mine. The duration time

was between forty-five and ninety minutes. Interviews were recorded on a digital recorder. I drew on phenomenological ideas of conducting an interview and building on the semi-structured interview (Smith & Eatough, 2007). My approach was collaborative and intensive, using open-ended questions and implementing a 'conversational style' (Charmaz, 2006). This approach sought to capture the explicit and implicit meaning of therapists' experience and endeavoured to create an initial rapport conducive to accessing depth and creating comfort in the process of disclosure. The initial interview question was designed to invite the participants to explore and describe their thoughts, feelings and views of sex addiction, how they thought about affect dysregulation as contributing to this problem and how they would work with affect regulation with this clinical group of females. My approach draws on Glaser's (1998) idea of using broad and open questions in order to *instill a spill* and allow therapists to talk freely about their experience. They were asked 'How would you describe female sex addiction?', 'How do you see affect dysregulation contributing to this problem?' and 'Tell me your experiences of working with affect regulation with your female clients?' As the interviews progressed, the interview questions became more focused on developing properties of categories, perceived dimensions and issues across interviews, with the goal of discovering the emerging theory (Bowers, 1990; Charmaz, 2000; Glaser & Strauss, 1967). The following are interview questions asked later in the interview process: 'How would you describe your experience of how persistent dysregulated affect influences relapse risk?', 'Tell me your experience of how dysregulated affect impacts the therapeutic alliance?', 'How do you use your own affect in your work?' and 'How do you work with the countertransference?' (see Appendix IX, p.149).

My psychotherapy training helped me to facilitate a flexible interview style, which seemed to establish trust and rapport. Using 'prompts' and 'probes' allowed for access to deeper and more focused material. Prompts were designed to 'encourage more elaboration' and specifically related to process rather than content (Fassinger, 2005:p.159). Like Fassinger I followed Corbin & Strauss's (2008) 'funnel like approach moving from broader to more specific questions' as the interview process developed, and was mindful to avoid posing assumptive questions which might 'impose constructions' (Fassinger, 2005:p.159) which might risk the quality of the interview data.

Field Notes

Initial field notes were recorded immediately following the interview and secondary field notes were recorded during the transcribing process. These were reminders of my experiences of the interview as well as thoughts and *hunches* that occurred. I was less concerned with my method of taking field notes and more with the principle of preserving these 'observations

and impressions' (Montgomery & Bailey, 2007:p.71). In line with Charmaz's (1995b) thinking I used field notes to 'add description of the situation, the person's affect and their perception of how the interview went' (p.35). They allowed me to pay particular attention to the 'situated vocabularies' and allowed me to note where the 'emphasis of attention' was located (Hammersley & Atkinson, 2002). While these included descriptions of intonations and rhythm of speech in participant style of disclosure, it also helped keep the data alive without having to revisit the audio recordings. Field notes also captured my impressions of participant style of contact, atmosphere between us in the interview, and my implicit responses to them in the relational field. These subtleties were not necessarily evident in the flatness of the written word as it appeared on the transcript. They helped to highlight aspects of the experience that may not otherwise be evident. Importantly the field notes constituted a substantial part of my memo-writing. In particular they contributed a richness and depth to the data and this integration particularly helped to transform mere 'descriptions into sophisticated more theoretical accounts' (Montgomery & Bailey, 2007:p.68). While this did not change any meaning related to the coded material, it did enhance its validity and helped contextualize some of the data, thus better informing my coding.

3.7.5 Data Analysis

I saw the grounded theory coding as a dynamic and interactive process involving many levels; the aim was to see the data 'broken down, conceptualized and put back together in a new way' (Flick, 2009:p.307). My approach to analysis used a 'smorgasbord table' (Strauss & Corbin, 1998:p.8) of techniques in order to 'pick and choose' which best reconstructed the theory from participants' experience. In this study I implemented the following: i) simultaneous data collection and analysis, ii) initial, focused, selective and theoretical coding processes, iii) memo-writing, iv) theoretical sampling, v) constant comparative analysis, and vi) sorting, saturation, and integration of the theoretical framework (Charmaz, 2006, 2000). These strategies and techniques constituted an 'inductive-deductive-abductive' approach to conceptualizing the 'development, refinement, and interrelations of the emerging theory' (Bryant & Charmaz, 2010; Charmaz, 2006, 2000; Ward, 2005). In this next section I will describe how I specifically implemented these strategies in the present study.

Coding

The first phase involved line-by-line coding (Charmaz, 2000; Glaser & Strauss, 1967), which opened up the data by identifying its smallest component parts, i.e., words and phrases of salience (see Appendix XI, p.153). Salience was evaluated by participants' prosody, repetition, phrasing and description of actions and events and body language (Charmaz, 2006; Ward, 2005). This generated numerous possibilities in terms of emerging patterns, direction

and themes and created an immediate immersion in the depth of the data. The meticulousness and thoroughness that line-by-line coding allowed 'reduced the likelihood of superimposing (my) preconceived notions on the data' (Charmaz, 2006:p.61) (see Credibility, Reliability and Trustworthiness).

In the second phase of coding I used a focused coding strategy (Charmaz, 2006), which allowed me to 'determine the adequacy' (p.57) of the codes identified in the first phase and to then 'sift through the large amounts of data and make decisions about which initial codes made the most analytic sense to categorize more incisively and completely' (p. 57). This 'condensed' and 'synthesized' existing codes that were considered significant into further and higher-level codes which best captured the main implicit and explicit themes in participants' statements (Charmaz, 2006:p. 59).

Table 2 Showing Line-by-Line and Focused Codes

Excerpt from Interview Transcript I	Line-by-Line Coding	Focused Codes
P1/42: Very interesting. So she was a sort of good example for all of us as a system of what doesn't work for it (SA). Although she was not an active sex addict she was an active anorexic and very armoured and very rigid. I would also think anyone who is active in their own addiction would have an extremely tough time with it too. It doesn't mean perfect recovery because there is no such thing but the awareness of working with my own issues within this particular subset of work I think is so essential particularly when this CT comes up I am is going to feel invaded by and injected by the other persons illness … and how do I separate that from my own sexuality. I mean you really have to be on your own personal edge with keep – being able to work with someone else and manage their affect because if I am in	Knowing what doesn't work Active anorexic Very armoured and rigid Therapists active in own addiction challenge this work Being aware of own issues Subset Feelings coming up. Invaded. Intruded Others' illness pervasive Separation of others' illness from own sexuality At 'personal edge' Own affect Others' affect	Personal defences/style Challenges personal limitations Self-awareness Particular personal issues Unconscious processes Projective identification Invasive Demarcating own material Being at your 'own

terror and suddenly infected with someone else's sadomasochistic patterns and I am noticing it in my masturbation fantasies or wherever I look I am imagining you know the person in front of me in the grocery store is a sadomasochist because of how she is dressed and I am frightened now when I sit with my client as I might not be extreme but it might be very low level and I might not even be aware of it. What's going to happen? So, this takes particular personal work and supervision.	Terror Someone else. Not own. S/M Deep projections. Co-experienced Shared implicit material Noticing 'other' in own masturbation fantasies. Self and not Self. Unfamiliar material Projection fantasies in personal social situations. Feeling frightened. Fear sitting with client Low level. Difficult to detect Perhaps out of awareness Not knowing what will happen. Precarious. Uncertainty Needing specialized supervision and personal work	personal edge' Shared implicit erotic material Carrying client material Expressing/ formulating material for client Therapists managing own terror Sexual fantasy. Shared implicit process The unknown. Holding precariousness Unconscious material Risks Requiring specific support

At the end of this phase, I had developed one hundred and twenty nine focused codes, or 'units of meaning' (Fassinger, 2005:p.160). The analysis of the second interview followed the same procedure and significant and salient initial codes were either added to the focused codes generated by the first interview or, where new codes did not fit into existing focused codes, new ones were created. Following the initial analysis of the first two interviews a total of two hundred and twenty nine focused codes/meaning units had emerged (see Appendix XII, p.156).

The third phase of coding implemented a 'selective coding' approach. This involved selecting focused codes that most closely *hung* together and beginning to create a cohesive picture of the emerging phenomena and the relationship between them. At the end of this stage of the analysis sixty-four codes/categories emerged. Many of the less robust or significant of these were either subsumed to buttress and enrich existing categories or were eliminated entirely. The subsuming category either remained the same or evolved with a new conceptual identity. This stage also involved splitting categories into two or more as it was judged to best reflect the emerging understanding of the data.

The data was now organized into twenty-two properties, or subcategories (Charmaz, 2006). At this stage I began to explore and experiment with the possible conceptualizations which, in the end, reduced the number of properties to seventeen and organized five iterative and mutually influencing, overarching categories (see Appendix XIII, p.160). I also integrated diagramming as a technique to better organize the emerging data which involved organizing the subcategories on large poster pages using coloured pens and paper. Integrating this technique of *play* allowed me to visualize and 'sharpen' (Clarke, 2005, cited in Charmaz, 2006:p.121) the complex and intricate relationships between categories and concepts so far (Strauss & Corbin, 1998; Strauss, 1987) and to explore the best possible theoretical representations of the data.

Memo-writing

Memo-writing was conducted throughout the analysis. This developed in both complexity and theoretical sophistication as the study progressed. In the early stages of the analysis, memos reflecting 'hunches' and 'random thoughts' concerning emerging data were recorded on index cards. This allowed me to consolidate the first phase of coding while reflecting the central and salient processes that participants were describing. Memo-writing continued to develop throughout the process and included 'capturing comparisons and connections to crystallizing questions and directions for further questioning' (Charmaz, 2006:p.72).

These evolved into more sophisticated, intricate pieces of writing that held the balance between raising codes to concepts and reaching for greater levels of abstract thinking whilst remaining grounded in the data. By using memo-writing I eventually raised my 'focused codes to conceptual categories' (Charmaz, 2006:p.91). These memos then formed the basis on which the final structure of the theory was organized. Memo-writing allowed me both to debrief and reflect on the analysis between each level of coding and to reality check the data (Saladana, 2009) (see Credibility, Reliability and Trustworthiness).

Theoretical Sampling

I saw theoretical sampling as serving a different function with each phase of coding and analysis (Draucker, Martsolf, Ross & Rusk, 2007:p.1142) and, as such, acknowledged that it is at times somewhat unclear in the research literature. I implemented theoretical sampling at various stages of analysis, including selecting relevant and specific participants to confirm or disconfirm the importance of emerging data. I recognized the importance of transparency in my implementation of theoretical sampling and draw on Charmaz's (2006) view that it allows the researcher to focus on specific issues in order to illuminate the emerging theory

(Charmaz, 2000), as well as to determine what data to collect next in order to continue to discover and develop the theory as it emerges (Bowers, 1990; Glaser & Strauss, 1967).

Later in the analysis procedure, and once categories had been organized into a skeletal framework (Flick, 2009) and positioned to best reflect a theoretical coherence, I conducted theoretical sampling with several aims in mind. First, to see *if* new data emerged, second, to confirm and enrich existing dimensions, third, to 'elaborate how the analytic categories fit together' (Bryant & Charmaz, 2010), and fourth to *buttress* the relationship between the existing categories (Charmaz, 2006; Glaser & Strauss, 1967). While I was guided by Charmaz (2006) and considered 'categories to be saturated when gathering fresh data no longer sparks new theoretical insights nor reveals new properties' (p.113), I continued to sample until I was intuitively comfortable that I reached what Dey refers to as 'theoretical sufficiency' (1999:p.257).

Constant Comparison

Throughout the analysis I implemented a strategy of constant comparison (Glaser, 1969; Strauss & Corbin, 1990; Charmaz, 2006, 2000). This process identified and compared dimensions across and within participant data in order to clarify understanding of the individualized dimensions as well as the interrelationships between them (Bowers, 1990; Glaser & Strauss, 1967). Aware of an emerging conceptualization but not yet satisfied with the level of cohesiveness or robustness of some properties within and between certain categories, I used constant comparison strategy to revisit the data three subsequent times. This involved revisiting the existing codes and the data numerous times to compare codes within and between interviews. I constantly checked and rechecked the emerging categories with the grounded data. Was it talked about in the same context or were they doing similar things in other contexts? I also compared the context within and between transcripts and codes to ensure validity and to ensure that the analysis was robust. On the one hand this was a spontaneous activity that seems to emerge organically from the analytic process, yet on the other became a consciously implemented strategy.

Smith (2011) describes finding very specific phrases and paragraphs in the data that both sharply encapsulate and conceptualize its complexity in elegant, succinct and potent ways. These 'gems' (2011) are the 'extracts' that both 'demand further analytic work' and offer 'analytic leverage' (2011:p.7). Consistent with his experience, gems were identified after the third or fourth review of the emerging codes and meanings. In the last stages of writing up I did my sixth and last full review of the data by rereading and checking the context of each question with the existing categories.

Using Literature

My use of literature in the process of analysis was consistent with Strauss and Corbin's (1990) view that one can interweave the use of literature through the process of analysis. Not only did it contribute to the theoretical reconstruction of the data, in my experience it was a technique to enhance theoretical sensitivity. An intelligent and sensitive use of literature 'stimulated thinking about properties or dimensions that can be used to examine the data in front of us' (Strauss & Corbin, 1998 cited in Mills, Bonner & Francis, 2006:p.4). It also helped home in on gaps in the field as an evolution of analysis and addresses this more effectively.

3.7.6 Structuring the Theory – 'The Drugless Trip' (Glaser, 1998:p.273)

Following several stages of 'collapsing and re-organizing the data' (Bolger, 1999:p.347) in order to best represent the relationship between categories, the emergent theory was integrated and considered 'a close fit with the data, a usefulness, a conceptual density, [with] durability over time, modifiability and explanatory power' (Charmaz, 2006:p.6). This theoretical model presents what is best described as *knowledge-for-understanding* of the processes underlying therapists' experience of relational work with affect regulation with female sex addicts. As such it sets out a succinct, conceptual framework to represent what is happening here in this current set of data.

To summarize, the emerging data was first organized into a linear model, which initially identified constituents that gave general structure to the process of working with affect regulation. However when I 'moved to clarification of the processes involved' (Bolger, 1999: p.347) and to grouping the data into categories I realized that the processes were too mutually influencing and reliant. The data did not constellate around a core category and I decided to organize a nonlinear and non-hierarchical model. I felt this theoretical construction more effectively reflected the equal significance of each category and the reciprocal and interactive relationship between them. Once this was established and links within and between categories were determined, further properties were 'mapped onto the model' in order to enrich and 'match the proposed framework' (p.347).

Writing Up

I understood the style of writing needed to be evocative of the participants' experience (Charmaz, 2001) and endeavoured to present the findings in a literary rather than scientific style. I draw on the view that the role of the researcher's voice is not to 'transcend experience but to re-envisage it, bringing fragments of the field – work, time, context, mood together in a

colloquy of the author's several selves – reflecting, witnessing, wondering, accepting all at once' (Charmaz & Mitchell, 1996:p.299).

3.8 Credibility, Reliability and Trustworthiness

Checking Data

Following each interview and between phases of initial coding, I asked a peer group of two psychotherapists (all of whom were doctoral students and counseling psychologists in-training and conducting their own grounded theory research), to code randomly selected sections of the transcribed interviews (see Appendix XIV, p.182). Reliability checks were conducted with a focus on the emerging relationships between categories and subcategories and the *good fit*. These were again compared to selected transcripts in order to ensure groundedness and enhance credibility of the data. Transcripts and codes were sent to the participants who confirmed they were happy with the accuracy of the representation of the interview and neither added nor withdrew any data.

Audit Trail

I maintained a journal, which archived, recorded and consolidated my experience and reflections of the research process over three years. The relevant content has been integrated into this methodology section.

Reflexivity: Use of Subjectivity

I recognized my personal views, attitudes, thoughts and feelings as having an unavoidable presence in the process of 'gathering, interpreting and presenting' the data (Tufford & Newman, 2010:p.81). Reflexivity aimed to heighten the usefulness of implicit and explicit autobiographical material and to ensure that it enhanced rather than hindered the trustworthiness of the process. Implementing reflexivity as a methodological technique involved acknowledging and exposing my presuppositions. I saw these as mitigating any undue influence my prior knowledge and experience might have on the research as well as facilitating a 'deeper level of reflection across all stages' (Tufford & Newman, 2010:p.81) including finding the topic, interviewing participants, gathering and analysing the data, constructing the theoretical model and writing up. Reflexive techniques involved personal therapy, journalling, field notes, memo-writing and holding an attitude of transparency with myself and my peers. These techniques allowed me to address my own 'implicit beliefs and biases' regarding my personal attitudes to gender, oppression and power, female sexuality and sexual/relational templates, and addiction, and to make these explicit to myself and to others (Luca, 2007). The literature mentions a reflexive approach to qualitative research as lending itself to a team approach and sees this as creating opportunities for 'mutual monitoring of

biases and constant discussion of emerging theoretical formulations' (Fassinger, 2005:p.164). While this was a single-person study, the individual and monthly group peer-checking process allowed for a critical and knowledgeable discussion about my perceptions and interpretation. I also sent sections of the early codes to participants in order to clarify that I had encapsulated their meaning and not represented my own.

I relied on the reflective practice skills developed in my training as a counselling psychologist and integrative psychotherapist and understood these as contributing to both the quality and rigour of the study as well as creating a rich and multi-layered result. I experienced this in-depth, reflexive involvement as drawing on both my ability for conceptualization and my capacity for using 'hunches' and saw this as allowing for greater sharpness of both thinking and intuiting. While I recognize that to fully know one's implicit and unconsciously held material is impossible I believe that raising awareness of my preconceptions permitted both the mitigation and integration of my own experience and knowledge as it contributes to an understanding of the implicit and explicit processes embedded in the data. I was aware of my perspectives as being operationalized during interviews (Hall & Callory, 2001) and with this in mind heeded Schatzman and Strauss's (1973) guidance that, as the researcher probes for detail, clarity, or explanation using nonverbal gestures and responses, this can shape and direct interviews toward the interviewer's expectations. I consciously monitored the subtle and nuanced ways in which my inner thoughts and feelings might influence the research to meet my own agenda. I noticed female participants talking about men in a derogatory way and was aware that while I felt a pull to collude at times this needed to be monitored and managed in way that facilitated the interview rather than manipulating it. The same was true of managing my strong negative response to a male participant who clearly held strong biases about women and masturbation. Field notes (see Field Notes) helped to mitigate the projection of my own thoughts and feelings onto the interviewee and enhanced a sharpness of awareness that allowed greater preparation for further interviews.

Managing the relationship between my preconceptions and the emerging data and constructs with this degree of vigilance was in reality more of a challenge than I had expected. At a few points in the process of the analysis, I lost some sensitivity in relation to the data and noticed that the reflective space of the researcher had become *contaminated* rather than *constructed* by my own preconceptions. Several times I had to pause and scrutinize the validity of the coding and ask: was this researcher- or data-driven? I reflected on the tussle between achieving *theoretical sophistication* in the face of numerous episodes of tumbling back into what felt like *theoretical tunnel vision* (Charmaz, 1990:p.1171). However, over time I began to recognize a space in which the part of me that could *experience* the data and the part of me

that could *observe* the data had become more integrated and simultaneously held in awareness, thus creating new ground from which a deeper understanding of the data could emerge. For me, noticing my preconceptions as inseparable from the data took place in a millisecond of time and without experience was difficult to catch. Whilst this led to revisions several times, and certainly reinforced my belief in the need for an ongoing awareness of managing my presuppositions, I also understood that without the proper use of my own material I might have been slower to recognize the emergent categories and theory than if I had held no preconceptions or expectations (Scott, 2007b).

This demonstrated that the findings are not, perhaps, just about the theory construction, but equally about the immersion of the researcher in the research and analysis process. The deeper and more thorough my involvement became in terms of really *feeling* the data, the more it penetrated the layers of my own unconscious material. This methodological process, requiring a subjective pull to personal depths initially unimaginable, I believe also required a continuous and deepening commitment to self-awareness and personal reflectiveness.

3.9 Ethical Considerations

I operated on the basis of informed consent and furnished all participants with a detailed (see Appendix XVI, p.189) prior to the interview. This communicated the aims of the study, the structure of the interview process and the protocol for securing the anonymity of the data as well as the storage of data files. I confirmed my commitment to maintaining anonymity and confidentiality throughout the process from interview to finished version of the study. I said that I was interested in the *process* and not the *content* of their clinical work (Day, 2011) and requested their agreement to use the data in publications, conferences and workshops. This was highlighted to participants at the beginning and end of each interview. They were given a debriefing protocol and asked to sign a consent form (see Appendix XV, p.188) that confirmed their understanding of and agreement to the terms set out in the (see Appendix XV, p.188).

A central consideration was my responsibility to the participants' continued subjective well-being during the process. I consciously sought to create an experience of a non-hierarchical and inter-professional dialogue. My ethical sensitivity to the intersubjective nature of the research dyad is also expressed in observing and protecting their uniqueness: 'Not forcing or leading the questions, taking a position of neutrality and actively bracketing my own material and checking any agenda I might have' (Day, 2011:p.41).

I understand the sense of integrity embedded in the notion of *ethics-in-action* (Cooper, 2009) and my ethical considerations were adapted to the specific sensitivities therein. This was demonstrated by my attention to the subjective well-being of each therapist in the context of the interview process. It was important to maintain a balance between the aim of getting rich data and the need to show care to the participant: to be too cautious risked the richness and depth of participant descriptive experience; to throw caution to the wind might risk negative impact on individual well-being. This required an awareness and attunement to participants' level of arousal and any interaction that might signal too much discomfort for them. I was sensitive to the balance between my need as a researcher for deep exploration and the possibility of being experienced as intrusive by the participant. I recognized when it was appropriate to hold back on the grounds of professional and personal courtesy and adherence to my ethical framework as a researcher.

3.10 Reflections on Implementing Grounded Theory Methodology

Temporal Factors

On reflection, the research process required an appreciation of the autonomy and rhythm of time in procuring meaning and understanding of these complex and often out-of-reach, implicit processes, often requiring time away from the data in order to gain distance, despite wanting to push on and through to get it finished. Often the picture emerged at the eleventh hour. Like a sculptress I was so often busy chipping away at the detailed *part* in front of me that the *whole* was out of view and not evident until I was writing up the paper as a whole. Throughout the analysis, despite my frustration and need to control the emerging process, I learned to understand time as a specific methodological consideration. On reflection, an appreciation of time allowed a process to occur at unconscious depths and allowed a reformulation of analysis to emerge with a greater intuitive understanding and a very particular level of insight: an unconscious-research-in-action.

Iterative and Circular

My experience of this process was far from the linear path suggested in the literature. This was iterative, circular, spiralling, flip-flopping backwards and forwards and always seeming unfinished. It involved a constant process of examining/re-examining, arranging/rearranging, checking/rechecking and formulating/reformulating. I revisited the transcripts and audio recording multiple times and reanalysed and revised the codes frequently. The emergence of categories took a long time and I never arrived at a place I could comfortably recognize as a certainty. This was more a case of adjusting my own expectations and recognizing the 'enough for now' point. I often became too prematurely abstracted and had to backtrack to the data to re-ground the emerging theory again and again. My expectations of the research

process as straightforward, linear and tidy were continuously contradicted by my actual experience of it as messy, fragmented and requiring a constant tolerance for incoherence, contradiction and ambiguity.

Cultivating Negative Capability

As part of my psychotherapy training I developed capacity for *negative capability*, which, expressed by John Keats, 'is to tolerate uncertainty, to remain open and receptive to phenomena as they are revealed and to resist the urge to reduce and categorize these phenomena' (Kaskett, 2011). The most significant experience, on reflection, was the overarching tension between maintaining a tolerance for *negative capability* in light of seeking some certainty and closure. Throughout the analysis I experienced a struggle against wanting to shy away from this challenge and succumb to prematurely foreclosing the analysis as a means of managing my own frustration, fear and doubt. Despite being tempted at times, it was not something I wanted to allow. This seemed to reflect the debate concerning the analysis process as *emergent* (Glaser, 1998) rather than *forced* (Strauss & Corbin, 1990/1998) from the data. I concur with the contentious reservations of Charmaz (2006) and Dey (1999) about axial coding, as addressed by Corbin in her later third edition of *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (Corbin & Strauss, 2008). The idea of using more structure in the coding experience really would have felt like a step 'that might have stifled the analytic process achieved from initial coding' (Saldana, 2009). By experimenting with it, I became aware of the risk to the pureness and richness of the findings and, when I found myself veering toward more structured and *forced* strategies of analysis, I recognized this to be a response to my feelings of overwhelm and frustration. I understood that my frequent urge to *pin down* the data was an expression of my own fear of chaos and *loss of control*. In December 2011, I reached a crisis in the research when I realized that my initial model was more a reflection of my pre-existing ideas rather than the grounded data and participants' experience. I had got caught up in the idea of *the grandiose theory* and had lost sight of what the data was actually saying. I returned to the data and re-scrutinized and reviewed the analysis with renewed perspective. On reflection, this critical point represented a pivotal shift in my relationship with the research and guarded against any subsequent risk to the integrity of the analysis.

The Embodied Researcher

The challenge of sorting and organizing the codes and categories and constructing a theoretical model was gargantuan. As the study progressed, experimenting with the possibilities in the data became less of a logical process about how they flowed and fitted together and more an embodied, instinctual, *in the gut* process. I noticed that as I had lived

and breathed the data for so long it had become an implicit part of me: an internalized and embodied ongoing dynamic. The construction, deconstruction and reconstruction of the properties and categories seemed to have relied on my instinctive and *gut* responses as much as on my cognitive and logical checking of the data. This often involved a leap of faith that, although the data might have *looked right*, it *felt wrong*, and I needed to tend toward following the latter.

I considered this personal embodiment to 'enhance the quality of categorization' (Rennie & Fergus, 2006:p.484). This focus reflected the phenomenological approach to analysing the data which emphasized the role of *feeling* and intuition in addition to using cognition, and allowed for more creative energy and freedom in exploring hunches and *gut feelings* about the data as well as minimizing any limitation of my preconceptions. This reflected Strauss and Corbin's (1998) notion of the value for researchers in following their 'gut sense' of the patterns in the material (p.50). By my experience of negotiating and engaging at affective as well as cognitive levels with the data, it was transformed into reflective and embodied knowledge. This involved recognizing my own thoughts and emotions whilst simultaneously trying to comprehend the minds of the participant. In Luca's (2007) words this required being conscious of my 'thinking about my thinking' and also 'my intuitive feeling about my thinking' (p. 19).

On reflection, the nonverbal and pre-symbolic nature of the *erotic* and *affective* material embedded in the research question meant that a particular requirement for this researcher was to draw on an embodied and intuitive response in order to better understand the emerging meaning and feeling of what was being communicated. To conclude, in the context of my training as a counselling psychologist and psychotherapist, immersing oneself in the subjective world of another is not unfamiliar. I believe this not only remained evident in the vocabulary used to define categories but also kept the participants' voices alive.

4. Findings

A Relational Model of Therapists' Experience of Affect Regulation in Psychological Therapy with Female Sex Addiction

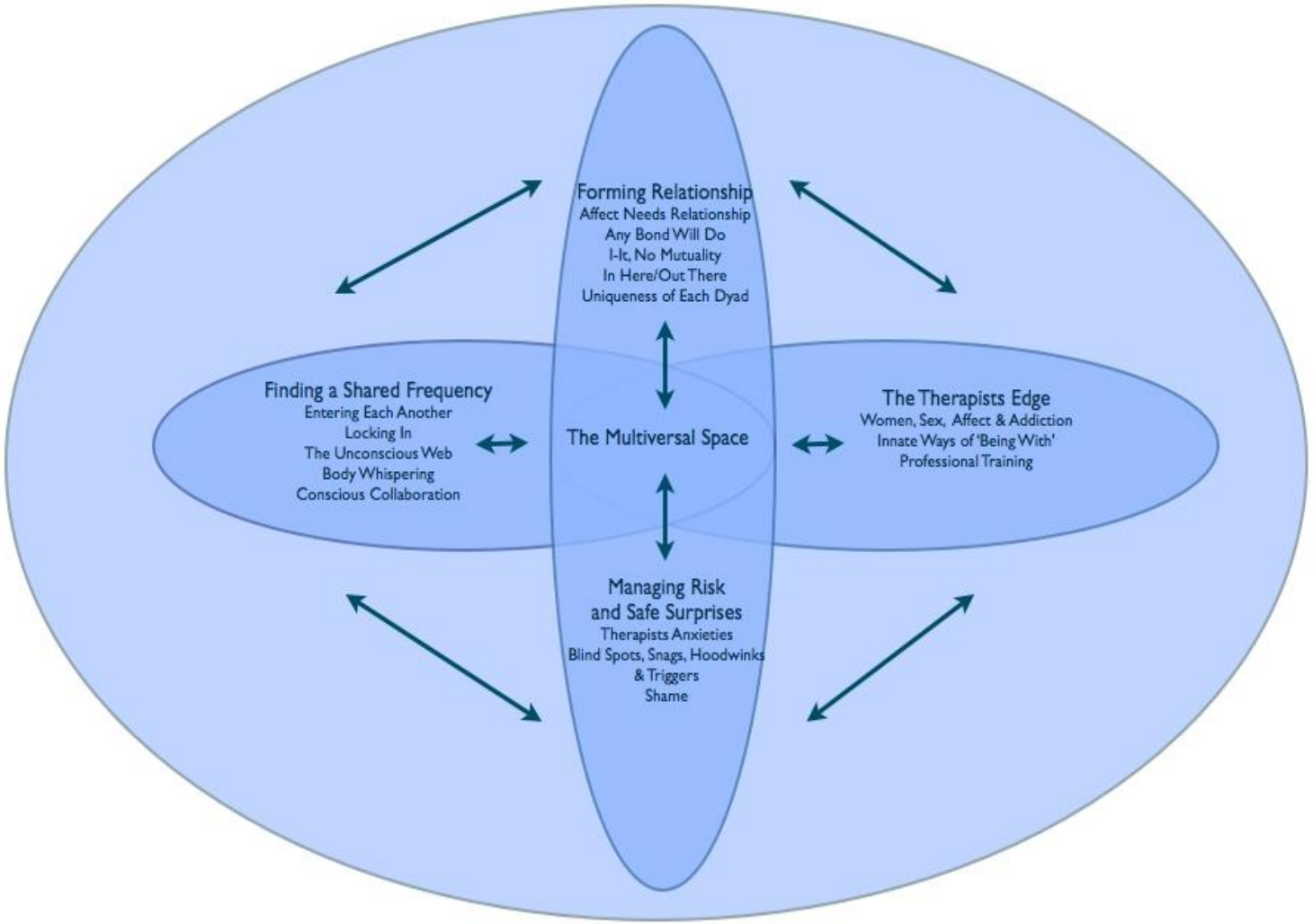

Figure 2.

Overall findings (see Figure 2) are reflected in five categories. Four of these are reciprocal, mutually influencing and iterative dimensions – namely, Forming Relationship, The Therapist's Edge, Managing Risk and Safe Surprises and Finding a Shared Frequency. These are cohered by a fifth, The Multiversal Space. Forming Relationship reflects the properties involved in establishing the initial therapeutic bond with female sex addicts. The Therapist's Edge organizes therapists' attitudes and beliefs about women, sex and addiction, and personal and professional characteristics that influence relational processes of regulation. Managing Risks and Safe Surprises incorporates dimensions reflecting therapists' sense of precariousness experienced in the work. This category includes therapists' anxieties, blind spots, snags, hoodwinks and triggers and working with shame. Finding a Shared Frequency organizes dimensions of the interactive processes that occur at the interface between therapist and client.

4.2 The Multiversal Space

The Multiversal Space reflects dimensions that mediate the interplay of properties incorporated in the categories of Forming Relationship, The Therapist's Edge, Finding a Shared Frequency and Managing Risk and Safe Surprises. All processes seem to traverse this space, run in and out, and are mutually influencing and reciprocally impacting. This space reflects the convergence of multiple dimensions including *moments of choice,* stopping time and using space that shape the process of therapy and shift relational configurations. As therapist and client come together, a myriad of multi-levelled, multidimensional processes occur both in and out of consciousness and in inter-psychic and interpersonal domains, with implicit and explicit, verbal and nonverbal properties of attuning and regulating.

4.3 Forming Relationship

This category incorporates properties and dimensions that reflect therapists'* descriptions of the processes involved in forming the relationship in the early stages of therapy with female sex addicts, and how they get it off the ground.

4.3.1 Affect Needs Relationship

Therapists said they experience affect regulation as a dyadic, shared and co-created process that, particularly for women, is embedded in relationship, whether in therapy with the

* Therapists' gender will be unstipulated unless relevant and then identified using gender specific pronouns i.e., he/she, him/her.

therapist, with intimate partners, in social relationships or in relation to self.

So it is actually all about the relationship – it always comes back to that. (P3/34)

While affect needs to be communicated, understood and expressed in the context of relationship, analysis also revealed therapists as seeing the initial contact in therapy to paradoxically represent a source of over-activation, anxiety, arousal and dissociation. While this relational contact was indeed mentioned as stimulating and heightening levels of affective and erotic arousal, it was also mentioned as key to establishing and sustaining crucial and mutually coordinated processes involved in the therapeutic alliance. The co-ordination of this affective encounter was described for one participant as the *'guts of it '*.

> *The shared emotional soup, that two people get into from the start in the therapeutic relationship; I believe that my emotions and my clients' emotions constituted about 80% of the therapeutic relationship whether it was good, excellent, fabulous, and bad or a nightmare. I think our shared affect and difficulty regulating affect from the beginning determined how the relationship went.* (P1/98)

While therapists mentioned their female sex addicts' affect as being persistently dysregulated, they also understood their sexually addictive behaviour to manage hypo-aroused and hyper-aroused states perpetuated by the absence of a 'good enough' internalized experience of a regulating self/other. Therapists understood this to be a strategy in which regulation is sexualized and saw relational experience emotional excitation for the female sex addict to be embedded in and indivisible from their sexual arousal templates.

> *Everything is sexual, even how she relates is sexual. She doesn't know how not to be. When she sits with me she will flirt with me, there is a type of sexual tension and we have talked about that.* (P4/9)

> '*Erotic is a space where this relational creativity can occur'.* (P11/45)

4.3.2. 'Any Bond Will Do'

Analysis revealed that therapists expect the initial stages of forming the relationship with the female sex addict to be challenging and difficult. They experience the female sex addict as resisting close contact and understood this to be rooted in anxious/avoidant and disorganized adult attachment patterns created by early relational experiences. They said this often meant attendance in therapy for these clients felt *frightening* and *temporary*. While the female sex addicts' avoidant pattern was mentioned as shaping the early therapeutic relationship, analysis showed this to be overlaid with a narcissistic personality style, which also created a

distancing in relational proximity. Therapists do experience the female sex addict as not seeking *closeness*, describing interpersonal connection as extremely difficult.

> *Almost all of them have significant early relationship disruption and attachment disorder. I have never found an addict wanting to climb up with me for years and years. They have a very hard time attaching in the work and the true female sex addict does not want to stay around for years and years to do the work.* (P1/55)

For this reason, therapists reported forming a bond as quickly as possible and said they looked for whatever connection might be available to work with. They mentioned the unconscious organizations of historical affective and relational experience for the female sex addict are particularly triggered by the interpersonal *contact* in therapy and, very quickly, transference and archetypal projections emerged. These established superficial and surface-level connections creating a *lens* through which the client can perceive the therapist as a familiar relationship figure, past object or archetype. Therapists made the point that while this maintains a psychological distance, it also allows for a connection and that while not ideal this bond is better than none at all, and gets the therapy work started. They commented that this opportunity appears immediately in the therapy and remarked on the fast speed and apparent spontaneity with which these configurations can emerge.

> *One of the things working with the female sex addict is that it is important for them to make the therapist into an archetype or projection quickly in order for them to begin to do the work.* (P1/55)

Therapists reported how, in the early sessions of therapy, they often become a past relationship figure for their clients and described various archetypal configurations on which they can begin to build a bond. One participant recalled that her clients *'very early on are going to label me something whether it is hag, a mum or the guy who is not there for her'* (P3/30). Another encapsulated the tensions for the client involved in managing closeness and distance in these early projections and mentions that, in most of her clients, whatever configuration the projected object takes, it is usually designed to maintain interpersonal distance.

> *It is going to be very superficial and an 'at arm's length keeping' projection that is just going to come out right away, you see it immediately and it (the transference relationship/alliance) does not take long to form.* (P10/35)

Other female therapists described the early bonding as involving processes of *twin-ship* (Kohut, 1971), with one therapist in particular describing how she identified similarities of gender with her female client in order to establish rapport. This she saw as emphasizing an equality and alignment as '*two women'* in the work together and as immediately establishing an ethos of connection, openness and honesty:

> *I said, you are the client and I am the therapist but we are also two women in this room, so we are going to work together and we will be as honest as we can with each other*. (P4/28)

Male therapists mentioned being perceived by the female sex addict in the immediacy of the transference as her possible partner figure and as an object of erotic fantasy. Therapists talked about the tension between immediately challenging clients' inappropriate sexualized/eroticized projections and transferences, expressed as being '*coy and coquettish'* (P11/35) and arriving seductively dressed, *'ready for sex'* (P5/15), and using the erotic transferences to create a working bond. While male and female therapists certainly confronted sexualized transference as it appeared in the first sessions, male therapists noted that some female clients did not return. Bonding with the female sex addict in the context of the erotic transference was mentioned more often, with clients presenting with *a 'higher level of romance'* (P1/55) in their arousal and attachment templates. This subtype is said to engage in the therapeutic relationship more eagerly from the beginning and to have a more preoccupied attachment style as well as borderline personality features. While therapists said these clients are more ambivalent, they did seem to form an attachment bond earlier in the therapy in a dependent way, with the complex transference tensions emerging later in the therapy.

4.3.3 Shared Understanding

While therapists indicated that they see the client's transference as offering the opportunity to form an immediate bond with the client, they also mentioned the co-creation of *understanding* of sexually compulsive problems to be key to the process of forming a working bond. Therapists described these as involving more explicit and cognitive processes, including dimensions such as using assessment tools and questionnaires, taking lengthy and thorough client history and psycho-education. While this was seen to provide the client with information about the diagnoses and treatment it was also mentioned as part of the early forming alliance, based on establishing *sharing understanding* and agreeing goals. There was also a tension in the data between the notion that thorough assessment could create an initial feeling of trust and safety for female sex addicts, and, in light of their high levels of secrecy,

confusion and shame, be too pragmatic and hinder open disclosure and bonding. This was a process in which there needed to be a human-to-human connection.

> *They are not going to be able to get going in the relationship with me if I am standing with a clipboard. They are only going to do that in relation to another human being, before they are going to do that with a therapist. The fact that I am a therapist and have a background of information and experience running at the same time is not the point. The point is it is in the human relatedness of it.* (P5/30)

An interesting finding is that therapists mentioned approaching the work in the beginning more cognitively with men than with women (P3/35).

4.3.4 'I–It', No Mutuality

Although analysis revealed therapists aimed to create an interpersonal experience of *'being with, in a mutual, giving and taking type of relationship'* (P11/23) with their female sex addict clients, they described the relationship in the beginning of therapy as being more characterized by properties of an I–It position (Buber, 1958). Despite this being typical of the early formative stages of the therapeutic relationship, they also mention it might continue for years.

> *Now although I am in the room they don't really see me in the room. I am an object and it could be like that for a few years.* (P4/14)

Analysis revealed therapists to feel like the client was an *object* and *'not a person in the room opposite them'* (P4/14). One therapist described perceiving his client to be so removed from his reach that he experienced her as a *'dead object'*. In describing her as an object to be observed, admired from a distance, he conjured up an evocative and complex image of both her beauty and deadness by comparing her to a white marble Michelangelo sculpture. While he described properties of aesthetic beauty he also recognized little or no potential for human relatedness. This tension was reflected elsewhere in the data: anything authentically erotic or creative was reported as being unreachable, heightening the therapist's struggle to find something on which to build some, or any, *spark* of vitality in relational connection.

> *She is a very, very beautiful object to look at. It was like looking at a beautiful statue by Michelangelo. There was a deadness about her but at the same time she had a beautiful smile. I perceived her as not so much an object of sex, not even desire, but an object of beauty.* (P9/21)

Therapists also reported experiencing a pull within themselves toward passivity which seemed to mirror some of the clients' *deadness* with one saying *'I won't have to work very hard – I will listen and just be supportive and empathic'* (P10/21). Therapists also mentioned their interventions particularly tended to implement early nonverbal proto-communications and core conditions such as empathy and support.

While findings showed therapists as seeing sex addiction as a reflection of the client's derailed attempt at *consummation* and *union*, they mentioned any shift into a more intersubjective or mutual connection in the therapeutic relationship as being managed both slowly and carefully. They described the movement toward mutuality as *not to be forced*, and noted if they moved too quickly or interpreted things too promptly they were in danger of evoking shame in the client. One therapist described *'holding back on interventions and questions to build the relationship and the contact slowly and gradually'* (P11/53). Therapists talked about avoiding a premature or misplaced attempt to move the early relationship from a one-person to a two-person to a three-person as it risks triggering her interpersonal defences.

> *In a one-person relationship position, if you introduce them to a two-person they will freak out and try to ban you or get rid of you. It is slow and difficult work.* (P11/51)

Therapists reported that in the early relationship there is little or no interpersonal energy, or *flow*, despite attempts to enliven the inner deadness of the client and get a relational flow going. The clients' fragile sense of *self* and intolerance for any deep relational contact or exploration meant that close relational contact can be experienced as overwhelming.

> *There was no way I could get any flow in any kind of conversations without her either collapsing again, and more often than not at the beginning, into terrible anxiety which would be overwhelming for her.* (P10/21)

4.3.5 In Here/Out There

A salient property of Forming Relationship involved a process of bringing the affective material, which is sexualized and *acted out* by the female sex addict, *into* the therapeutic relational space. Findings indicated that while clients frequently arrive *'with a huge excitation to act out'* (P11/15), the formation of the relationship relied on a shift in the female sex addicts' centre of regulation from an externalized and sexualized behavioural pattern of *acting out* to an internally experienced process of self/other-soothing. This *acting in* was mentioned as occurring in the therapeutic relationship with the therapist as well as with significant others outside the therapy.

> *It is so much about bringing that affective energy back into a relationship and not having it split off. Then I think the affect regulation changes. But that's the difficult bit I think. They want to take it outside rather than bring it in.* (P11/30)

> *Their dysregulated affect gets pushed all over the place and as they have no internal objects to regulate this so they want to get rid of it outside of themselves.* (P12/23)

While analysis revealed therapeutic contact to stimulate affective and erotic experience, abstinence from sexual acting out led to *'the return of some of the affect that has not been regulated'* (P5/9); as one said, *'when the behaviours stop it* (affect) *is brought inside the relationship and into the therapy'* (P11/30). Therapists reported helping clients to identify the boundary between their feelings and their behaviour and helping them to see that, while they can have their feelings, they cannot act them out (P12/46). Findings also showed sexual abstinence to be a key and contentious dimension and mentioned it as either underpinning or undermining the therapeutic relationship.

Analysis showed the forming of relationship as central to the work and that this included relationships *in* and *out* of the therapy room. Therapists saw female sex addicts' capacity to use intimate partners and social relationships (particularly in groups with other women) as being as important as the processes which occur inside the therapeutic space with the therapist. In fact, a client's relationship with her intimate partner is often mentioned as being the focus of work in sessions.

> *A lot of the time I am doing couples therapy even though there is only one person there. How to manage a relationship and how to manage yourself in the sense of asking for your needs to be met and your feelings to be dealt with effectively.* (P2/13)

Therapists described how these interventions inside the therapy room are designed to have a direct impact on how the client uses her relationships outside the therapy.

> *She needs to be able to do this with her partner and that is the key. She has to be able to do that with her partner – in partnership and say to her partner this is what I am feeling and this is what I am thinking. Maybe she needs reassurance or maybe she needs him to stop doing something.* (P2/12)

4.3.6 Uniqueness of Each Dyad

Therapists reflected that each therapeutic dyad comprised unique conscious and unconscious, co-created dimensions and said that they work differently with each female sex addict. While one expressed the consensus of approaching the work without any *'pre-constructed framework'* (P3/33), another reflected on the *uniqueness* of each woman and described a group therapy in which she observed her female clients engaging in individual ways with the same task and remembered that *'each woman did it differently'* (P1/31).

> *I have worked with some very badly damaged clients and each one I work with differently. I don't mean unethically or improperly, I mean I am going to have a different relationship with each one. Every client I am going to have a different relationship – it has to be different for each one.* (P3/20)

Findings exposed a tension in the data between the pull to approach the client in a top-down or bottom-up way. While therapists mentioned the importance of seeing the subjective individuality of the client, and described their focus as being on the *person* sitting in front of them rather than the *symptoms* of the condition, they mentioned wrestling with seeing the uniqueness of the person versus the sex addict.

> *I am getting to know the person sitting in front of me and am always looking to see what the addiction is about for the woman sitting in front of me and always looking at the primary issue going on underneath the sexually addictive behaviour and asking what this constitutes.* (P5/12)

Analysis showed that forming a relationship involved a *unique set of responses* to one another and this to involve an inherent quality of *multiplicity* in the emerging multi-layered relationship. Therapists commented that each dyad co-creates a set of unique responses and acknowledged that what was therapeutically helpful for one client may not be as helpful for the next.

> *You are getting to know the person, your responses and her responses to you, both conscious and unconscious. I mean you sort of find your way into the person. Your response to her and her response to you, both conscious and unconscious.* (P3/10)

The following section reflects therapists' descriptions of their personal characteristics, professional training and beliefs and attitudes to women, sex, and affect as it is mentioned as influencing and shaping the process of affect regulation in the unfolding relational processes.

4.4 The Therapist's Edge

Analysis found that, while properties and dimensions of forming and developing the relationship are key in therapy for the female sex addict, these processes were significantly influenced by therapists' sociopolitical and personal beliefs about women, sex and addiction, and their innate and learned styles of relatedness and personal regulation. These processes were also mediated by each therapist's level of experience, type of training and focus of personal work.

> *Each therapist will have different ways of dealing with it depending on who they are. Depending on their regulating style, the training, all in very different ways.* (P1/81)

4.4.1 Women, Sex, Affect and Addiction

Analysis revealed therapists to hold beliefs and attitudes to women, sex, affect and addiction which they described as being shaped by personal and socio-political-cultural influence and at times as feeling like a *presence* in the intersubjective space. These are reflected in both their conscious attitudes and their implicit beliefs and at times were more observed by the researcher than acknowledged by the therapist. While therapists' said they can *bracket off* this material they also reflected that *'it is crazy to think that social constructs don't exist'* (P11/31–32). Therapists' presuppositions about gender, sex and addiction were revealed to influence the processes of relational engagement and approach to regulation and levels of *'safety and trust'* (P5/6) in the client. This is reflected in dimensions of attitudes, beliefs and biases which particularly involved processes of complying or non-complying with social sanctions, using stereotypes, dealing with stigma and considering difference.

Stigma and Stereotypes: While there are certainly similarities and differences revealed in the analysis in terms of views on gender, some therapists see women as being more difficult to treat than men and part of this challenge as being based on the *stigma* created by social, cultural and personal attitudes to sex and women. These were mentioned as being experienced at semi-conscious and unconscious levels by both therapists and female sex addict clients and include issues of stereotyping, negotiating gender difference and power difference. These dimensions were said to influence relational processes by either enhancing or inhibiting the creation of *'safety and trust'* (P5/6) for the client. This was particularly mentioned as mediating levels of client disclosure, robustness of the alliance and level of depth of relational process.

There was reference to a societal split or *double standard.* On the one hand we are bombarded at close quarters by tantalizing, seductive images in the media and yet on the other

discouraged to challenge the *status quo* surrounding society's good and bad ideals about sex and women. One therapist described the illusion of *safety* in complying with social expectation and stereotyping.

> *In our society sex is in our face all the time wherever you go, but if you cross the line by God do people attack you.* (P6/48)

A female therapist illustrated this sociocultural discrepancy:

> *Good girls aren't meant to be sex addicts – good girls go to heaven and bad girls go everywhere.* (P2/40)

Power: While therapists viewed men as using sex to achieve *power* they saw women as using sex to achieve *relationship security*; there was a strong theme constellating around gender difference for therapists that revealed held beliefs about power in the context of sex and addiction. While therapists mentioned having an understanding of fundamental differences between men's sexuality and women's they were aware of distortions of power in the room with the female client. Female therapists often voiced anger, regret and frustration that women suffering from all forms of hypersexuality and sexual addiction are expected to fit into a male-oriented model of assessment, diagnosis and, specifically, treatment approaches.

> *I wonder if we looking at different types of female sexual behaviour where it may be labelled within a patriarchal society as drug companies are trying to find a female disorder sake we will give you a pill. Are we playing into the male-dominant field and are you actually opening up how female sexuality is expressed particularly sexually compulsive behaviours. Some women might be very happy with their activities – people who are polyamorous for example. Perhaps what they are doing is disconcerting the status quo and hence getting labelled.* (P3/42)

The Masturbation Myth: While therapists said they made the same treatment decisions for men and women the analysis clearly did not describe this. This was particularly demonstrated in relation to facilitating client disclosure. Therapists believed female sex addicts to be more resistant to opening up about problematic sexual behaviours, and suggested that this often occurred in the context of compulsive masturbation. The clients' level of openness about sexual self-stimulation was mentioned as reflecting qualities of the therapists' *style of enquiry* and this was seen to be influenced by their underlying beliefs about sex, addiction and women. While therapists talked about facilitating their clients' capacity and *willingness* to

disclose sexual behaviours, one male therapist reported his experience that *'women don't masturbate'* (P2/6) and a belief that *'women lie about that stuff'* (P2/8). At times a sort of defensive humour seemed to manage his discomfort, revealing an attitude toward his client's sexual behaviour.

> *I had one recently who is really pretty blatant [laughs nervously] and almost pornographic describing her affair she was having with someone at the same time that she was living with another man. She was pretty blatant about just describing having sex in the parking lot and having sex under a table somewhere at an exhibition! It was pretty wild, but that is pretty uncommon at least for the clients that I see. They are more the romance type.* (P2/4)

Social Sanctions: Views were also expressed of what seems like an *unsanctioned* sexuality for women.

> *The difference is reflected in the lower power position women have. It is not socially sanctioned for a woman to act out. If she breaks up with a partner and goes out on the prowl to find another man it is not considered good. If a man does it they say oh well poor guy has a broken heart.* (P12/28)

Attitudes to Gender: While therapists described an emerging trend of women presenting for therapy with a more male sexual template, one said, *'I don't think it can be a totally divided male/female behaviour'* (P3/11) and said she was *'very wary of anything that lumps the girls with the boys too much'* (P3/1). Analysis indicated therapists to believe women sex addicts are too often understood from a male-oriented perspective and yet they still had an expectation of gender-role-characteristics in sexually addictive behaviour patterns, saying that *'more and more of my female sex addict clients are coming in with what look like a male template type of sexual addiction'* (P1/7). While they said they believed women needed to be understood in a different way, evidence of their sexual-social conditioning emerged in how they make meaning of female sexual behaviour. One gay therapist commented:

> *She would say things in a very bravado way saying that she liked to have sex probably more like a gay man because she would do sex with waiters at parties in the lavatories.* (P10/9)

Analysis also revealed therapists to hold beliefs about gender-specific styles of affect. Therapists reported having expectations of female sex addicts as *'more likely than men, not to*

be in control of their feelings' (P2/3) and used the word *'hysterical'* to describe the female sex addict's intense and unpredictable affect. One reported finding *'women's nervous energy often very high and exhausting to be around'* (P11/44). Another reflected a tendency to stigmatize under-regulated and hyperaroused affect in women, saying:

> *Women are more agitated generally, with females there is much more agitation. I would even go so far as to say hysterical – high intensity and more than the men I have worked with. That is a generalization but definitely more than the men I have seen.* (P8/145)

This gender difference is also mentioned in the context of the perceived capacity of male therapists to work with early implicit developmental disruption in a relational approach with female sex addicts. A female participant said:

> *I don't know how male therapists do it but they do. They learn it but it doesn't come naturally. What is it like to have a child who is screaming with tears and fear having scraped their knee and how do you do that as a mother. Mothers 'know' how to do that – but fathers have to watch and learn.* (P1/71)

> *I think as a female sex addict I don't know that I would want to go to a man.* (P12/55)

In holding attitudes to therapists' competence determined by gender, one believed gay male therapists are *'gifted with this issue and have a strong feminine'* (P1/84); she believed most straight male therapists do not and had a view that male therapists are naturally more cognitive in their approach (P1/84). There was a tension in the data about whether it is the gender of the therapist that has greater influence on the capacity for relational depth in therapeutic work or the particular training, personal work and length of supervised clinical experience. One female therapist reported feeling more at ease with male sex addicts and their gender-specific characteristics and explained: *'my own kind of feminine strength I never had much time for.* (P12/85). She reflected that her personal work in women's groups enhanced her own feminine strength which supported her capacity to work with women in a deeper relational way (P12/85).

4.4.2 Innate Ways of 'Being With'

Therapists mentioned their innate personality characteristics as influencing their style of contact and *being with* their female sex addict client. As analysis progressed what seemed to emerge was a demonstration that therapists attribute innate characteristics (including at times

gender and autobiographical factors) to the style of contact in which they engaged with their clients. Some talked about *being born that way* and even suggested that perhaps this was not open to change or revision, that they were just *'meant'* to be this way and *'couldn't work another way'* (P1/99). Others mentioned character *traits* as having a sort of embedded quality of permanency and suggested a more fixed quality located *deep inside* themselves. While one therapist observed *'it's the avoidant in me. I don't encourage dependency'* (P12/95), another said:

> *The dependency needs and the fear of abandonment for the female sex addict is such that they get hooked into relationship and evoke feelings in me of wanting to get the hell out.* (P2/18)

Some therapists tended to be more oriented than others toward using *intuition* and working more with implicit processes of the countertransference in the work in a *'raw, intimate way'* (P1/98). While this was described as being an inevitable part of the early reparative, developmental work, and, as one said, *'they become very attached to me. I do not worry about dependency*' (P6/39), others seemed to be more contact-averse and task-focused, using left-hemisphere-orientated interventions involving behaviours and cognitions. They described being more *in their heads* and relying more on words and logic. While one saw his style as being more *'distant and detached'* (P2/17) and another reflected on a supervisee who exhibited *'a very armoured and a very rigid'* (P1/42) personal style, others believed they could be *'too emotionally reactive'* (P8/171).

One described how her innate personality traits perhaps shaped her choice of training.

> *Now there are many, many ways of working with people in therapy that do not have much emphasis on the therapist's affect and regulation, classic psychoanalysis is an example – I was never meant to be a blank screen thus I never even bothered trying to train into that way … So I think this is the engine that drove the train.* (P1/98)

What also emerged from the analysis was the notion that while *ways of being with* the client were, on some level, considered to be innate qualities in the therapist and as such remain fixed, new patterns of regulating and relating were also mentioned as being *acquired*, *learned* and *developed*. This is specifically referred to in the context of training, personal work and development and supervision.

4.4.3 Professional Training

All therapists saw their clinical work with sex addiction as continuously evolving and developing over time and to involve the continuous integration of new knowledge, being on the edge of emerging information and theory, and holding an attitude of openness and willingness to learn.

Capaciousness, Flexibility and Adaptability: Therapists mentioned training as having an impact on aspects of personal growth and development, particularly in terms of expanding their capacity to *be with* their clients in an interactive and relational way. These included dimensions of capacity for proximity in terms of closeness and distance and depth of intimacy, as well as levels of tolerance and compatibility in the coordination of shared affect regulation with the female sex addict. While Certified Sex Addiction Therapy (CSAT) training provided therapists with a task-focused model for sex addiction, one mentioned how Somatic Experiencing (SE) training actually changed her way of working by creating new and greater personal self-function capacities. This, she said, enhanced her competence, confidence and efficacy in working with female sex addicts, and in particular she was now able to work beyond her previous personal limitations which historically hindered the work.

> *I believe I can now work with clients I couldn't have worked with before because of this significant additional piece which has allowed me to change my affective system because of the training I went through. If I hadn't I would still have the limitations we talked about and now I can work fairly well with most of these clients even if I bomb out spectacularly.* (P5/100)

Analysis revealed that aspects of therapists' personal development are experienced as developing a greater sense of embodied or *inner space.* They said that in this larger sense of space they felt like they could hold more of their own and their clients' affective processes and that this allowed them to work with a greater range of dysregulated affective client styles.

> *The somatic work and regulation of affect and the body senses has expanded and deepened how I work so as I said earlier I could probably work with that client now and I couldn't then because I didn't have enough capaciousness in my own system that I can now hold and as I said it's only because of the somatic uh work that I was able to develop that. That was the only way I could hold it.* (P12/98)

Training was also mentioned as developing a capacity for *flexibility* in terms of being more fluid and less rigid in the changing and swirling movements of the intersubjective affective rhythms and dances. This was reported by therapists as allowing a greater capacity for *adaptability,* which they say is so important in terms of being able to adapt their own affect

systems to the system of the client and manage diverse relational rhythms from client to client. This creates a capacity to manoeuvre with the variation in the breadth and depth of the clients' affective experiences. Therapists said that this meant that they become and remain more *available* for each client by adapting to the client's relational and regulatory style more effectively. This was seen as enhancing deeper contact over time.

> '*I am different with everyone who comes into the room'* (P10/73).

Very Particular Personal Work: While analysis revealed the dimension of personal work to influence therapists' approach to regulation in relationship with the female sex addict, male therapists mentioned their work as being particularly shaped by their experience of personal sexual relationships and sexual templates and that as male therapists, they recognized issues of working with women to be insufficiently addressed in training; '*I think there is a gender-specific piece here and we are not made to think about that and include that'* (P11/29).

Personal therapy with an opposite-sex therapist was mentioned by male therapists as being important and was reported to open up the parameters of personal limitations in relation to their responses as a male to female sexuality. This resulted in therapists being less vulnerable to *missing key elements* in the processes of the work with female sex addict; one reported that he intentionally chose an opposite-sex therapist, so that his own erotic energy could be explored at depth in therapy in relation to a woman. He recounted:

> *I purposefully sought a woman to go and see for analysis. I have been in therapy before and I knew there was a part of me missing, the part that really is able to get inside her, be part of her, that real experience as a man. From my personal experience there is a difference and a necessary difference.* (P10/32)

Part of the personal work for therapists is mentioned as involving integrating the learning value of personal experience from a personal arena. Therapists described the value of the personal growth in their sexual relationships and commented that this had a direct impact on the level of clinical sensitivity in their work. One reflected on the value of *'taking some nourishment from that which has been fertile in my life outside in my own sex life'* (P4/18) and another reflected:

> *It's been an interesting awakening for me to experience the sexual energy and sexual frustration of women and sexual power of women through sexual appetite, the capacity to multiple orgasm, to stay longer in sex, all of those things feel quite intimidating, quite powerful on some level, and I believe that comes into the therapy*

and based on my development as a therapist can get missed by me. If I have not really considered it, worked through how I feel about it and how I understand it then I will miss it and if I am really honest I have missed that sometimes because it has come into awareness in supervision. (P11/41–42)

Serving the Apprenticeship*:* A poignant finding showed therapists as needing to *serve the apprenticeship* (P5/13) in experiencing their own sexual recovery. They mentioned learning how to regulate their own affect and sexuality in non-addictive/non-compulsive ways. One mentioned that if he had not learned how to regulate himself he could not participate effectively in the therapeutic process of co-regulating with the client:

I had to learn how to regulate my affect in more wholesome and efficient ways. That means I am in a good position to hold, absorb, and to be with another person in their affect. (P5/17)

While therapists disclosed their personal experience of sexual addiction, one reflected that the personal work *'is not so much about perfect recovery'* but more about raising personal awareness of these processes and arousal triggers (P1/42). Sexual issues not explored in the personal work for the therapists were mentioned as inevitably interfering with the therapeutic work, creating difficulty in the therapy and limiting the capacity for engagement.

The first thing is that for a psychotherapist if he or she has in any way got unresolved issues around their own sexuality and their own sexual experience and their own comfort in their own skin then it is going to come up in the work – it has to. (P1/40)

Getting Down, Dirty and Honest: Therapists said their own particular sexual arousal template can occasionally be triggered in the work, although this occurred less often with greater levels of personal work and length of clinical experience. Therapists noted their personal work contributed to having a *'great ease and comfort'* (P4/18) with sexual and erotic material while working with female sex addicts. They described this as arising from being able to talk openly about the experience of clinical work with colleagues and supervisors, as well as from the depth of their exploration in personal patterns and honesty about difficult personal material.

If you don't look at your own life and get down and dirty and honest with it you won't pick up those strands of the people you work with and therefore you won't lead them to a different way of actually being in relationship with better boundaries and more containment. (P11/70)

Training, personal work and supervision are also mentioned as enhancing the capacity of the therapist to work effectively at depth with unconscious processes (P11/51) and to engage fully with the implicit relational dynamics with the female sex addict. Therapists described working with unconscious material; such as clients' unformulated and dissociated erotic-affective experience, and derailed intra- and inter-psychic working models and internal object representation. They saw this as being central in the relational work with female sex addicts, who typically present with high levels of early and adult relational trauma.

> *Awareness of working with my own issues within this particular subset of work I think is so essential, particularly when this countertransference comes up ... it might not be extreme but it might be very low level and I might not even be aware of it. What might happen? So this takes particular personal work and supervision*. (P1/42)

4.5 Managing Risk and Safe Surprises

While Risk and Safe Surprises are seen to be two sides of the same coin, this category reflects the tension described by therapists in the data in managing *'the balance between protection and availability'* (P8/179). Analysis indicated that while therapists experienced anxiety and a sense of precariousness around the risk of enactment, at the same time they sought to create a reparative experience for the female sex addict in therapy. These dimensions were organized into properties of Therapist Anxieties, Blind Spots, Snags, Hoodwinks and Triggers, and Shame.

4.5.1 Therapist Anxieties

Therapists mentioned that they experience higher levels of anxiety in the therapy with female sex addicts than with most other clinical groups and one reflected, *'the nature of the client's material can elicit such emotional intensity for me'* (P1/49). This was evident in their response to clients' disclosure containing affective and sexual material and in their sense of precariousness described in relation to certain interventions in the processes of therapy. Findings revealed therapists to feel at times disturbed, worried and concerned by the sexual content of client disclosure. While one therapist described it as *'dark, hair-raising and horrendous'* (P1/32) another expressed concern about the affective intensity of the clients' distress especially at times when *'it's about to get out of control'* (P5/18). This activated affect was reported as being *'quite terrifying to listen to'* (P9/28).

> *I always feel worry and a concern that there is something fraught or hysterical about it [heightened affect] which is looking to be in a sense contained and made sense of.* (P11/46)

Therapists mentioned that the biggest challenge seemed to be when client material in the context of relational and sexual patterns most *'closely resembled one's own'* (P3/27). While therapists acknowledged female sex addiction involves an *acting out of anger* that cannot otherwise be experienced or articulated, and that this is usually towards men (P4/80), they expressed fear and concern about managing it in the therapeutic dyad. Male therapists were certainly more anxious than female therapists, with one female therapist reporting *a calm expectation* of this sort of encounter in therapy with female sex addicts (P3/8).

Bird in a Cage: Data revealed therapists to experience the therapeutic process with this client group as *'fraught with difficulty'* (P11/51), and particularly mentioned this as occurring in the context of the erotic transference.

> *If they are sexualizing me, which many clients will, both the females and the males, it can be grim and very difficult for the practitioner.* (P1/59)

Male therapists also displayed higher levels of preoccupation with a range of perceived potential risks and vulnerabilities in the work with female sex addicts, including psychological attacks and complaints being made against them, and described fears of *'ending up in court'* (P10/43). Both male and female therapists described a sort of vicarious anxiety following their witnessing of colleagues or supervisees losing jobs, being fired, and being involved in court cases, lawsuits and complaints being made against them by clients.

> *I've known people who've had complaints made against them. I think it's an area that's fraught with difficulty.* (P10/43)

> *When you are dealing with probable perversions and areas which are kind of dangerous and looking at the potential of legal difficulties this needs a lot more containment and different supervision.* (P11/51)

Men mentioned feeling frightened that the female sex addict could misperceive therapeutic interventions as predatory or sexually intrusive. One male therapist described this anxiety as influencing his interventions and said he felt nervous about probing too deeply or asking for

more detail in his sexual assessment questions just in case the client saw him as being deliberately seductive or attempting to be sexually arousing:

> *I suppose my fear is appearing to be prurient, you know asking questions about what makes you, what trips you into orgasm. Not what you're doing when you're having sex but what trips you into orgasm. Whenever I want to ask anything like this, I always quote the thing that someone said and then ask 'would you find that would be so for you' and then kind of go into it that way.* (P10/43)

Analysis showed that therapists work with an attitude of *vigilance* as they manage proximity to the client, and, demonstrating the female sex addict to be particularly fragile, they managed this sense of precariousness in the work with a delicacy of touch. One male therapist described how he monitored the psychological proximity to his female sex addict client and reported being cautious and nervous about *'frightening'* her with any perceived intrusion.

> *I've stayed back from it rather than putting my foot on the gas, which I might do with other clients. There is something about her energy. It's like a bird that will just fly out the window if it's kind of frightened and yet she is no stranger to the sordid or the extreme kind of pornographic ends of the imagination - her own and other people's.* (P9/44)

Flanks Covered: Therapists described feeling deeply permeated and fearful about uninvited fragments of the female sex addicts' unconscious affective erotic material, and mentioned this as feeling like being *contaminated* by something that is experienced as *'of me, but not mine'*. This material emerges in intimate and personal spaces for therapists, including their own sexual masturbation fantasies. One revealed this material as s*adomasochistic* and reported feeling *'invaded and infected by the other person's illness'* (P1/42). She described her client's unconscious erotic and affective material as fusing so profoundly with her own unconscious sexuality that it was hard to differentiate the two. This was mentioned as emerging into awareness in situations of least psychic defence, including domestic and personal situations, as a mild social paranoia, as well as in private sexual activity when is it identified as an *'unfamiliar'* sexual fantasy (P10/24).

> *It feels like I am infected with someone else's sadomasochistic patterns and I am noticing it in my own sexual masturbation fantasies or wherever I look I am imagining you know the person in front of me in the grocery store is a sadomasochist*

because of how she is dressed, and then I am frightened now when I sit with my client. (P1/42)

Therapists reflected on strategies they use to manage their *anxieties* in various ways. While one described a defensive counter-therapeutic part of himself as the *'false therapist'* (P11/32) another reflected that he notices what seems like a feigned empathy, lack of emotional authenticity and incongruence in response to the female sex addicts' pain and distress. Therapists recognized entering these places of hardened defence in order to manage their own real, and imagined fears and anxieties as creating a sense of security:

Working with the female sex addict if you have not got your flanks covered you will have some problems. (P5/13)

4.5.2 Blind Spots, Snags, Hoodwinks and Triggers

Analysis revealed that therapists hold a tension between the risks of enacting some affective or eroticized process that *'replicates back then'* (P5/18) and seek to *'enable some new insight/experience to occur'* (P11/45) in the interpersonal process with female sex addicts.

Findings showed that therapists experience this in conscious and unconscious dimensions, describing '*blind spots'* where the client could '*just screw around with her'* (P1/62), *'snags'* (P1/60) and *'being hoodwinked'* (P1/104) at some point in this work. They mentioned engaging in processes of avoiding, working through or repairing enactments with the female sex addict and by taking their affective experience beyond their personal tolerance sometimes resulting in irreparable ruptures and the premature ending of therapy. They mentioned being *embroiled* and *enmeshed* (P9/36) with the female sex addict as occurring often, and this to feel like being stuck in a '*sticky net'* that has been cast out by the client (P1/63) and unconsciously *'caught up in the mess of it'* (P9/36). Certainly this was described as having an involuntary if not passive and powerless quality with one therapist feeling: *'I was really getting sucked in'* (P9/28). Therapists reported the inception of an enactment to occur in *blind spots* where without adequate reflection they remained unrecognized until a significant rupture ensued.

I think based on my development as a therapist that can get missed by me. If I have not really considered it, worked through it, and know how I feel about it and understand it then I'll miss it. (P11/41)

Being Walter Raleigh: Male therapists mentioned an enactment process involving the role of *rescuer* with their female sex addict clients and described this as often pre-empting the premature ending of the therapy. This *rescuer/victim* reciprocal role dynamic was reported by male therapists who described the female sex addict as often pursuing a *'man to rescue them'* (P3/14). Analysis revealed one male therapist as being entangled in a *rescuer* role enactment (P9) with his female client and engaging in contact with her family, and taking on a *helping* role beyond the boundary of the therapeutic relationship. Another therapist also mentioned this *blindness* to the boundary around role.

> *I got involved with her son's case and helped with it so it was a bad idea from the therapy point of view because I crossed boundaries and she began to respond to me in a dysfunctional way, in that old unhealthy way.* (P2/21)

Findings showed therapists as identifying a boundary they say they can overstep in the context of an enactment in therapy (P9/36). They described this process as feeling like crossing an invisible line, or *overstepping the mark*, but often noticing it too late; as one says, *'I realized after a while that I was getting enmeshed in the mess'* (P9/36). Some therapists were more aware than others of their narcissistic pull toward female sex addicts and their need to *'cure'* or *'get them well'* (P9/31) as well as feelings of powerlessness and impotence. A female therapist recalled feeling deeply disturbed by a process involving a supervisee.

> *She would never have become sexual with this client but fell right into a co-transferential blind spot where she allowed this young women to just screw her around and stay in her house one night and sleep on her couch and cuddle up next to her and then filed a lawsuit the next day.* (P1/62)

While findings showed therapists to be aware of implicitly co-created enactments they also reported that they experienced episodes of more explicit seduction and mentioned these to feel *'really gruelling; hard, difficult and gruelling'* (P1/114). This was more likely to occur for male therapists who mentioned female sex addicts as engaging in eroticized behaviours in session, observable both in their physical appearance with seductive dress and make-up and gesturing with eyes, and body movements such as: *'ruffling hair in seductive moments'* (P9/19), *'licking chocolate on her coffee lid'* (P11/45), and bringing a banana to a session which she *'ate after propping it up like an erect penis'* (P10/46). Certainly all male therapists experienced female sex addicts arriving in particularly seductive dress and *'fairly obvious manipulations like short skirt and buttons undone on her shirt'* (P9/21).

While analysis found that therapists experienced enactments as leading to problematic and risky situations they also described the relational field as being like a minefield replete with *danger, triggers* and *alarms*. Therapists described often *'bombing out'* (P1/41) in therapy and on occasion endings as involving '*an explosion of some kind'* (P1/41); they also described the precariousness around invisible triggers with one describing his awareness of his female sex addict's *'false suffocation alarm which fires off at the tiniest event'* (P9/24) – describing something as *firing off* implies both risk, speed and danger. Others also mentioned holding this sense that something unexpected could happen *'at a moment's notice'* (P5/18). One therapist described perceiving clients' unexpressed erotic and affective material as being *'pushed into one small intense area, which becomes dangerous'* (P11/48), and being easily triggered with no warning signs (P12/82). These properties evoked an image of the intersubjective field as dangerous terrain and reflect therapists' consistent sense of working with unpredictability and uncertainty.

4.5.3 Shame

Analysis revealed therapists to see shame as a central affect involved in organizing and perpetuating sex addiction and as involved in complex processes of dissociation, isolation and acting out. One therapist illustrates this with The Little Prince:

> *Do you know The Little Prince? 'Why do you drink?. 'Because I am ashamed'. 'And why are you ashamed?', 'Because I drink'. That cycle repeats itself in sex addiction. I had a woman client who was a sex worker who committed suicide and she used to say 'shame is to sex addiction is what oxygen is to a fire', and I have never forgotten it.* (P8/8)

Therapists mentioned shame as an interpersonal obstacle in therapy between themselves and the female sex addict and said that it required working with sensitivity and caution. It was also seen as mediating dimensions of openness and availability (P7/179; P12/31), levels of disclosure (P2/11), reinforcing interpersonal isolation, and perpetuating sexually addictive behaviours. The importance of reducing shame is seen as central to the treatment of sex addiction.

> *Someone who has a low level of shame is not going to do shameful things*. (P2/27)

Therapists mentioned working to reduce clients' levels of shame as involving implicit and explicit processes. Explicit processes included educating clients about the nature of the condition they suffer with, and providing knowledge, information and understanding; one therapist remembers a client reaching an understanding of what was wrong with her, declaring *'I am not a freak!'* (P6/33). Directly addressing and exploring the relationship between sexual addiction and shame with clients was mentioned as important in helping them *'know where the addiction comes from'* (P6/34).

> *I think there's a lot of shame around and I don't think it's really named early on but it is always looming over the horizon. At some point in the therapy I usually will say to people, you know what this is, this is shame isn't it. This is a wound to the self and you can start doing some education work around it.* (P10/45)

Shame is mentioned as being *held in a balance* and implicitly felt as being a *'hair's breadth'* (P12/82) away from being triggered by therapists who linked it to episodes of dissociation and *'explosions'* (P1/41). Interventions concerning shame are described with more over-regulated clients as being more paced and measured so as not to *push* those with alexithymic presentations to identify their feelings when they do not have adequate self-function or ego strength to do this. This is mentioned as risking evoking shame and beliefs of inadequacy and leading clients to *'wonder why they can't feel and thinking that there is something flawed about them*' (P2/27). This said, one therapist described an intervention with his client in which he revealed his great care not to collude with her existing patterns of overexposure and of shame:

> *What I often find is that for many people who can't feel, who dissociate and are numbed out, the first feeling is of relief when we honour it as a defense that kept you safe, rather than as something that defines you as being wrong or bad.* (P5/18)

While female sex addicts were observed to be *'deeply embarrassed if they have been particularly promiscuous'* (P2/27), therapists talked about endeavouring to *decouple* shame from other affective experience and about how shame, blocking the experience of fully feeling other emotions and needs, is said to be particularly prevalent for women:

> *Any emotion not effectively dealt with becomes a source of shame so the female sex addict will get a fix for the shame by getting someone else to care about them and give them love and admiration that they cannot give themselves.* (P2/12)

4.6 Finding a Shared Frequency

This category organizes processes that emerged from the analysis, which describe the relational interface between therapists and their female sex addict clients. Dimensions are organized into properties that reflect the most salient processes involved in *tuning into* as well as *retuning* the frequency on which clients and therapists interact with affective and erotic experiences in the therapeutic relationship. The data yielded from analysis reflects these co-regulating processes as occurring in unconscious inter- and intra-psychic, somatic and cognitive dimensions and as involving implicit and explicit, nonverbal and verbal communication between therapist and female sex addict. There was a rich variation in the properties, dimensions and qualities within this category, which both unfold from and are influenced by factors already mentioned in Forming Relationship and The Therapist's Edge.

4.6.1 Entering Each Other

Analysis revealed therapists to experience processes involving relational rhythms of contact and engagement and indicated these to involve the ebb and flow of interpersonal connection, which included dimensions reflecting a sensuous dyadic dance. These involved *uncovering, opening up, drawing out, finding their way into each other, getting underneath* and *waiting* for material to bubble up into awareness. Therapists described these interpersonal rhythms of attuning to each other as having a sort of sensual and reciprocal ebb and flow, reflecting a sort of erotic and sensuous inter-relational dance involving unconscious and somatic harmonies and melodies.

> *You are getting to know the person, your responses to her and her responses to you, both at a conscious and unconscious level. You are finding your way into the person.* (P3/20)

While this contact was said by some to be more *on the surface* with some clients, for others it was said to be more obscured, with processes requiring a deeper exploration to uncover and retrieve pockets of hidden, affective material located *'deep between layers'* (P10/20) of the clients' psyche. These erotic rhythms were noted in the subtlety of the dynamics of intimate contact, which reflected a sort of entering and receiving of each other. Therapists reported processes of *penetrating* the female sex addict with dimensions such as: *trying to get into*, *getting in, opening up* and *getting up and under*. This was particularly mentioned in the context of navigating clients' psychic blockades, including shame, dissociation and denial. Metaphors of movement including *flow*, *sway*, *in and out* and being *'pushed and pulled back and forth'* (P11/23) echo the rhythms of synchronized dance involving affective, sexual and

erotic components and creating a gentle movement of interconnection between themselves and their client. The mutuality of this process is described thus:

> *It is about bringing the coexisting parts into the other.* (P11/43)

Therapists demonstrated this interpersonal rhythm as involving processes of *allowing* and *inviting* mutual access and described this as a gentle movement, arising from the interconnection between themselves and their client. This was seen as involving the process of the female sex addict *picking up on* and *taking in* psychic parts of the therapist and while therapists described being aware of the clients' capacity to *take them in* this was often monitored and measured as not involving taking in *a whole* but slowly and *'bit by bit*'. One therapist described acknowledging this to her client.

> *And you don't have to take me in as a whole, you can use bits at a time. Some you might use and some you might not. There are bits of Mother you liked and bits of Mother you did not.* (P4/28)

Therapists commented that at times they felt like they had to *be invited in* by clients or wait to be *given permission*, and sometimes they were *not allowed* in at all. At times, when contact was perceived as too intrusive and *too much* by the client, it was *suspended in the room*, rejected, kept out or pushed away. Notwithstanding the complexities of these interpersonal rhythms, therapists did also mention a different type of contact and connection involving a *locking in* and connecting to each another.

4.6.2 Locking-In

While analysis demonstrated processes of attuning and connecting to occur at multiple levels, therapists reported their experience with female sex addicts more often than not as resembling the early mother/child dyad, and described this as being a nonverbal, and implicit, *merged* state. Therapists described a strong, implicit and primal connection with their clients which they characterized as *joining* or *merging together* and saw this as reflecting a function of the addictive relationship.

> *Like addiction this is a merger experience.* (P7/25)

Therapist said this sort of *'locking in'* (P6/49) or *'plugging into one another'* (P4/14) established a sort of *exclusion zone,* which intensified and heightened the focus on each other and created a feeling of immunity to outside intrusion. This was mentioned as allowing the

exchange of implicit intra- and inter-psychic material, early implicit forms of communication, and stimuli and nourishment to occur between therapist and client. These implicit processes reflected processes of *absorbing* of and from each other and as configuring a complex, mutually reliant and influencing system, which is described as involving intuitive and automatic processes that are not intentional or planned (P5/26). This primal, or womb-like state echoes the early symbiotic attachment between the mother and infant and suggests the connection as involving *'absorbing'* (P5) of each other's psychic parts, and *'mirroring'* of feeling states, as well as the movement of material from one to another.

> *I think that sometimes this is what our brains were designed to do and what we do is mirror that. As an infant absorbs from the mother, so the mother absorbs from the infant. As an adult to adult we are co-communicating as well. I am absorbing from them and they are absorbing from me.* (P6/50)

While therapists mentioned that they were able to absorb the client material they said that they were *'not phased by it'* (P5/17 and mentioned this level of connection as being intuitive and automatic and not as intentional or planned.

> *It is intriguing because at one level I am doing this intentionally but at another I am not.* (P5/26)

This *locking in* together was also mentioned as occurring through explicit, nonverbal processes of proto-communication including: eye gaze resembling the dynamics of early mother/child transactions –*'it is visual, through the retina'* (P9/18), visual expressions, body posture, gesture and movement, and prosody.

> *On one level you are actually in the proto-conversation with the client. I think just as they look at you … it is like babies/infants and mothers who are locked and so are we, we are locked in like this in the therapy.* (P6/49)

Therapist as a Conduit: Therapists saw themselves to be *conduits* of connection, and, as such, reported the connection with their own affective and erotic subjectivity to create a synchronicity with subjectivity of the client. Analysis showed this to be particularly important with female sex addicts in maintaining connection to the therapist: *'if I do not stay engaged with my own process they do not stay engaged with me'* (P3/15). Therapists mentioned that by monitoring and identifying their own range of affective experience in response to the client that this seemed to ensure the client did not disconnect either from herself, the therapist or the therapy.

> *If I am not able to connect with my affect and my own bodily reactions with my sex addict clients whether it is disgust or it's excitement or it's my own eroticized rage, whatever it is, if I don't connect with it to some consistent extent throughout my work, clients either dissociate, they leave, they shut down or they act out.* (P1/43)

Therapists commented on the ongoing tensions involved in remaining *embodied* and connected to their subjectivity in this way, and described navigating between head and heart; one said, *'I have to watch myself. I can also become too heady. I can get too cognitive'* (P3/14). Others mentioned the importance of moving *'from head to body'* (P7/176) as ensuring a particular quality of relational intersubjectivity and consistent awareness of their embodied affective experience as safeguarding the connection to the client.

4.6.3 Co-Regulating

A central finding showed therapists to engage in processes of retuning clients' regulation settings and this to involve processes reflecting early developmental repair. Therapists reported taking on the role of the co-regulating, reparative other/mother, transitional object and regulator. They mentioned modelling how to regulate affect to their clients, saying *'I practise what I preach, just as I regulate my emotions they see it in action'* (P2/ 27), as well as being a channel for the client. Findings also showed processes of regulation between therapists and their female sex addict clients to occur in multiple domains and to involve multiple selves. This was described as feeling like *'conducting an orchestra'* (P10/59), or:

> *Like trying to pull it all together, you know it's been often placed in parcels all over town and it's like retrieving them and locating them where they really belong so that she can then have the experience of her affect.* (P10/60)

> *On another level I am watching the person and monitoring what is going on and looking at what is working for them and what is not - I am also observing. Another layer I am aware of when talking about it supervision is that I am observing us both.* (P6/49)

Therapists mentioned processes of co-regulation as being on a dimension ranging from *action* to *observation* (P10/62) and this as being influenced by the clients' style of regulation. Working with clients' under-regulated affective styles was described as involving processes of *'softening', 'calming'* (P6/35) and *'dampening down'* clients' affect by *'containing',* and holding it in the room, in the intersubjective dynamic and in the therapists inter-psychic and somatic system. This was particularly mentioned in moments when affect was perceived as

becoming *'out of control',* creating in clients' an *'urge to reveal all'* (P5/18), despite the risk of feeling emotionally over-exposed. Therapists said with under-regulated clients they tended to intervene more directly with explicit and verbal approaches, gently and firmly controlling the clients' pace of disclosure and thus their affective arousal. With over-regulated *'numbed'* and *'shut down'* clients, therapists described using interventions involving unconscious intra- and inter-psychic processes as well as nonverbal somatic interventions to *'open up', 'enliven'* and *'stimulate'* clients' affective experience.

4.6.4 The Unconscious Web

Analysis revealed therapists as seeing processes of attunement and co-regulation with their female sex addict to involve implicit communication including unconscious and implicit inter- and intra-psychic processes. Therapists mentioned this dialogue as involving both the clients' and their own dissociated erotic and affective material, which they said inevitably, merged and emerged in their own psychic system.

> *Addicts communicate mostly through splitting so I know I am going to feel everything at some point they do not want to feel for themselves.* (P10/30)

Fantasy and Dreams: This unformulated, shared material was experienced by therapists at a *'very low level that* [they] *might not be aware of it'* (P1/41) and as being often represented in their own, and the client's, psychic system as erotic and affective imagery and cinematic narrative in fantasy and dream life. These images, metaphors and stories were seen to represent the nonverbal intra- and inter-psychic affective and erotic material shared in the therapy between client and therapist. Therapists described experiencing recurring images and dream sequences as well as sexually sadistic fantasies in the sessions. One gay male therapist mentioned being *baffled* by his unexpected and out of context response toward his middle-class female client at the beginning of the work. He reported having thoughts such as *'get your tits out'* and the urge to *'make her come to therapy but not pay',* or to *'take the money but not give her therapy'* (P10/53). Details of the client's double life emerged later in the work and involved deeply dark masochistic sexual activity. The therapist understood the client as wanting him to know this about her *'unconscious to unconscious'* and described his conscious awareness of this implicit communication as allowing:

> *'Something to shift in me which did open up a different space for us in the therapy*' (P10/41).

Dreams were mentioned as being an important dimension of pre-symbolic and unformulated erotic and affective communication between therapists and the female sex addict. They were mentioned as occurring in the therapist and client and seen as a representation of the shared unconscious object organization. As such, they were described as key to grasping and understanding the unexplored unconscious erotic energy between them and the female sex addict.

> *Parts of me could be used as a part object to be thought about and to be drawn into dreams. We could then think about it and bring it into the relationship. Now we can see something different.* (P11/42)

> *She has either dreams about you or keeps asking to marry you, have sex with you, and so on. So it kind of works its way through to them saying I'm having dreams about my father, I want to be with my father, and bit by bit letting that go, so they can let the father go and go and have their relationship.* (P11/27)

Unconscious Resonance: Therapists mentioned the shared and unconscious experience of regulation with the female sex addict as involving mutual yet asymmetrical processes and this as involving acknowledging, *interpreting* and *making meaning* of unformulated material within their own intra-psychic system. With a focus on the internal and intra-psychic processes of the therapists these internal processes are mentioned as creating and enabling a resonance and shift to occur in the intersubjective unconscious.

While therapists talked about a shift occurring from *making meaning* of the clients' and their own experience this was often not articulated as an explicit intervention to the client but mentioned as involving more of an internal process for the therapists. One specifically mentioned how in supervision he was able to reach an understanding of his client's unformulated affective material as it resided in his own psychic experience, and instead of feeding it back to the client or openly exploring it in an explicit process he says he *'placed it on his unconscious web'* (P11/43) where it organically drew itself up and into the implicit spaces of the shared intra-psychic and inter-psychic dimensions:

> *You just put that on your unconscious web and leave it, then it resonates, then it's right it will draw itself in naturally and just remain with, with beyond approach of that, with that memory or desire as best you can. That's what I did, but I mean that insight enabled something to shift and draw me into a more intimate relationship with*

her, then opened it up to let me be used much more as the sexual object, the past sexual object. (P11/43)

One therapist reflected this gain of insight as a state of knowing that required no explicit action and said *'I don't say it, but I feel it and know it'* (P12/47). Others mentioned processes creating interpersonal and affective shifts in the relational space (and in the client) as involving the therapist being able to express and experience the client's unformulated emotional material. One therapist described being awoken from sleep by an overwhelming need to cry. He intuitively understood this intense emotional pain to belong to his client and recognized that not only was it out of reach in the therapy it had also thwarted a deeper contact level with her. He implied here that while this affective material remained unfelt, unconscious and undetectable it created relational distance from the client and had to be experienced in his own conscious awareness in order to free up something between them:

I had not understood the pain behind her destructiveness. Although I might have known it theoretically I had not felt it located in me. From that point on the therapy changed in that I was able to be back in the room with her. (P10/37)

4.6.5 Body Whispering

Umbilical Cord: Analysis revealed therapists to also focus on the somatic and body-based processes that occur in relationship with their female sex addict clients. This intersomatic connection is described as functioning as more than a mere joining of the two; it sets up a sort of umbilical-like portal through which implicit visceral/somatic material can be exchanged.

The Somatic Ear: Therapists mentioned particular processes involving nonverbal bodily awareness and attunement where they *'listen to the client's body affect'* (P5/18). This seemed to be like having a *'somatic ear'* (P9/21). Therapists described feeling a resonance in their own body, which they say resembled a *'sensing*' and *'intuiting'* rather like having *'body intelligence'* (P5/20) in order to *hear* the clients' body. Therapists said this awareness provided them with access to the *unspoken* affective material of the client and allowed them to ascertain and monitor the clients' levels of emotional arousal that is seen often as indicating the presence of more subtle, defended or dissociated information that is hidden from consciousness more typically with numbed clients. One described it as follows:

So if they are telling me their story, their narrative I can get a sense of their somatic affect, emotional affect – their affect bodies and know that this is going into a space where it is out of control and dissociative or re-traumatizing. (P5/18)

Inside Body: For therapists, the work with dissociated and numbed female sex addicts requires deeper somatic and more implicit levels of process; they described experiencing the client's affect as indivisible from their bodies and talk about it being actually inside their own viscera and their soma. Therapists talked about the carried feelings they hold in their body for the client. They mentioned picking up agitation for the client and described feeling the heightened, uncontained, if not *'hysterical'*, affect of the client as a generalized muscle and stomach tension, a change in body temperature and rhythm of breathing, and a generalized body stress (P1/74). This was experienced either in a *part of the body* or as a *whole body* state. One therapist described how her body mirrored the frozen dissociated affective state of her client.

> *My own body, my emotions, now that is the place where I have to look for the subtle work, particularly with very sexually anorexic, numbed, avoidant clients. There is no affect. There is nothing. No energy. No affect. There is very little going on. I notice my body feel a little colder and that is where I have to go for the much more subtle work. My breathing becomes very constricted and I notice my body get colder, my muscles are tightening – this person is very frozen I am sitting with*. (P1/72–73)

Despite clients being terrified of any bodywork and reportedly having no healthy sense of body, with *'their sense of body [having] been removed'* (P3/19), analysis showed therapists to attune to clients' affect using their own bodies in the work. Therapists mentioned this as feeling like the sharing of bodies, occurring *in-between* bodies, *inside* their own bodies at a visceral level as well as on the envelop of the body i.e., sensations on the skin. The body was mentioned as a central focus/frequency of attunement and co-regulation, particularly for the more overregulated *'numbed'* and *'shut down'* clients:

> *Because these women are so shut down, the talking therapies are not going to get us very far.* (P1/74)

Observing Client's Soma*:* Therapists mentioned a process of *'observing'* clients' bodily cues, which they then consider in a process of assessment. They assess the type of affect and the level of clients' arousal by the speed of clients' physical micro-movements and gestures (P5, P12). One therapist mentioned attuning to clients' increasing agitation, identifying low mood and assessing client tolerance, particularly at times when the client appeared *'somatically*

charged at a moment's notice' (P5/18). They said they can assess the need for containment by watching the somatic signals and expression *on* the client's body.

> *I am noticing somatic affect, emotional affect and I am looking at their faces and bodies, I am watching their whole being.* (P5/18)

> *I watch the posture, the way their shoulders are and I watch the breathing, very carefully watching their bodies you know gives me a hint about how where they are you know in terms of their tolerance.* (P12/74)

While findings showed processes here to include attuning to clients' physiological cues, particularly those indicating an escalation of affective arousal, therapists mentioned contexts in which this dimension of attunement was counterproductive. One male therapist mentioned that, working with a disorganized and seductive female sex addict, somatic observation can be counter-therapeutic and misunderstood. He described how, while being sensitive to maintaining an appropriate boundary, he also attempted to remain aware of affective communication in the client's body movements.

> *I had to be very conscious of facial expressions and there was no way I was going to scan her body, as I would do with a man. I would just have to hope that I would see it out of the corner of my mind as she was crossing her legs, tapping her foot, anything that might give away a clue about how she was feeling.* (P10/21)

'Affect-Bodies': Therapists mentioned using specific somatic interventions to adjust their own affective/somatic arousal state and that of their clients. This was reflected to occur in the room by *'ticking up the heat'* (P1/74) as a physiological intervention with emotionally *frozen* clients as well as by explicit body gesture, postural position and facial expression. Therapists also described that by regulating their own somatic/affective state they created a corresponding shift in the client. It was mentioned particularly in the work with under-regulated and over-activated clients that when therapists tended to over-regulate and slow down their own systems the same occurred in the client.

> *I do the other I stay measured I stay calm I look at what emotional state is probably going on inside of me as a reflection and then I try to use my system to regulate them so that they can feel safe and anchored and just ease them gently into an affect transition and eventually their system will just regulate back down again and that has*

a lot to do with somatic work which I do, you use your own *system to help another person regulate.* (P1/61)

She had an anxiety attack right in the room in the second session and I just sat there. The more upset she became, the more calm I became and, I was amazed at this exchange. (P10/65)

4.6.6 Conscious Collaboration

This property organized dimensions revealed by analysis to involve conscious and explicit processes including engaging in collaborative tasks and using cognitive and verbal interventions. These included imparting knowledge, educating the client about the nature of the condition, and putting a frame of understanding around the presenting symptomology, giving homework and in-between-session exercises, and generally implementing a more task-focused approach. While all therapists integrated a certain degree of stage-in-therapy and client-personality-appropriate left-hemisphere interventions, there were some who tended to use this to a greater degree (see The Therapist's Edge). The processes that emerged from the analysis included *'helping her to learn'* (P2/12), teaching, guiding, telling, imparting information, *'correcting misimpressions'* (P2/12) and building *new* narratives reflected a process of *doing together.*

I help her to learn to deal with her feelings in an effective manner and she might be feeling anxious based on incorrect information or misinterpretation. (P2/12)

Therapists described collaboration as occurring in the context of working with both right- and left-hemisphere functions and that interventions reflected these domains as both autonomous and reciprocal systems. While one reflected that working to calm the emotional, right hemisphere arousal *'got her to the point where she is thinking more clearly'* (P2/12), another mentioned the work with the left hemisphere as central to the *volume control* for the more emotional, amygdala-controlled-right-hemisphere. Therapists described an oscillation and integration as occurring between the right- and left-hemisphere functions particularly in the context of psychological development. This was significant for therapists in terms of reflecting the point of developmental damage for the client (P6/19). Therapists saw regulatory repair as involving the collaboration between both.

5. Discussion

This study is one of the first to implement a qualitative methodology to investigate how therapists work with affect regulation in the context of relational therapy with female sex addicts. The data is presented in a theoretical, iterative model, which organizes the most significant findings into five interrelating dimensions. Four categories reflect properties constituting the therapeutic process and these are cohered by a fifth, The Multiversal Space. The emergent findings will be discussed in relation to the literature and the contribution to both theoretical understanding and clinical applicability in the field of psychology, psychotherapy and addition therapy will be considered.

5.1 The Multiversal Space

Findings show the interrelated and multidimensional dynamic nature of relational therapeutic processes. This category reflected a definitive space, which is governed by dimensions of timing and 'moments' of choice, and is a traversal space in which all other processes meet, converge, excite and collide. Consistent with the BCPSG's (2010) idea of a space holding therapeutic processes and influences, this *'field of tension'* reflects the simultaneous, interactive and iterative nature of the other four categories.

5.2 Forming the Relationship

A significant finding shows therapists to secure an initial relational bond in order to initiate the work with female sex addicts. Although this is explored in psychology and psychotherapy research, there are no studies addressing these issues in therapy with sexually addicted women. Connors *et al's* (1997, 2000) research shows the alliance to mediate in-therapy processes as well as predicting the outcome of alcohol addiction treatment, while King and Canada (2004) found non-engagement in treatment and attrition rates for female cocaine users were twice that of men. While this research addresses alcohol and substance abuse and not sex addiction per se, it does reflect the challenge for clinicians working with clients with

addictive disorders in establishing a relational bond/alignment and getting therapy off the ground.

5.2.1 Affect as a Relational Process

While affect regulation was acknowledged to be a central process in the treatment of female sexual addiction (Adams & Robinson, 2001; Goodman, 1998, 2001), it was reflected here to involve relational processes in therapy and with intimate partners and social groups. This is consistent with the view that affect is the neurotransmitter of human relations (Schore, 2012a). Perhaps the most significant finding suggests the quality of the therapeutic relationship to be influenced by the shared implicit and explicit coordination of affect, and as such suggests it to be a primary determinant of the success or failure of the therapeutic bond/alliance (Beebe and Lachmann, 2002; BCPSG, 2010; Schore, 1991, 2012).

5.2.2 Managing the Contact Edge: 'Any Bond Will Do'

An interesting finding showed therapists' strategies of early bonding and engagement to constellate around female sex addicts' expectations of relational experience that emerge immediately and at the contact boundary in the therapeutic encounter. This is indicated to involve the client designating the therapist as an archetypal object, a transitional object and a figure of early attachment dependence as they are expressed in the context of *attachment transference* (Mikulincer & Shaver, 2007). These are organized by the female sex addicts' early developmental disruption and relational trauma and expressed in avoidant personality style and insecure, disorganized adult attachment patterns. Brumbaugh and Fraley (2004) support this finding and show an individual's previous representation of relationships to be 'primed and activated' in new ones, and in particular to evoke negative affect when there has been negative experience in the past. There is also consistency with the research indicating clients' early memories of emotional bonds with parents to be significantly associated with client ratings of the working alliance (Mallinckrodt, 1991; Mallinckrodt, Coble & Gantt, 1995). In addition, evidence in the wider field of psychotherapy research points to the negative correlation between the alliance and client characteristics such as *'avoidance and interpersonal difficulties'* (Costantino, Castonguay & Schut, 2002). While there are no studies addressing the specific issues arising for therapists working with female sex addicts, Katehakis (2012) has contributed a theoretical chapter, *Best Practice for Addressing Attachment Injuries,* in which she supports an attachment framework as key to female sex addiction treatment and regulatory repair.

5.2.3 Shared Understanding

Establishing a *shared understanding* with the client is a central finding and is consistent with Bordin's (1979) ideas of forming the alliance. While engaging in thorough assessment protocols, therapists were found to wrestle with the ambiguities of using diagnoses and diagnostic frameworks without losing sight of the client. While therapists acknowledged that the use of the term *sex addict* creates difficulty for women seeking help, and raised concerns about *pigeon holing* or forcing individuals into diagnostic categories, they also demonstrated a proneness of overuse diagnostic labels. Dimon (2005) reflects the tension in the findings inherent in psychological assessment as the 'ambiguous power of diagnosis' and sees it as creating 'both relief and the bitter and sharp fusion of shame and suffering' (p.382). Perhaps this *shared understanding* is better contextualized by the ideas of the Boston Change Process Study Group (2010), who describe the importance for the therapist of having a sense of *'fitted directionality'* (p.194) with the client to both proximal and distal objectives. They see intentionality in therapy as being a shared and embodied *'felt meaning'* and this as being implicitly communicated to the client.

5.2.4 'I-It, No Mutuality

Therapists aimed to create with female sex addicts a capacity for mutuality; however, the interpersonal configurations in the early stages of therapy were characterized by an I-It (Buber, 1958) position with the transition to an I-Thou (Buber, 1958) position seen as being difficult. These findings are consistent with the ideas of integrative psychologists like Evans and Gilbert (2005) who emphasize that it is the experience of mutuality facilitated by the therapist with the client that is an objective of the therapy. Therapists reported a *part object relating* and managing a tension between the relational inter-objectivity and intersubjectivity. This is consistent with Khan's view that in seeking an incomplete sex partner or object, the sex addict 'fails to involve herself because the sex partner is not seen as a whole person with depth', and that the provision of therapy is positioned to address this (1981, cited in Guigliano, 2003:p.281). Findings also suggest that therapists have difficulty in establishing an interpersonal *flow* with clients and that, while seeking to *enliven* the inner deadness or relational contact, they become passive themselves, engaging with a slow pace and with micro-movements. This category perhaps also reflected a tension between aliveness and death and the female sex addict using promiscuity to avoid grief and mourning. It was suggested that the loss of adult relational and sexual fulfilment, as well as related childhood injuries, have not been grieved for and that, while sex addiction is simulating a feeling of aliveness, it also ensures the destruction of any potential for creativity by ensuring the female sex addict remains *dead* in parts of her psyche.

5.2.5 In Here/Out There

Findings showed that therapists see the formation of the relationship as containing and holding, which echoes Winnicott's (1965) notion of the holding environment. While the provision of the relational space allows the female sex addict to express, articulate and experience herself in relation to a co-regulating other, it is the close interpersonal contact that triggers surges of affect which underpin the compulsion to sexually *act out*. A central finding demonstrated therapists to seek to shift the clients' locus of affective experience from an externalized, sexualized, acting out addictive pattern to an internalized and embodied experience embedded in the relational field of self and other. This finding is consistent with ideas of developmental psychology and relational psychotherapy, that conceptualize the formation of the dialectic relationship in therapy as facilitative in shifting the alcoholic's externalized function of tension reduction and affect regulation with alcohol use to the relationship with the therapist (Krueger, 1982:p.601). Although Krueger (1982) refers to alcohol dependency, it is arguable that this is also true for female sex addiction. The literature supports the view of the female sex addict as having insufficient internalized object representation with which to adequately regulate affect or sexual arousal in self and projecting this need for a regulating other or object into her sexual activity in her external world (Beebe & Lachmann, 2002; Fonagy *et al.*, 2002, 1999; Schore, 2003, 2002).

5.2.6 Uniqueness of Each Dyad

Each therapeutic dyad was reported by therapists to be uniquely shaped by their and the female sex addicts' individual characteristics. The idea that the individual's coexisting parts operate in a unique interpersonal matrix with the parts of the other is consistent with the relational psychoanalytic view that individuals are not only 'profoundly context dependent and context sensitive' (Atwood & Stolorow, 1992:p.773) but that intersubjectivity involves the action and interaction of a multiplicity of selves (Benjamin; 1988; Mitchell, 2000). These findings also concur with Sullivan's (1964) view that we have as many different *selves* as we have relationships, and with Polster (1995), who understands this 'multiplicity of selves' (p.10) to function autonomously and to be called upon to optimize relational experience. Findings showed therapists to value an attitude of openness and curiosity, and to avoid a more formulaic, task-focused and top-down approach. This is consistent with Gabbard's (2005) research indicating that therapists who really immerse themselves in the subjective uniqueness of the client and her problems are able to empathically understand and communicate this to the client, which is necessary to establish a bond. With this in mind. findings showed that therapists look beyond the diagnostic symptoms of *sexual addiction* to understand in depth the inner struggle and subjectivity of the female client. This draws on the debates between case formulation and diagnostic classifications reviewed in an earlier chapter (Vanheule, 2012).

5.3 The Therapist's Edge

A main finding demonstrated therapist's attitudes, biases and beliefs about sex, addiction and women, as well as their professional and personal development, to have an influence on interpersonal contact and regulation with female sex addicts in therapy.

5.3.1 Attitudes, Constructs and Relational Process

Evidence of therapists' conscious and unconscious beliefs was considerable and manifested in both personal and sociocultural attitudes towards women, sex and addiction. This finding was consistent with ideas from relational psychoanalytic and cognitive neuroscience that see the organization of the intersubjective personal constructs as being rooted in intra-psychic representations of sociocultural-political influence. The therapists' held system of beliefs appeared to influence the level of relational connection and comfort with the female sex addict client. Carnes (1989) mentions that 'all helping professionals struggle with two levels of pathology: the illness of the people who need help and the cultural pathology' (p.49). Goodman (1998) comments that 'we clinicians are no more capable than is anyone else of transcending our sociocultural context but the more aware we are of how our sociocultural context influences our perceptions, our beliefs and our feelings the less likely are such contextual influences to undermine our therapeutic effectiveness (p.51). The notion that therapists hold society's collective prejudices and biases is perhaps also consistent with Dimon who suggests that 'stigma leaps from practice to practice just as genes in certain species of corn jump from chromosome to chromosome' (Keller 1983, cited in Dimon, 2005:p.380). Although this refers to attitudes surrounding homosexuality, it translates well into an understanding of the significance of the current findings and suggests therapists' views, prejudices and biases are communicated implicitly to the female sex addict within the intersubjective field.

5.3.2 Does Sex Female Addiction Exist?

The tension in the findings as to whether or not the term sexual addiction is a diagnostically useful term for women reflects the contention in the literature debating sexual addiction as a psychological diagnostic classification for women or as a response to *out of control* female sexuality born from socially constructed anxiety and an attempt to impose order (Covington, 1997; Levine & Troiden, 1998). Certainly, while therapists see the female sex addict as struggling with deep disturbance and painful interpersonal, erotic and affective issues, they were found to experience responses to the female sex addict's affective style with

expectations of women as being *hysterical* and out of control and engaging in high-risk behaviours with awful consequences and catastrophic outcomes. There is an indication in the findings that therapists' desire for certainty, order and control in the work with female sex addiction involves imposing a more rigid diagnostic framework at times and that female sexual addiction is merely a cluster of symptoms. Benjamin's (1988) ideas of the loss of female subjectivity extended to sexuality locate this ambiguity in the findings somewhere in the middle of the sociopolitical debate. While findings demonstrated that sexual addiction for women involves acted-out anger and revenge, I am less sure that this is relevant for women. Joyce McDougall comments in a personal communication with Stoller:

> *Joyce, don't you realize the fundamental role hatred plays in all sexuality*? *I wanted to write back and tell him that he was talking about male sexuality and I about female sexuality. They are not identical. Differences exist.* (McDougall, Modell & Meadow, 2000:p.81)

Despite therapists acknowledging gender difference in the context of sexual addiction, they did not appear to make gender-specific treatment decisions. They often described female sexual addiction using a male-orientated framework in approaching assessment, diagnosis and treatment. However, while therapists said their approach to therapy and treatment of female sexual addiction is no different from their approach to male sexual addiction, they did see women through a particular lens of beliefs and constructs. Both male and female therapists talked about women's sexual patterns in terms of *codependency*, or else saw characteristics such as autonomous, conquering and promiscuous sex for females as concurring with a male sex addict template. Findings suggest that when female sex addicts' sexual patterns do not conform to social norms of female sexuality, male therapists view them with some skepticism. This concurs with literature that observes female sexuality and addiction to be *forced* into established male constructs in the context of treatment and therapy (Covington, 2007; Ferree, 2001).

5.3.3 Professional Training and Personal Development

Schore (2012) suggests the inner working of the therapists' internal subjective regulation as being key to the implicit regulatory process. Therapists' awareness of their own erotic shadow, and a willingness to 'get down, honest and dirty' about it, created an embodied comfort with sexual and erotic material, which was communicated implicitly to the client in the co-created space (Katehakis, 2012, 2009). The nature of the personal work leading to high levels of comfort, ease and awareness with their own erotic and arousal templates was central to the findings. Therapists' personal work involving the raising of awareness of these erotic

templates in relation to opposite-sex clients and of understanding their own sexual patterns in personal domains meant any triggered erotic material could more likely be used in the service of the therapy rather than be an iatrogenic influence.

A critical finding showed therapists' characteristics, both innate and learned through further training, to support or hinder their work particularly in light of the intensity elicited by the psychic disturbance of the female sex addict; this influenced how they engaged with their clients and shaped their approach to affective and erotic regulation. While therapists said they had learned to be with the female sex addict in ways that were not possible before particular training and personal work, they also recognized a deeper relational predisposition that was less open to revision. At first it appeared that the variation in qualities of relationality was linked to gender, with male therapists tending to avoid deeper, intimate contact and dependency. However, as interviews progressed, it emerged that, despite the underpinnings of personality or overlays of autobiographical experience, the tendencies to either avoid or engage in intimate contact and a more intersubjective way of working were influenced equally by the type of training and level of personal work. There were varying degrees of flexibility and adaptability in how therapists described maintaining contact with their clients, involving a wide range of relational and regulatory styles. Findings indicated training and personal work to develop an internal capaciousness, adaptability and flexibility, which increased the ability to connect with female sex addicts, who are particularly characterized by disorganized, seductive, traumatized and often dissociated relational and regulatory styles of engagement. Certainly, there are consistencies with the literature showing that therapist characteristics such as; facilitating the clients' expression of affect, flexibility, openness, and trustworthiness mediate the therapeutic relationship and contribute positively to the alliance (Ackerman & Hilsenroth, 2003), whereas characteristics negatively associated with quality of the relationship include rigidity and being critical (Ackerman & Hilsenroth, 2001).

5.4 Managing Risk and Safe Surprises: Conscious Anxieties, Unconscious Enactments

Findings indicate that therapists experience a heightened sense of vulnerability and vigilance working with relational processes with the female sex addict and that this feels like being at a precarious personal edge. Therapists' subjective responses suggest they have a personal threshold or limit to their capacity to *be with* their client in the context of relational contact, and that this is influenced by factors in The Therapist's Edge, the disturbance in the client and the content of the material. Findings suggest therapists feel heightened levels of anxiety, are blind to or wary of the inevitability of unconscious enactments, and are concerned about the

risk of rupture and premature termination of therapy as well as the potential for moments of repair, correction and surprise. Although there is an absence of any existing empirical study, this finding is consistent with the observations in the addiction literature that highlight these particular challenges (Hagedorne & Juncke, 2005, Hagedorne, 2009; Katehakis, 2009, 2012).

5.4.1 Therapist Anxieties

A significant finding shows therapists to experience an implicit sense of precariousness and anxiety in their approach to the therapeutic work with female sex addicts. There is evidence of therapists' anxiety in response to clients' affective unpredictability and emotional intensity and more perverse, dark material, and that this creates an embodied trepidation around close and fragile interpersonal connection. Findings suggest a wariness of *bad* and early endings in therapy, particularly involving *explosions* of some sort. Consistent with Rothschild's (2006) idea that client trauma can be experienced vicariously by the therapist, it seems reasonable that trauma experienced by one therapist can be communicated to and embodied by another in multidisciplinary teams, supervision or collegial peer groups. The exposure to the risk of complaints procedures, court cases and legal action was evidenced to cause levels of worry to therapists and compromise therapeutic responses to female sex addicts in therapy. These were certainly shown to influence their level of confidence in taking or avoiding risk in the therapeutic process with their clients. Anne Kearns (2007) offers a context for this with her study and indicates that an overrepresentation of complainants in therapy have a background of complex post-traumatic stress and a fragile self-process and generally assume the therapist to set out to deliberately cause harm (p.40–42). Kearns (2007) adds that therapists need to be aware of their own fragile self-process, as this not only creates a vulnerability for the therapist but also a risk of counter-therapeutic and iatrogenic influences in the unconscious intersubjectivity.

5.4.2 Blind Spots, Snags, Hoodwinks and Triggers

Cramer (2002) acknowledges that the combination of PTSD and addiction, particularly in women, is a 'marriage made in the avoidance of unbearable affect' (p.194) and that this does not create difficult clients but rather creates *'*difficult treatment dyads' involving vicarious trauma and unconscious affects that conspire to pull the therapists out of connection with the client at critical points in the treatment, particularly toward 'sadistic abandonment or collusive indulgence*'* (p.194). While findings show all therapists to have an expectation of unconscious enactments and an awareness of the risk of ruptures, the main finding shows that male therapists drop into the role of *rescuer* with their female sex addict clients. Therapists were found to enact certain unconscious, co-created dynamics, which involved what Sandler

and others describe as 'role responsiveness' (1976:p.44; Casement, 1985; Ryle & Kerr, 2002; Smith-Benjamin, 2003). Certainly, the vulnerability of male therapists to enacting reciprocal role dynamics with the female sex addict in therapy was evident. It might be the case that the need of the female sex addict to be rescued is a good fit with these therapists' own rescue fantasies (Gabbard, 2010). There was a high level of addiction in therapists' family backgrounds, which might account for this particular finding where perhaps the victim–rescuer dynamic can be understood as a seduction and manipulation of power. Evidence revealed therapists often to feel attacked by clients, which is contextualized by Knox (2013), who sees the therapist as collapsing at times into *victim* only to rescue himself by asserting him/herself as a rather too 'exquisitely attuned and potent' clinician in the form of the *rescuer*, i.e. Walter Raleigh. This, Knox suggests, is actually created by a failure in the therapist to adequately stay with the client's level of distress in the intersubjectivity.

5.4.3 Shame

Shame is mentioned in the literature as being a central organizing affect in sexual addiction and is particularly mentioned in the context of narcissistic injury (Birchard, 2004; Hall, 2013). It is the primary affect associated with interpersonal isolation and alienation, which are both demonstrated to increase the risk of relapse and promote patterns of acting out (Gilliland, South, Carpenter & Hardy, 2011; Reid, Harper & Anderson, 2009a). Findings suggest that, for women, shame is not only greater than for men but is also perpetuated by different factors, including a response to a breach of socialized and personal sexual expectations, the label sex addiction and the sense of the loss of self-control. The findings also suggest shame to be an interpersonal dimension comprising processes of connection and disconnection, dissociation and integration. Schore (1991, 2003) regards affect as the central organizing factor of the cohesive sense of *self* and sees early relational disruption and misattunement as creating psychic fragmentation and primary experience of shame. Shame becomes a central structure to the developing self with other affect locked into *shame binds*, unable to find expression or be experienced with associated feelings of shame. This is consistent with relational theories that conceptualize shame as a mediating factor of interpersonal contact and proximity. Mollon (2002) understands the intersubjective and co-created context of shame as hinging on the individual's experience of not being able to evoke an empathic response in the other (2002). Certainly the awareness of shame as an interpersonal process is echoed by Knox (2013) who suggests the therapists' distress replicates an experience for the client of the distressed mother which creates shame in the client who, while hoping that mother at last understands, realizes she does not.

5.5 Finding a Shared Frequency

A critical finding indicated therapists' engagement with clients in the therapeutic regulatory encounter to involve what Mitchell (1988) describes as a *multifaceted relational matrix*. While there is no existing research exploring these processes in the context of female sex addiction, Katehakis's (2012) theoretical perspective provides some context suggesting that the efficacy of any therapeutic work with female sex addiction needs to centralize implicit relational processes of regulation in the work. Findings indicate therapists to navigate the relational terrain in order to find the frequency on which the client can best be *met*.

5.5.1 Entering Each Other and the Erotic Encounter

A critical finding concerns therapists' experience of the erotic interpersonal rhythms in therapy, and while that is unique to the characteristics of the individual and the dyad, it reflects the *ebb and flow* of interactivity in the in-between. This sits well with what Erskine (1998) describes as 'a kinesthetic and emotional sensing of others, knowing their rhythm, affect and experience by metaphorically living in their skin', and is consistent with David Mann (1997), who suggests the psychotherapeutic relationship to be an erotic encounter. He suggests that clients' interpersonal rhythms and patterns as they relate to therapists reflect their style of sexual intercourse and that this is learned in the early interactive rhythms in relation to mother. This is consistent with Lyons-Ruth and the BCPSG (2001), who sees therapy as involving 'the improvisation of relational moves' and Smith-Benjamin (2003), who conceptualizes the minutiae of interpersonal therapeutic exchanges to orchestrate a relational song comprising harmonies and melodies. In support of the current findings is the theory that it is the facilitation of melodic and harmonic relational rhythms between therapist and female sex addict client that facilitates the action potential for change (BCPSG, 2010). With this in mind we can perhaps locate the finding in developmental research of affective and erotic rhythms between mother and infant reported by Trevarthyn (1993) and the conceptualizations of Stern (1985), which see these to be embedded in the relational interactions between therapist and client. Certainly there is a consistency with Mann's (1997) notion of the rhythms of interaction between a mother and child as the precursor of adult erotic experience, and with Lichenstein, who states that 'in the primitive sensory exchanges taking place between mother and infant one could see the precursor of adult sexuality' (1961 cited in Mann, 1997:p.121).

While metaphors in the findings suggest an embodied process as navigating closeness and distance, they also revealed therapists as experiencing concern about moving apart from and breaking contact with the client. Andrew Samuels sees this as part of a natural relational rhythm and in a personal communication to Dr Bonnie Meekhams (2013), Samuels mentioned the value of the relational 'shadow component' and posits that disconnecting or

being *non-relational* at moments in therapy is as important as connecting. Knox (2013) concurs that *withdrawal* and distance is essential in any relational rhythm in therapy and that 'the client needs to be allowed to *be away* from the therapist at times in the session. This participatory action is balanced, allowing both union in common experience yet difference in agency'.

5.5.2 Locking In

Findings showed therapists to experience feeling tightly connected and *locked in* with their clients at a preverbal and pre-symbolic level. This specifically links to the early developmental ideas of Schore (2002, 2003), which have been integrated by Katehakis into the theoretical frame of female sexual addiction (2009, 2012). Right-hemispheric connection between therapists and the female sex addict are essential in order for them to create a deep, implicit and empathic attunement to each other. From this experience, revisions to existing beliefs of self and other in internal working and erotic models can become embedded in a positive-affect-laden, relational experience informing and influencing future expectations of sexual and interpersonal encounters. These implicit, right-hemisphere-to-right-hemisphere transactions, which resemble the early symbiotic and shared connectedness of the mother/child matrix, were reported as feeling like a tight, intuitive joining or *merging* with each other, creating an important energetic correspondence. Findings also show therapists as seeing this connection as being maintained by their own capacity to connect with self, as if their internal subjective consciousness is a conduit for this connection with the client and this connection to feel like an '*inside to inside'* bond.

5.5.3 The Unconscious Web: Working with Unconscious Processes

While Imhof, Hirsch & Terenzi (1985) highlight the attitudinal negativity and scepticism in more traditionally held psychoanalytic views of addiction, in particular working with the countertransference, Burton's (2005) more contemporary psychoanalytic perspective locates implicit communication at the centre of the therapeutic work with addicts. In support of the findings, Burton (2005) sees the therapist's central role as fostering the use of projective identification in their work with addicts. She suggests this object-relational dynamic not only facilitates greater shifts, but contributes to emotional alignment, thus creating a better 'link between patient and analyst' (Bion, 1959:p.313). Findings certainly indicate therapists work with unconscious and implicit communication and show this to account for a large part of the therapeutic process. Casement's (1985) ideas of *communication by impact* support this well. He sees the therapist's job as involving working out an understanding of the client's early, unformulated and unconscious material, which for the client remains *'unspeakable*'. Findings show that extremely intense affective and erotic countertransference experiences occur deep

inside therapists' intra-psychic and subjective world, and that these reflect the client's affective and erotic disturbance. This exiled client material is often enacted in the therapists' private sexual world (Mann, 1997). Consistent with Evans and Gilbert (2005), unconscious material, although mutually impacting, is not symmetrical and often therapists will feel everything for the client in the therapy that the clients cannot feel for themselves. The inevitability of this in the work requires the therapist to become like the mother to the infant and to experience the *unspoken cries* of the other. While Casement (1985) sees this as 'the most primitive way in which one human being acts upon another and is reacted to' (p.72), he suggests it is also essential for clients to know that they can impact another human being in this deep way. It is the capacity of the therapist to be impacted by the client in this way that allows for the essential acknowledgement of understanding of the client to occur, thus creating an affective resonance. The therapeutic value of this is mediated by the personal characteristics of therapists, their training and personal work, which determine either a transformative or iatrogenic experience for the client. Therapists also rely on processes of a *theory of mind*, in particular their capacity for cognitive reflection of their embodied experience. This was shown to be useful in differentiating what material belongs to the client as opposed to the therapist and is perhaps what Fonagy *et al*. (2002) describe as the therapist's capacity to simultaneously draw on observations of self-as-object and reflect on experience of self-as-subject.

5.5.4 Somatic Attunement and the Somatic 'Third'

Evidence of inter-somatic communication was a central finding and reflects the somatic connection between therapist and client as feeling like a *shared body* experience through which communication, attunement and regulation can occur (Sheedy, 2012). While this is consistent with Katehakis's (2012) idea that sex addiction treatment requires attention to the between-bodies communication, as she integrates ideas from the trauma literature (Herman, 1997; Ogden, 2006; van der Kolk & Fisler, 1994) with Peter Levine's (1997) model of Somatic Experiencing, more significant support and explanatory salience is perhaps provided by the relational psychoanalytic theorists. While Aron and Anderson (1998) argued for a two-body psychology and highlighted this mutual and reciprocal function as an interactive sensory regulation, Rappaport, (2012) comments that *an umbilical cord* of somatic and psychological connectedness creates a regulation of somatic body experiences in both members of the dyad' (p.375). She considers 'relational knowing to become accessed through somatic experience before it can be verbalized and articulated' (p.375) and dissociated material within the self and the client to rely on 'somatic sensations', cues and experience. Rappaport concludes that this process involves the 'lending of the therapist's nervous system to the patient as a resource for interactive and mutual regulation' (p.375). Ideas of neuronal mirroring established by

fMRI studies signal a process of somatic emotional contagion to occur which is more about 'catching' a feeling than mimicking one with corresponding shifts in posture and micro-movements (Knox, 2013). Meanings are co-created through inter-corporeal encounters, particularly when reflective and executive function fails and the body keeps score. The body of the other is experienced not as an object but as a *live* other, thus the experience is intersubjective (Meekhams, 1991).

5.5.5 Conscious Collaboration

Collaborative processes between therapists and the female sex addict demonstrated a strong element of *joining the client* and *doing with* the client and as involving cognitive re-framing and meaning making, experiential tasks and exercises. While this is interesting in the context of the more traditional approaches to addiction treatment with the focus on the provision and application of specific stage-focused tasks (Carnes, 1983, 1989, 1991a), it is perhaps more consistent with Benjamin's (2004) idea of shifting the focus from the therapist *doing to* the client, to a therapist *doing with* the client and the co-creation of subjective *thirdness* created by the task itself. This finding is also consistent with the ideas of gender-responsive treatment (Covington, 2002) as it highlights the level of collaboration between therapist and sexually addicted female clients as particularly important. This also perhaps addresses in part a concern raised by Hadghorne and Juncke (2005) who are critical of the one-dimensional, task-focused approaches to addiction treatment and like others, urge that the work should include therapy both at cognitive explicit levels and deeper implicit nonverbal dimensions (Covington, 1997; Goodman, 1998; Katehakis, 2009, 2012).

An important finding showed explicit verbal and nonverbal processes as involving left-hemisphere and right-hemisphere processes and as including narrative work, challenging cognitive misimpressions and co-creating new meaning of affective experience. Therapists implemented experiential and task-focused interventions to practise mindfulness, create insight and build knowledge with their clients. Certainly, this is supported by Reid, Karim, McCrory & Carpenter (2010b) who explored the role of executive function amongst hypersexual men drawing on theories of reflective function and mentalization (Fonagy *et al.,* 2002). Knox (2013) also emphasizes a cognitive perspective to be essential for the therapist in the co-created and coordinated effort to attune to and regulate affect with the client and the development of internalized self-soothing mechanisms for the client as involving the capacity for self-governance (Goodman, 1998), self-agency (Knox, 2011) and self-mastery.

5.5.6 Eroticized to Erotic

Findings show that therapists work toward shifting the clients' eroticized affect from addictive behaviour to an *erotic* relational connection in the context of therapy, and to revise the client's internalized and implicit relational, affective and erotic template through the relational therapeutic encounter. Certainly, the links between sex addiction and affect dysregulation are well documented in the literature, but more neglected are issues concerning clinical approaches involving deeper, implicit work, particularly involving the erotic.

While the development of healthy sexual patterns is the aim of therapy with female sex addiction (Katehakis, 2010; Schneider & Irons, 2001), the notion of erotic intersubjectivity is not addressed in any depth in the addiction literature; nor is working with the complexities of the relational unconscious and yet it is very evident in the findings. As the literature describes the mutually regulated encounter as providing a relational experience that revises the clients' internal working models, so too is the erotic intersubjective experience with the therapist influential in updating templates informing expectations of intimacy and sexual experience. While the sexualization of the therapist for the female sexual addict is unique and not like a falling in love or erotic attraction, it is perhaps more about seeking a sexualized, addictive, regulating self-object. Female sex addicts reportedly experience the absence of an adequate self-object in their early history and as adolescents, young adults and adults see *sex* as the auxiliary regulating self-object. The fear and anxiety around erotic transferences was very high amongst all therapists and a resistance was noted in terms of who becomes involved in this material in the relationship. While Katehakis (2012) suggests dealing with the sexualizing transference immediately and directly in therapy and findings showed that therapists either confront it head on, or say it rarely comes up, perhaps the question is whether working directly in therapy with the erotic transference is a help or a hindrance. Certainly, it is necessary to differentiate between what is an inappropriate manipulation of soothing by the client with seduction and sexualizing behaviours and what is an experience of the erotic transference in the context of therapy as a reworking of the oedipal and attachment transference relationship (Stirzaker, 2000).

5.6 Reflections on the Study

On reflection, I was surprised that the final model varied so much from my initial expectations. Throughout the research process I wrestled with the complexity and potency of the material, which continuously presented diverse possibilities in terms of gathering data and directing the analysis. I frequently paused in spaces of painful indecision and frustration. This personal response to analysis and writing up often involved resisting an urge to prematurely foreclose on an unfolding idea and reach for the security of certainty. I understood this

attempt to impose order to reflect both my own and the therapists' unconscious response to the chaotic dysregulation and deep disturbance of the female sex addict. Both generate an unconscious sense of intersubjective chaos. Constructing a grounded theoretical understanding while resisting the internal pull to reduce the data to a level of flat description and allowing the complexity to unfold took me to previously unimaginable depths of my own subjective world. I would argue that as my responses and presuppositions have the potential to influence the study, so too is subjective influence indivisible from both the therapeutic and the research endeavour.

As I approached the end of the first draft I reflected that throughout the research I was continuously required to refocus the therapists and the interview process on female sex addiction as it drifted toward male sex addiction. I realized this is likely to be what happens in the field of sex addiction treatment but became curious about why this might occur. It seems that therapists almost can't frame their ideas of sexuality outside i) a male and/or ii) their own frame and that when therapists are discussing sexual addiction and perhaps sexuality in general they cannot do this out of their own set of beliefs. When I think about this in terms of my experience working in addiction treatment, and more recently in my training as a counselling psychologist and psychotherapist, what I see is that the way the therapist understands what is happening is through their own lens, informed by their own sexuality and culture.

I particularly noticed the tensions between trusting my intuitive hunches in order to maintain an analytic reflexivity and the reliance on a more objective and pre-informed style. What this brought into view was the challenge involved in representing the more subtle and implicit processes in the findings, without reducing or undermining the sense of embodied aliveness and implicit meaning. While I believe the struggle to raise unformulated, implicit material into a consciously constructed conceptualization mirrors a central struggle for therapists in their work with female sex addicts, I also understand some of this material will often remain unformulated and at times can't or won't survive the translation into language and articulated form. Again, while I understood this tension to perhaps mirror the challenge for therapists in balancing conscious and unconscious processes, working at this level of disturbance is inevitably of course a challenge to the subjective responsiveness of the therapists.

While the research yielded a much richer and complex model, in which polarities are paradoxically integrated by their disparity rather than further divided, I was struck by the polarity in my thinking – by some of my earlier *either/or* expectations. I realize reading the first draft that I initially saw the data to contain polarity between male and female, good sex

and bad sex, right hemisphere or left hemisphere, and held a bias that one or other would have more merit or credibility. While I reflect on this tension as being experienced by the therapist, and the researcher, and perhaps society at large I recognize the merits of capacity for ambiguity, paradox, complexity and uncertainty.

5.7 Contribution and Applicability

This study contributes to the field as it addresses counselling psychology's 'demand for rigorous empirical enquiry with a firm primacy of the counseling or psychotherapeutic relationship' (Division of Counselling Psychology, 2005:p.1) and in doing so contributes to a 'greater understanding of explicit and implicit communications' between therapist and client (Kaskett, 2011). The implications of the findings for counselling psychologists lie more in the value of a trans-theoretical framework, as it transcends adherence to one modality and, by centralizing processes of the therapeutic relationship, therefore has applicability to a wider range of clinical presentations. While this argues for the therapeutic endeavour as drawing on multiple perspectives it particularly highlights the reliance on the *person* of the therapist of the therapeutic process and as such as drawing on their tolerance and capacity for the deep sexual, affective and relational disturbance that is communicated in the implicit dialogue with female sex addicts.

This research adds to the small number of empirical studies addressing female sex addiction. By drawing on the field of addiction, attachment, neuroscience and relational psychotherapy, this investigation contributes to the understanding of the therapeutic endeavour with female sex addicts as a two-person psychology, thus pushing the concern further into the field of relational psychology. It highlights the importance of the subjective in the work of the therapist and of the researcher and suggests that the extent to which counselling psychologists are able to use their subjective receptivity in response in the service of the client and of the work is a clinical concern worthy of consideration. This topic generates in the therapist a strong countertransference response both to the client and in the therapist's own unformulated and unconscious relationship with their sexuality which is arousing in and of itself. There is something here, therefore, for clinicians in the field, of the subjective availability of the therapist in order that the client must not be left *alone* with the disturbance. I argue that what this demands of counselling psychologists is both a capacity for conceptualization as a vehicle for thinking and the emotional range and capacity required to convey to the client an experience of non-judgmental and empathic relationality. While I would argue that both approaches are imperative, perhaps the greater contribution lies in contemplating the fallacy of therapeutic objectivity and neutrality and instead asserting that the 'emotionally responsive therapist is always irreducibly subjective' (Renik, 1993:p.565). I would argue that we might

not reject the use of any standard technique and that, while therapists, of course, need all the theory, without the responses to it we are unable to truly contribute.

There are significant implications for the *personhood* of the individual psychological therapist in terms of suitability to this particular work, both before the work commences and once they have found themselves committed to the work. Therapists need to have a particular capacity for their own subjectivity and a tolerance for the deep affective, erotic and relational disturbances in these clients so that they can offer the client a quality of therapeutic connection and responsiveness. A central contribution of this study is to highlight the centrality of specific and ongoing supervision as well as the availability of professional training that supports personal development, particularly as involving and navigating the unconscious relationship and erotic intersubjectivity. I would argue that what this demands of *counselling psychologists* is both a capacity for conceptualization as a vehicle for thinking, and an emotional range and capacity; therapists' willingness to explore and engage in depth with their own social and political constructs around gender, sexuality and addiction stands to enhance capacity to work relationally with this challenging clinical group. While this research has certainly taken me beyond my own thinking, having to think deeply and reflect on the process of immersion and emergence enabled me to reflect on the therapist's ability to use their subjectivity in the service of the client, and to understand that inevitably we cannot go into these areas with our clients until we inevitably can go into these areas ourselves.

Sex addiction for women can perhaps be understood as an extreme version of dysregulation characterized by the outlet of deep relational and psychology disturbance created by the derailment of internal mechanisms of self and self/other regulation and, as such, as sharing features of addiction, deliberate self-harm, borderline personality disorder (BPD) and trauma. While the processes underlying these conditions may share certain features, I argue that female sex addiction reflects a severe and damaging acting out behaviour reflecting the deeper and greater level of internal disturbance. Therapists might be aware that the presence of sexually excessive and risky sexual behaviours points to an underlying borderline and/or narcissistic personality organization arising from a disorganized attachment style and that this creates ongoing difficulty with affect regulation as it organizes the *self* and *self/other* configurations. The contribution of the study to counselling psychology, lies in and beyond the understanding of the relational processes involved in the therapeutic encounter with female sex addicts and as such has value in the context of its clinical applicability to the therapeutic work in the wider field with clients suffering deep psychological disturbance.

The originality of this study is in not using questionnaires or measures of symptomology to create something objective, but is in the pursuit of a theoretical construction that requires subjective immersion and involvement. This research has gone beyond description of what therapists do, and makes an attempt to explain the processes involved in the experience of doing. This contribution required a particular pull on me as the researcher to allow conscious and unconscious processes to emerge and, with this in mind, great emphasis was placed on care in the struggle not to impose my presuppositions on the data.

5.8 Limitations and What Next

The main limitation of this study lies in the parameters set by a single-person study, particularly as this limited access to subjects. This had implications for the sample in terms of recruitment, screening and selection. The resources of a team would have allowed for a much larger initial sample pool, perhaps located in a wider geographical area from which a very tight-fitting sample of perhaps eight to twelve participants could have been scrutinized and selected. Constraints of time, geography and resources (including financial) meant this was not possible. Perhaps a larger sample pool would have allowed for a third and younger generation. As it is, the ages span two generations from late thirties to mid-sixties. While certain data was excluded, this was an inevitable limitation of the word count.

The absence of ethnic or cultural diversity in the sample was perhaps a limitation of the single-person study in terms of constraints of recruitment. The sample comprises an all-white group of British and North American participants, which perhaps presents a particularly Western-influenced subjectivity, although this similarity to the researcher may also have meant that beliefs and attitudes of participants were more forthcoming in the interviews. There were two therapists from the United States and one from Canada, and six therapists of the twelve were trained by Patrick Carnes, which influenced a variety of attitudes to female sex addiction in the findings. Paula Hall (2013) calls for more indigenous home-grown research into sexual addiction. Certainly there is a high level of import from across the pond, including specific sex addiction training, and this study contributes a British perspective. Hall (2013) suggests that psychologists, psychotherapists and professionals involved with mental health provision here in the UK need to develop their own culturally relevant conceptualization of sexual addiction which is not detrimentally influenced by the social prejudices and biases occurring in response to controversies of over- and misdiagnosis of the US approaches, and that open and curious, responsible consideration be apportioned to this severe mental health problem. A further study might seek to explore these differences further.

While the sample was not made up of, nor included, counselling psychologists, this is understood as reflecting a finding in itself and as highlighting the dearth of counselling psychologists working in this field. My decision to approach the recruitment strategy from inside the addiction field marked a 'deliberate engagement with diversity' (McAteer, 2010:p.8) and I saw this as 'reflecting the enriching influence and contribution of other fields' (p.8). I understand there to have been a contribution made by the fact that, as the researcher, I embody multiple perspectives resulting from my training as an integrative psychotherapist, a counselling psychologist and an addiction therapist. I believe this positions me with a unique view of the field as domains may overlap and integrate, and see this as placing me as a practitioner/researcher in the pluralistic tradition at the heart of the field of counselling psychology, and the study as being a true reflection of this. I see this as representing something of moving beyond 'the need to define the counselling psychologist as distinct from other applied psychologists and allied mental health professional that are similar such as clinical psychologists or psychotherapists who are not psychologists' (Milton, 2010) and in the course of this I see myself as remaining open to exploring 'the new' in order to contribute individual understanding of subjective experience over universal truths without losing sight of my place in it (Kaskett, 2011:p.22).

In the context of methodology, grounded theory as an approach does not allow much room to explore individual participant data. While this would reflect more of the *particularity* and uniqueness of the experience of each participant, it was set aside in the name of seeking *generalizability*. Although this is an inevitability of the current qualitative grounded theory approach, as a method it perhaps does not speak sufficiently to the individual stories therein. An alternative to or extension of the current research might be to study a single case in greater depth and implement a specifically phenomenological approach.

6. Conclusion

In conclusion, this study has highlighted affect regulation in therapy with female sex addicts as being embedded in processes of relationship and, as such, to be inextricably bound up with therapists' subjective response as it creates or inhibits a quality of relationship, which is reflected in the consistent, empathic and reflective qualities of the psychotherapist (Knox, 2011:p.169). This research highlighted the irreducibility of therapists' subjectivity (Renik, 1993:p.565) and responsiveness to implicit therapeutic processes as being central to the *'therapeutic action of change'* (BCPSG, 2010:p.199) in the work with female sex addicts. My immersion in this research journey from thinking of the idea, gathering and analysing the data

and writing up has not only enhanced and enriched my own clinical work but represents an invaluable investment in my personal and professional development. This developmental process has sharpened both my clinical thinking and subjective capacity and as such has created ability to work at greater relational depth with complex and challenging clinical groups. I believe this contribution produced a study representing something more than just going through the research hoops and so doing makes a valuable contribution to the field of counselling psychology while reflecting the essence of the type of person of the researcher. My subjectivity, my feelings and thoughts were opened up from and beyond my own *normality,* creating a dimension of *soul beyond self,* and taking me further than the scope of my previous experience, which was necessary to both the service of the research study and my clinical practice.

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Appendix I

Proposed Criteria for Hypersexuality Disorder (APA, 2012)

A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:

(1) Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior

(2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to

dysphoric mood states (e.g., anxiety, depression, boredom, irritability)

(3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events

(4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior

(5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others

B. There is clinically significant distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.

C. These sexual fantasies, urges, and behavior are not due to direct physiological effects of exogenous substances (e.g., drugs of abuse or medications), a co-occurring general medical condition or to Manic Episodes.

D. The individual is at least 18 years of age.

Specify if: Masturbation, Pornography, Sexual Behavior With Consenting Adults, Cybersex, Telephone Sex, Adult Entertainment Venues/Clubs.
Other:

Specify if: In a Controlled Environment, In Remission (No Distress, Impairment, or Recurring Behavior for Five Years and in an Uncontrolled Environment.

Appendix II

Diagnostic Criteria for Sex Addiction/Compulsivity (Carnes, 1989, 1991a)

1) Recurrent failure (pattern) to resist sexual impulses to engage in specific sexual behaviour
2) Frequent engaging in those behaivours to a greater extent or over longer periods of time than intended.
3) Persistent desire or unsuccessful efforts to stop, reduce or control those behaviours

4) Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experiences.
5) Preoccupation with the behaviour or preparatory activities.
6) Frequent engaging in behaviour when expected to fulfill occupational, academic, domestic or social obligations.
7) Continuation of the behaviours despite knowledge of having a persistent or recurrent social, financial. Psychological, or physical problem that is cuased or exacerbated by the behaviours.
8) Need to increase the intensity, frequency, number, risk of behaviours to achieve the desired effect, or diminished effect with continued behaviours at the same level of intensity, frequency, number, or risk.
9) Giving up or limiting social, occupational, or recreational activities because of the behaviour.
10) Distress, anxiety, restlessness or irritability if unable to engage in the behaviour.

Appendix III

Diagnostic Criteria for Sex Addiction

(Goodman, 1998)

1) Recurrent failure to resist impulses to engage in a specific behaviour.
2) Increasing sense of tension immediately prior to initiating the behaviour.
3) Pleasure or relief at the time of engaging in the behaviour.

Involving at least five of the following:

i) Frequent preoccupation with the behaviour or with activity that is prior to the behaviour.
ii) Frequent engaging in the behaviour to a greater extent over a longer period than intended.
iii) Repeated effort to reduce, control, or stop the behaviour.
iv) A great deal of time spent in activities necessary for the behaviour, engaging in the behaviour, or recovering from effects.
v) Frequent engaging in the behaviour when expected to fulfill occupational, academic, domestic, or social obligations.
vi) Important social, occupational, or recreational, activities given up or reduced because of the behaviour.
vii) Continuation of the behaviour despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behaviour.
viii) Tolerance; need to increase the intensity or frequency of the behaviour in order to achieve the desired effect, or diminished effect with continued behaviour of the same intensity.
ix) Restlessness, irritability if unable to engage in behaviour.
x) Some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time.

Appendix IV

Diagnostic Criteria for Alcohol Abuse and Dependence

(DSM-IV-TR, 2000)

Alcohol Abuse

(A) A maladaptive pattern of drinking, leading to clinically significant impairment or distress, as manifested by at least one of the following occurring within a 12-month period:

Recurrent use of alcohol resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household)

Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use) • Recurrent alcohol-related legal problems (e.g., arrests for alcohol- related disorderly conduct) • Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (e.g., arguments with spouse about consequences of intoxication). (B) Never met criteria for alcohol dependence.

Alcohol Dependence

(A) A maladaptive pattern of drinking, leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period:

- Need for markedly increased amounts of alcohol to achieve intoxication or desired effect; or markedly diminished effect with continued use of the same amount of alcohol
- The characteristic withdrawal syndrome for alcohol; or drinking (or using a closely related substance) to relieve or avoid withdrawal symptoms
- Drinking in larger amounts or over a longer period than intended.
- Persistent desire or one or more unsuccessful efforts to cut down or control drinking
- Important social, occupational, or recreational activities given up or reduced because of drinking
- A great deal of time spent in activities necessary to obtain, to use, or to recover from the effects of drinking
- Continued drinking despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused or exacerbated by drinking. (B) No duration criterion separately specified, but several dependence criteria must occur repeatedly as specified by duration qualifiers associated with criteria (e.g., “persistent,” “continued”).

Appendix V

Email Rory Reid to SASH (2011)

From: "Rory Reid, Ph.D." <rreid@MEDNET.UCLA.EDU>
Subject: **Re: [SASH] interesting neuroscience article -- Reid rebuttal**
Date: 7 December 2011 05:01:29 GMT
To: SASH-PROFESSIONAL@COMMUNITY.LSOFT.COM
Reply-To: "Rory Reid, Ph.D." <rreid@MEDNET.UCLA.EDU>

** To reply to entire list use REPLY TO ALL **

Thanks Wendy. I would like to suggest those interested to view our rebuttal in the source of the article, not a website that simply replicated it. The source is:

http://www.surgicalneurologyint.com/text.asp?2011/2/1/64/81427

For those who read Hilton's original article posted by Stephanie earlier this morning, my colleagues and I felt Hilton's work was poorly written and has numerous flaws in the way it erroneously cites and disorts findings from the research. It was so badly written, we were invited to submit a letter to the editor which we did. The authors response to our criticisms never really addressed the issues that we had with their article and I suggest caution in citing or referencing their article as providing any evidence that there is neuroscience supporting an addiction model for pornography problems or hypersexual behavior. This doesn't mean that some evidence may emerge in the coming years, but we're not there yet.

R-

Rory C. Reid, Ph.D.
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Appendix VI

Ten Items of Acting Out with Sex Addiction (Carnes, 1990)

i) Fantasy sex: items focusing on sexual fantasy life and consequences due to obsession. Themes include denial, delusion, and problems due to preoccupation.

ii) Seductive role sex: items focused on seductive behaviour for conquest. Multiple relationships, affairs and unsuccessful serial relationships.

iii) Anonymous sex: engaging in sex with anonymous partners, having one night stands.

iv) Paying for sex: paying prostitutes for sex, paying for sexually explicit phone call.

v) Trading sex: receiving money or drugs for sex or using sex as a business. Highly correlated were swapping partners and using nudist clubs to find sex partners.

vi) Voyeuristic sex: items focused on formal, visual sex, including pornography, window peeping, and secret observation. Highly correlated with excess masturbation, even to the point of injury.

vii) Exhibitionistic sex: exposing oneself in public places or from the home of car, wearing clothes designed to expose.

viii) Intrusive sex: touching others without permission using position of power, (eg professional, or religious) to sexually exploit another person: rape.

ix) Pain exchange: causing or receiving pain to enhance sexual pleasure. Use of dramatic roles, sexual aids and animals were common themes

x) Exploitive sex; Use of force or partner vulnerability to gain sexual access.

Appendix VII

Integrated Diagnostic Criteria for Addictive Disorder (Goodman, 1998)

A maladaptive pattern of behavior, *leading to clinically significant impairment or distress,* as manifested by three (or more) of the following, occurring at any time in the same 12 month period.

1. Tolerance as defined by either of the following:
    a) a need for markedly increased amount or intensity of the behaviour to achieve the desired effect.
    b) Markedly diminished effect with continued involvement with the behaviour at the same level of intensity
2. Withdrawal, as manifested by wither of the following:
    a) characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the behaviour.
    b) The same (or closely realted) behavior is engaged in to relieve or avoid withdrawal symptoms.
3. The behaviour is often engaged in over a longer period, in, in greater quantity, or at a higher level of intensity than was intended.
4. There is persistent desire or unsuccessful efforts to cut down or control the behaviour.
5. A great deal of time is spent in activities necessary to prepare for the behaviour, to engage in the behaviour, or to recover from its effects
6. Important social, occupational or recreational activities are given up or reduced because of this behaviour
7. The behavior continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the behavio

Appendix VIII

Email From Stephanie Covington (2010)

From: fiona mckinney <fmckinney@me.com>
Subject: **Re: Web site message - SSC**
Date: 17 November 2010 08:18:08 GMT
To: SSCIRD@aol.com

On 17 Nov 2010, at 00:18, SSCIRD@aol.com wrote:

> Hello,
>
> I'm sorry but I do not have any references for you. In terms of women and sex addiction, I have treated women who have this as a presenting problem. However, they have also had untreated trauma. Working with the trauma has been more effective in my work than focusing on the sexual addiction. But this is a very small clinical population.
>
> Best wishes as you proceed.
>
> SC
>
> In a message dated 11/16/2010 10:53:38 A.M. Pacific Standard Time, fmckinney@me.com writes:
>
> > Name: fiona mckinney
> > Phone Number: uk 07834774174
> > E-mail: fmckinney@me.com
> > Message: Hi Stephanie
> >
> > I am a doctoral student in London currently doing research exploring how therapists work with affect regulation in their work with female sex addiction. I am writing to ask if you might be able to recommend any resources I might try. I was very interested to read your paper on women and addiction treatment and particularly interested to know your thoughts on sex addiction amongst female population. It is a strikingly under explored area although gaining some ground in the last few years but not much! I think even less so here in the UK.
> >
> > Look forward to hearing from you and thank you for your time.
> >
> > best wishes
> >
> > Fiona

Appendix IX

Interview Question Protocol

Outline of Initial Interview Questions:

Question I: Sex Addiction

How do you understand sex addiction particularly with women?

- How do you experience this presentation in your clinical practice?
- Describe any difference in presenting symptomology to male sex addiction.

What are your thoughts on women, sex and addiction in this area and How do you see attitudes to shape issues of treatment for women?

Question II: Affect Regulation

- How do you think affect dysregulation contributes to this problem?
- How would you describe working with affect regulation with female sex addicts and please use case material? Describe differences in treatment experience or approach for women and men in you work?

Question III: Treatment Approach

- How do you work with co-regulation?
- How do you work with the co-regulation of affect in particular with the therapeutic alliance?
- How do you work with the (affective) counter-transference?
- How do you work with the transference?
- How do you think about persistent over-regulated or under-regulated affect and relapse prevention?
- Do you draw from a transpersonal philosophy at all?
- Use of self. What do you bring to the mix?
- How do you think about change in this work?

<u>Further Examples of Interview Questions:</u>

How might you reflect on your relational style or approach?

How do you think about your gender and training, personal work with female sex addict clients?

How do you think about the meaning of the terms sexual compulsivity and sexual addiction?

Countertransference and transference and the erotic.

How you think about your own self-care in this work. How do you see yourself in this work of regulatory repair?

How do think about the importance of client therapist gender, attachment style and affect regulating style?

What are the highs and lows for you personally in this work what do you enjoy?

When and what are the most challenging aspects/experiences for you?

Tell me how you might value specific training?

Is this an area of specialism?

How you approach female compulsive masturbation?

Do you experience any different treatment issues for men and women?

For you, is there any difference in how you might approach the work with women as oppose to men?

How do you think about dysregulation and relapse?

How do you approach repair to regulation – what for you does this involve?

Do you particularly address right or left hemisphere in damage/repair/your style.

Experience of assessment and disclosure?

Relationship/alliance in your work?

Appendix X

Recruitment Letter:
Emailed to Agencies and Therapists

Fiona McKinney
35 Octavia Street
Battersea
London, SW11 3DN

Mobile: 07834 774174 Email: fmckinney@me.com

Dear Member

Re: PARTICIPATION IN DOCTORAL RESEARCH INTO THERAPISTS' EXPERIENCES OF WORKING WITH AFFECT REGULATION IN WORK WITH FEMALE SEX ADDICTION FROM A RELATIONAL PERSPECIVE

I am currently in the final year of Doctoral Practitioner training in Counselling Psychology and Psychotherapy by Professional Studies at the Metanoia Institute. For the research aspect of my training, I am very interested in investigating how therapists (qualified psychotherapists, psychologists and counsellors), who have experience of working in the addiction field and/or with sexual compulsivity, use affect regulation in a relational approach in their work with female clients.

Sex addiction is a complex condition which is defined by a person's recurrent failure to control patterns of sexual acting out, despite significant harmful consequences to self and others. I believe no form of sexual behavior in itself constitutes sexual addiction. I see it defined by the relationship between the behaviour pattern and the individual's life, not the by type of behaviour, its object, or its frequency and its social acceptability.

I am curious to know if therapists work with affect in a more behavioural approach such as the Dialectical Behavioural Therapy model of Marsha Linehan? How central is the co-regulating relationship described by Beebe and Lachmann, (2002)? Do therapists choose to disclose affect in the countertransference (Maroda, 2002, 2004) with the client or not, and why. How is the countertransference used as a means of working with affect? How does trauma work overlap here? Which are the affects that therapists particularly experience in working with this clinical group. How do they work with unconscious affect like shame? How is under-regulation and over-regulation worked with in therapy, once the regulating addictive behaviour is arrested?

The reason for my interest is my belief and experience of the significance of sex addiction among women and the dearth of significant empirical research addressing issues of treatment. Therapists with experience of working in the addiction field with women and who identify themselves as working with a relational approach with affect regulation in their work are more likely to have come across women who present with this challenging condition and meet the inclusion criteria for this study. This is an **under-researched area and** anticipate that the findings of this research to serve as a basis for informing the

planning and enhancement of effective therapeutic interventions in working with women who engage in sexually addictive behavioural patterns.

I would really appreciate your participation and contribution to this important research. For further information about what participation would involve, please see the attached sheet.

Yours sincerely

Fiona McKinney
Counselling Psychologist in Training

Supervisor:
Prof. Vanja Orlans
Department of Psychology & Psychotherapy
Metanoia Institute/Middlesex University
13 North Common Lane
London, W5 2QB

Tel: 020 8579 2505

Appendix XI

Example of Initial Coding: Line by Line Coding (Interview 5)

Transcript: Interview 5	Line By Line Codes	Focused Codes	Notes
R/4: First of all I wonder how do you think about sex addiction			
P/4: Sex addiction? Well I see it as a pathological relationship with a mood altering behaviour that has profound consequences.	Defining sex addiction. Being clear. Using text book definition. Seeing addiction as pathological. Mood altering. Profound consequences.	Having a clear understanding.	All therapists so far mention having a clear understanding of sex addiction as a pathological *relationship* with sex as mood altering behaviour.
R/5: There are many ideas about it….I hear so many different views			
P/5: Yea, yea I am pretty clear about this because from my experience you know there is a whole wealth of grey area where people try and slot them into being a sex addict or not….for me I know it is important to get really clear with the client…….you know….about the affects and the impact. Its like that whole thing……a women can have multiple partners, excessive and risky sexual behaviour but that does not make her a sex addict. I am curious about that and I am curious with her. I want to understand with her what this is that about for her. I want to go with her and see where this takes us and what comes from this and then from that you know other stories may or may or not materialize. It gives me a chance to understand the way she sees the world and feels about herself in the world. This helps me inform and create a picture with her so that we can get clarity about that. Essentially though the diagnosis comes back to that pathological relationship with a behaviour that is mood altering in this case sex.	Using experience. Clear about definition. Grey area. Forcing diagnosis/Risking misdiagnosis Clarity with client. Doing together. Clarity in assessment. Impact and consequences. Type of sexual activity not necessarily criteria for diagnosis. Avoiding premature diagnosis. Being curious. Understanding together. Doing with client. On a journey. Client-lead. Going where 'this takes us' Opportunity. Getting understanding. Facilitating stories. No expectation. Creating whole picture. Together. Understanding client's perspective of self in her world.	Diagnosis being confusing. Importance of clarity. Avoiding misdiagnosis. Bracketing assumptions Collaboration. Not presupposing diagnosis Client no in 'box'. Importance of assessment. Client leading About process. Open therapist. Being curious about/with client. Attending to the person of the client	Again there is a tension here between accurately diagnosing the female sex addict but not using diagnostic labels to pigeon hole or diminish the *person* of the client. Collaboration and managing power in the relationship is a consistent theme for co-researchers. There is a sense here of *doing with* of being curious *together.* *Curiosity* also suggests openness and a guarding against imposing presuppositions about client. Getting inside the clients world

	Specific diagnostic criteria. Taking care.		
R/6: So you *get really curious* 'with' the client?			
P/6: That is my style though. I don't tend to slap people with a label or try to pigeon hole them. I find I get much more receptivity if I don't and what I am trying to do is open up their receptivity. Because addiction is predominantly about secrets, its about denial, its about resistance, I want to help her open up, and get in on working with resistance and make her receptive. So I try to do that as transparently and congruent way as I can. I will even tell her I am not playing tricks and that sometimes therapy can 'hold the mystery' – therapists can hold the mystery and I try not to do that - I try to be as transparent for her as I can so that enhances the safety and the trust, which then facilitates her being able to drop the resistance and makes her more receptive. This means they can get to the truth quicker can then help them. It doesn't mean I get my fair share of denial and game playing and the rest of it but I am always coming from that principle.	Having a personal style. Not 'slapping' labels on the client. Avoiding pigeon-holing clients. Labeling shuts down process. Enhancing receptivity. Opening clients' receptivity. Secrecy dominates addiction. Denial. Resistance. Seeing role as supporting clients opening up. Working with resistance. Using transparency and congruence. Humanity of therapist. Humility. Not 'playing tricks'. Not holding mystery. Avoiding idealizing transference. Prioritizing 'transparency' Holding attitude of authenticity. Enhancing safety. Establishing trust. Secure therapeutic alliance facilitates 'dropping of resistance'. Creates receptivity. Facilitates contact? Creating safety and trust. Bonding. Facilitating access to truth. Availability to receive help. Getting fair share of denial. Denial integral to problem. Having a stance. Expecting game playing and denial.	Avoiding labelling. Taking care with proper diagnosis. Openness v's secrets. Therapists personal qualities Therapist's use of self. Demystifying therapy. Working with pre transference. Forming a bond. Therapists qualities and alliance. Building relational contact. Access.	The style of working enhances client receptivity – important with the female sex addict who is distanced and prone to *holding secrets.* Safety and trust in early relationship again important with female sex addicts. Something of the challenges of the work - expecting games and denial.
/7: So you're describing your particular style to be about developing collaboration and in relationship with the client?			
P/7: It is core to ALL of my work. Doesn't matter where in the work or if someone is in the first session or has come to see me for a number of months or a number of years. It is the same…same…same fundamental principle of relationship.	Core to all of work Ongoing throughout therapy. All clients. All stages. Having consistent values. Integrity of	Having a particular style.	*This therapist seemed to reveal his own personal qualities and values here. Again a sense of the person of the therapist. Again seeing*

	approach. Specific style.		*therapist's qualities as central to building alliance. Seeing personal beliefs and stance of therapist as central to their relational approach.*

Appendix XII
Example of Focused Codes

Focused Code	Initial Codes Contributing to Focused Code	Key Cross References	Examples of Indicative Quotes	Notes
Being Collaborative	Style of working P5/4. Sharing P4/38 Exploring together P4/38. Solidarity with women P3/11, 42. Sisters P4/30 Power: *doing to/doing with*: P7/15, 16 Giving clients jurisdiction P5/21, no hierarchy P8/174, *we had the controls* P1/38. Antithesis to secrets and isolation P5/13. Learning, identifying and creating from each other (ALL). Co-constructing narratives P2/12 Creating together P6/46. Helping her to P2/12 Being curious together (P2/5) Guiding (All) Helping her to see Like parent to teenager P8/123; P6/46 We/Us/*You and I*/They (ALL) Joining in tasks & exercises (ALL). *Doing* together -playing P1/67,76; P6/35,44. Collaboration not easy/possible P9/21 Working with both hemispheres P6/13, P12/94. Showing them how P6/44, P7/16. Exploring what it means to be a woman together P4/48	P1/38, 67, 68 76, 100 P2/12, 13, 28 P3/8, 11, 42 P4/27, 30, 38, 48 P5/6, 12, 13, 19, 21 P6/13, 20, 34, 35, 44, 46 P7/15,16 P8/123, 134, 174 P9/21 P10/20, 53, 56 P11/52, 53 P12/ 94	*'Why don't we do something a little differently today…'* P1/76 '*We can talk about that…'* '*I did not like the feeling of separation or hierarchy from the client'* (P8/174). '*A collaborative style is central to how I work'* (P5/6). *'So lets <u>you and I</u> …'* (P5/12). '*I try to facilitate them holding some of the power and jurisdiction round their own work with me'* (P5/21). '*<u>We</u> look at it so she has understanding'* (P2/??). '*Trying to get <u>with</u> her'* (P8/134). '*Helping her to think more clearly'* (P2/12). '*<u>Let's</u> talk about what's going on here'* (P11/53). '*<u>Let's</u> just take a few moments'* (P5/19). '*Doing it* [playing] *<u>together</u> is the basis for learning'* (P6/35). '*<u>They</u> play together'* (P6/20).	Therapists mentioned collaboration to involve individual style and to be a sharing of tasks and activities in sessions and with other collaborative partnerships outside therapy. Female therapists particularly mentioned a sort of gender-driven-collaboration. A 'sisterhood' and a sort of solidarity for women with women. There is a *doing to* and a *doing with* involved in this code of *collaboration.* Collaboration seems to involve explicit processes such as decision making *deciding to, talking, telling, learning guiding etc.* It is mentioned as involving the participation with each other/an other, and to involve conscious left hemisphere task focused activities involving co-constructing narratives, gaining insight together etc.

Focused Code	Initial Codes Contributing to Focused Code	Key Cross References	Examples of Indicative Quotes	Notes
Building 'Conscious' Coherence	Teaching about sex P3/22, P6/37, P4/34 Talking about/explainingP3/12. Education as a soother P8/156. Building skills. soothing P12/84. How to use relationship P2/13. Using protocols P6/28 and exercises (All). In session. Out of session. Between sessions. Explicit techniques. Explicit questioning P1/66. New methods old adaptations. P6/64. Exercises P1. Aversion exercises. P7/16. Educating the *mind* P7/16. All requiring patience. Rehearsal and practice P6/43 & P7/16. Learning to self soothe P6/46. Left hemisphere P6, P7/15. *The more you learn* ...P6. Drawing genitals P4/29. Building autonomy P4/33, P6 & all. Linking thoughts and feelings to actions P12/46. Telling them what to do. Being supportive P4/25. Knowing old scripts P8/170. **Into words:** articulating, speaking, *saying it out loud,* P5/9. Explicit questions P1/66. Naming feelings. Talking about *what's going on.* P11/53. Asking.	P1/66 P2/13, 18 P3/12, 22 P4/25, 29, 33, 34 P5/9 P6/28, 37, 43, 46, 64, 66 P7/15, 16 P8/156, 170 P9 P10 P11/29, 53 P12/46, 84	*'So basically, based on the idea of coherence and how someone relates to their past what <u>we are engaged in</u> is helping her relate to her past differently. To help her to learn to deal with her feelings in an effective manner so even if she is feeling anxious based on <u>incorrect information or misinterpretation</u> of what is going on there are still things she needs to do in order to deal with her anxiety'* (P2/12).	

Focused Code	Initial Codes Contributing to Focused Code	Key Cross References	Examples of Indicative Quotes	Notes
	Creating insights: P6/46, P7/15Getting her to see P3/4&8. Helping her to thinking more clearly P2/12. A chance to realize P3/17. Explaining why P2/12. Seeing patterns P4/40. Creating choice P3/4, P5/19. Trying to get her to see P3/4, 8. Womanhood P4/48. Insights through play P4/48, P6/. Powerful and revealing P1/29. Getting conscious P12/48. Mindfulness. Making unconscious conscious P2/12. Getting conscious P12/48 & all. Constructing new narrative and rationale P2/12, P6/16, 28 & 44. Challenging misimpressions/creating new impressions P2/12, P12/39. Telling an old/new story P1/33, P7/16. Deconstructing to reconstruct P11/41. Making new meaning P5/18, P12/39. Keeping a journal P4/24, P7/16. Do-coding the story of their life P10/23. *She realizes* P10/44. Using left brain – volume control P6/16 &18. Right and left hemisphere. Getting balance. P7	P1/29, 31, 33 P2/ 12 P3/4, 8, 17 P4/24, 40, 48 P5/18 P6/16, 28, 34, 35, 44, 46, P7/15, 16 P8/170 P9/ P10, 23, 44 P11/41 P12/39, 48	*'We started off looking at affect regulation and looking at the whole thing of the sexual behaviours when really we can't make sense of that unless we deconstruct it into the parts of this particular person's history, character development projects into it as a way of managing'* (P11/41).	

Appendix XIII

Table of Categories

Category 1: The Multiversal Space

Properties of this Category	Participants Contributing Category	Dimensions of Category	Key Cross References	Indicative Quotes
Multiversal Space	All	Time & Space Movement Processes converging/meeting *In/Out*		

Category 2: Forming Relationship

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Affect Needs Relationship	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Affect co-created process Occurring in relationship Relationship is sexualized 'Shared emotional soup': co-ordinating affect.	P1/11, 56, 98, 100. P2/2, 4, 11,12, 13, 23, 27, 35. P3/3, 4, 18, 27, 34, 35. P4/ 4, 8, 9,17, 27, 30, 35, 36 P5/4, 5, 18, 31 P6/23,25, 43, 45 P7/8, 22, 23, 25 P8/22 P9/8, 12 P10/12, 18 P11/18, 23, 29, 35, 45, 76 P12/25, 74	*So, it's actually all about relationship, it always comes back to that'.* (P3/34) '*Everything is sexual, even how she relates is sexual. She doesn't know how not to be. When she sits with me she will flirt with me, there is a type of sexual tension and we have talked about that'.* (P4/9) '*The shared emotional soup two people get into in the therapeutic relationship is, I believe all about my emotions and my clients' emotions. I think they constitute about 80% of the therapeutic relationship whether it was good, excellent, fabulous, bad or a nightmare. I think our shared affect and difficulty regulating affect determined how the relationship went'.* (P1/98)

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
'Any Bond Will Do'	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Creating/not creating early bond Clients personality style: avoidant/narcissistic Proximity: closeness/distance Duration: short term/long term Finding opportunity to bond Using transference: projections and archetypes Working with sexualized/erotic transference	P1/22, 53, 54, 55-57 P2/12, 24 P3/28, 30, 35, 55 P4/4, 28, 55 P5/14, 15 P6/24, 39 P7/8, 24 P8/174, 175 P9/20, 21 P10/10, 24, 35 P11/23, 29, 34, 45, 46, 47, 55-57, 175 P12/82	'*Almost all of them have significant early relationship disruption and attachment disorders. I have never found an addict wanting to climb up with me for years and years. They have a very hard time attaching in the work and the true female sex addict does not want to stay around for years and do the* work'. (P1/55) '*One of the things working with a female sex addict is that it is important for them to make the therapist into an archetype or projection quickly in order for them to begin to do the work'.* (P1/55) *'Very early on and are likely to label me something whether its hag, mum or the guy who is not there'* (P3/30) '*You are the client and I am the therapist but we are also two women in this room and we can be as honest as we can with each other'.* (P4/28). '*Ready for sex'.* (P5/15) '*Coquettish and coy'.* (P11/34) '*Higher level of romance'.* (P1/55) '*It is going to be a very superficial and arms length keeping projection that is just going to come up right away, you see it immediately and it does not take long to form'.* (P10/35).

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Shared Under-standing	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Understanding problem Co-creating meaning Assessment tools Psycho-education Creating trust Goals Human to human connection	P1/11, 13, 15 P2/3, 12 P3/12, 35 P4/12, 13, 25, 28, 34 P5/5, 6, 12, 18, 30 P6/28, 29 P7/13, 14, 24 P8/156, 157, 161, 168 P9/18, 35 P10/15 P11/17, 52, 76 P12/39, 47	'*They are not going to be able to get that going in the relationship with me if I am standing with a clipboard. They are only going to so that in relation to another human being, therefore they are going to do that with a therapist. The fact that I am a therapist and have a background of information and experience running at the same time is not the point. The point is that it is the human relatedness of it'* P5/30.

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
It-It, No Mutuality	P1, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Mutuality/no mutuality Object-to-object Therapist as 'it' object. Deadness: the 'dying' client/erotic Pacing interventions/therapist passivity Subjectivity feels precarious 'No flow' Slow work	P1/7, 54, 55 P2/? P3/13 P4/3,14, P5/12, 18 P6/22 P7/23, 25 P8/74, 133,137,156 P9/20, 21, 30, 35, 37 P10/11, 21, 22, 25, 37, 60 P11/16, 21, 22, 23, 25, 28, 44, 48, 50, 51, 52, 53, 54, 55, 76 P12/	'*Being in a more mutual giving and taking type of relationship'.* (P11/23) '*Now although I am in the room they don't really see me in the room. I am an object an it could be like that for a few* years'. (P4/14) *'I am not a person in the room opposite them'* (P1/55) '*She was a very beautiful object to look at. It was like looking at a beautiful statue by Michaelangelo. There was a deadness about her but at the same time she had a beautiful smile. I perceived her as not so much as an object of sex, not even desire but an object of beauty'.* (P9/21) *'I won't have to work very hard – I will listen and just be supportive and empathic'.* (P10/21) '*Holding back on interventions and questions to build the relationship and the contact slowly and gradually'.* (P11/51) '*In a one person relationship position, if you introduce them to a two-person they will freak out and try to ban them/you or get rid of them/you. It is a slow and difficult work'.* P11/51 '*There was no way I could get any flow in any kind of conversations without her either collapsing again (and more at the beginning of therapy) without collapsing again into her terrible anxiety which would be overwhelming for her'.* (P10/21)

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
In Here/Out There	P1, P2, P3, P4, P5, P6,P7, P8, P9, P10, P11, P12	Locus of regulation. Inside/outside Acting 'with' not acting 'out'. Differentiating affective from sexual arousal. Context of relationship for client: with therapist, intimate partners, social groups. Couples work. .	P1/93 P2/12, 13, P3/15 P4/24, 32, 34 P5/6, 9, 35 P6/32, 37, 40, 46, 52 P7/15, 16 P8/180 P9/7,8 P10/18, 29, 30, 44, 53 P11/12, 30, 54, P12/35, 46, 87,	'*Huge excitation to act out.* (P11/15) '*The return of affect that has not been regulated'* P5/9. '*They want to take it outside rather than bring it in'* P11/30 '*Their dysregulated affect gets pushed all over the place and they have no internal objects to regulate this and they want to get rid of it outside of themselves'.* (P12/23) '*As they start to get abstinence we will see a return of the affect that has not been regulated or that they are unable to regulate'* P5/9 '*Its important they have people to share this with on the outside because otherwise they open up and then they close up'* P3/40 '*It is brought inside the relationship in therapy'*. (P11/30) '*You take the locus of control that is out there and you put it in here'* P12/87 *'A lot of the time I am doing couples therapy even though there is only one person there. How to manage a relationship. How to manage yourself in the sense of asking for your needs to be met and your feelings to be dealt with effectively'* P2/13 '*She needs to be able to do this with her partner and that is key. She has to be able to do that with her partner – in partnership and say to her partner 'this is what I am feeling and this is what I am thinking'. Maybe she needs reassurance or maybe she needs him to stop doing something'.* (P2/12)

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Uniqueness of Each Dyad	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Person/symptom Top down/bottom up Adapting to each client Uniqueness of each dyad Curiosity	P1/24, 29, 31, 108, 109 P2/2 P3/10, 13, 19, 20, 35, 35 P4/37 P5/10, 12, 25 P6/42 P7/13-19 P8/50, 137, 154 P9/15, 90 P10/73 P11/17, 21, 23, 27, 70, 76 P12/85	'*I have worked with some very badly damaged female sex addicts and each one I have worked with differently. I don't mean unethically or improperly I mean I am going to have a different relationship with each – it has to be different for each one'* P3/19 '*I am getting to know the person sitting in front of me and am always looking to see what the addiction is about for the woman sitting in front of me and always looking at the primary issue going on underneath the sexually addictive behaviour and asking what this constitutes'* P5/12 '*You are getting to know the person, your responses and her responses to you both conscious and unconscious. I mean you sort of find your way into the person* P3/10 *All women do it differently* P1/31

Category 3: The Therapists' Edge

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Women, Sex, Affect, and Addiction	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Beliefs & biases Conscious/unconscious Safety in Stereotypes/Stigma/Power The Masturbation Myth Social Sanctions Attitudes to Gender	P1/12, 71, 98, 99, 104 P2/2, 3, 4, 6, 26, 40 P3/1, 4, 9, 10, 11, 24, 42, 43 P4/4, 18 P5/6, 24, 30, 40 P6/6, 7, 18, 23, 24,28, 48 P7/4, 20, 23 P8/143, 146 P9/9 P10/11, 17, 19 P11/17, 20, 31-32, 34, 38 P12/22, 25, 26, 28, 33, 85	'*It is crazy to think social constructs don't exist in therapy'* (P11/31-32). *'In our society is sex is in our face all the time where ever you go, but if you cross the line by God people will attack you'* (P6/48). '*Good girls aren't meant to be sex addicts – good girls go to heaven and bad girls go everywhere'* (P2/40). *'So we are looking at different types of female sexual behavior where it might be labeled within a patriarchal society as drug companies are trying to find a female disorder saying we will give you a pill. Are we playing into the male dominant field and are you actually opening up how female sexuality is expressed particularly sexually compulsive behaviours. Some women might be happy with their activities – people who are polyamorous for example. Perhaps what they are doing is disconcerting the status quo and hence getting labeled'* (P3/42). '*I had one recently who was pretty blatant and what she was describing as almost pornographic. She was married and having an affair and the sex was out of control. She was having sex in the parking lot and having sex under a table at an exhibition. I was pretty wild and that was pretty uncommon for the clients I see' They are more the romance type* (P2/4). '*The difference is reflected in the lower place women have. It is not socially sanctioned for women to act out. If she breaks up with her partner and goes out on the prowl to find a man it is not considered good. If a man does it people will say – oh the poor guy has a broken heart'* (P12/28). '*Women don't masturbate'.* (P2/6) '*Women lie about that stuff*' (P2/8).

Properties of this Categories	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
				'The difference is reflected in the lower position women have. It is not socially sanctioned for a woman to act out. If she breaks up with a partner and goes out on the prowl to find another man it is not considered good. If a man does it they say oh well poor guy has a broken heart' (P12/28). '*I don't think it can be a totally divided male/female behaviour'* (P3/11) . *'I am very wary of anything that lumps the girls with the boys too much'* (P3/1). *'She would say things in a very bravado way saying that she liked to have sex probably more like a gay man because she would do sex with waiters at parties in the lavatories'* (P10/9). *'More and more of my female sex addict clients are coming in with what look like a male template type of sexual addiction'* (P1/7). *'More likely than men, not to be in control of their feelings'* (P2/3). '*Women's nervous energy is often very high and it's exhausting to be around'* (P11/44). *'Women are more agitated generally, with females there is much more agitation. I would even go so far as to say hysterical – high intensity and more than the men I have worked with. That is a generalization but definitely more than the men I have seen* (P8/145). *'I don't know how male therapists do it but they do. They learn it but it doesn't come naturally. What is it like to have a child who is screaming with tears and fear having scraped their knee and how do you do that as a mother. Mothers 'know' how to do that – but fathers have to watch and learn'.* (P1/71)

Properties of this Categories	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Innate Ways of 'Being With'	P1, P2, P3, P4, P5, P6, P7, P8, P10, P11, P12	Personality traits Autobiographical influence Style of contact: born with/inevitable Permanency/fixed way of relating Cognitve/intuitive Intimacy/avoidance Style enhanced by training Gender	P1/38, 42, 98, 99 P2/6, 17, 18 P3/13, 15, 35 P4/16, 17, 18 P5/6, 16 P6/39, 49 P7/20, 22, 24 P8/120, 123, 133, 171 P10/53 P11/20, 23, 29, 32, 48, 52, 78 P12/85, 95	*'I couldn't work any other way'* (P1/99). '*It's the avoidant in me I don't encourage dependency'* (P12/95). '*The dependency needs and the fear of abandonment for the female sex addict is such that they get hooked into relationship and evoke feelings in me of wanting to get the hell out'* (P2/18). *'…a raw intimate way'* (P1/99). '*They become very attached to me. I do not worry about dependency*' (P6/39). *'I perhaps am more distant and detached'* (P2/17). *'A very armoured and a very rigid style'* (P1/42). *'Too emotionally reactive'* (P8/171). *'Now there are many, many ways of working with people in therapy that do not have much emphasis on the therapist's affect and regulation, classic psychoanalysis is an example – I was never meant to be a blank screen thus I never even bothered trying to train into that way … So I think this is the engine that drove the train'* (P1/98).

Properties of this Categories	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Professional Training	P1, P2, P3, P4, P5, P6, P7, P8, P10, P11, P12	Evolving over time Integration of new knowledge Attitude Personal growth/Learning and acquiring skills Capaciousness, flexibility, adaptability beyond own limitations Specific training Particular personal work Serving the Apprenticeship Getting, down, dirty and honest: sexual arousal/unconscious	P1/29, 37, 38, 40, 42, 43, 54, 57, 84, 100, 101, 115, 116 P2/6, 12 P3/16, 27, 28, 35 P4/16,17, 18 P5/5, 6, 12, 13, 14,16, 17, 18, 100 P6/49 P7/17, 125 P8/122 P9/28 P10/6, 9, 10, 32, 36, 37, 73 P11/ 46, 51, 68, 70, 76, 78 P12/14, 15, 32, 46, 78, 85, 98	*'I believe I can now work with clients I couldn't have worked with before because of this significant additional piece which has allowed me to change my affective system because of the training I went through. If I hadn't I would still have the limitations we talked about and now I can work fairly well with most of these clients even if I bomb out spectacularly* (P5/100). *'The somatic work and regulation of affect and the body senses has expanded and deepened how I work so as I said earlier I could probably work with that client now and I couldn't then because I didn't have enough capaciousness in my own system that I can now hold and as I said it's only because of the somatic uh work that I was able to develop that. That was the only way I could hold it'* (P12/98). '*I am different with everyone who comes into the room'* (P10/73). *'The benefits of my training and own personal work is that I have been able to regulate my own affect and learn to do that in more wholesome efficient ways that means I am in a good position to absorb, to hold, to be with another person in their affect'* (P7/17). *'I think there is a gender-specific piece here and we are not made to think about that and include that'* (P11/29). *'I purposefully sought a woman to go and see for analysis. I have been in therapy before and I knew there was a part of me missing, the part that really is able to get inside her, be part of her, that real experience as a man. From my personal experience there is a difference and a necessary difference* (P10/32). *'Taking some nourishment from that which has been fertile in my life outside in my own sex life which filters through into the work at different levels'* (P4/18).

Properties of this Categories	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
				'It is not so much about their own perfect recovery' P1/32. *'The first thing is that for a psychotherapist if he or she has in any way got unresolved issues around their own sexuality and their own sexual experience and their own comfort in their own skin then it is going to come up in the work – it has to'* (P1/40). *'My sexual arousal template can occasionally be triggered*' (P5/14). *'I have to have great ease and comfort in my own skin'* (P4/18). *'If you don't look at your own life and get down and dirty and honest with it you won't pick up those strands of the people you work with and therefore you won't lead them to a different way of actually being in relationship with better boundaries and more containment* (P11/70). *'It's been an interesting awakening for me to experience the sexual energy and sexual frustration of women and sexual power of women through sexual appetite, the capacity to multiple orgasm, to stay longer in sex, all of those things feel quite intimidating, quite powerful on some level, and I believe that comes into the therapy and based on my development as a therapist can get missed by me. If I have not really considered it, worked through how I feel about it and how I understand it then I will miss it and if I am really honest I have missed that sometimes because it has come into awareness in supervision'* (P11/41–42). *'Awareness of working with my own issues within this particular subset of work I think is so essential, particularly when this countertransference comes up..... It might not be extreme but it might be very low level and I might not even be aware of it. What might happen? So this takes particular personal work and supervision*' (P1/42)

Category 4: Managing Risk and Safe Surprises

Therapists' Anxieties	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Eliciting intensity Fear, worry & concern In control/out of control Legal issues Complaints/attacks Flanks Covered: protection/availability Invaded/Infected/Contaminated Alien/*me, but not mine*	P1/21, 29, 32, 37, 41, 42, 43, 56, 60, 62, 63, 79, 97, 98, 99, 100, 114 P2/4, 11, 18, 21, 23, 29, P3/8, 16, 22, 27, 35 P4/13, 16, 22, 37 P5/9, 10, 12, 13, 18, 21 P6/28, 45 P7/8 P8/144, 149, 176 P9/7, 18, 21, 24, 25, 28, 33, 35, 43, 44 P10/43, 44 P11/34, 44, 51, 70 P12/38, 84	'*The nature of the client's material can elicit such an emotional intensity for me'* (P1/49). *'Dark, hair-raising and horrendous'* (P1/32). *'Quite terrifying to listen to'* (P9/28). '*Its about to get out of control'* (P5/18). *'I always feel worry and a concern that there is something fraught or hysterical about it [heightened affect] which is looking to be in a sense contained and made sense of*' (P11/46). *'Closely resembles one's own'* (P3/27). *'Fraught with difficulty'* (P11/51). '*If they are sexualizing me, which many clients will, both the females and the males, it can be grim and very difficult for the practitioner* (P1/59). *'Ending up in court'* (P10/43). *'I've known people who've had complaints made against them. I think it's an area that's fraught with difficulty'* (P10/43). *'When you are dealing with probable perversions and areas which are kind of dangerous and looking at the potential of legal difficulties this needs a lot more containment and different supervision'* (P11/51). *'I suppose my fear is appearing to be prurient, you know asking questions about what makes you, what trips you into orgasm. Not what you're doing when you're having sex but what trips you into orgasm. Whenever I want to ask anything like this, I always quote the thing that someone said and then ask 'would you find that would be so for you' and then kind of go into it that was.* (P10/43).

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
				'I've stayed back from it rather than putting my foot on the gas, which I might do with other clients. There is something about her energy. It's like a bird that will just fly out the window if it's kind of frightened and yet she is no stranger to the sordid or the extreme kind of pornographic ends of the imagination. Her own and other people's' (P9/44). '*Invaded and infected by the other persons illness'* (P1/24). *'An unfamiliar sexual fantasy'* (P10/24). *'It feels like I am infected with someone else's sadomasochistic patterns and I am noticing it in my own sexual masturbation fantasies or wherever I look I am imagining you know the person in front of me in the grocery store is a sadomasochist because of how she is dressed'* (P1/42). *'False therapist'* (P11/32) '*Working with the female sex addict if you have not got your flanks covered you will have some problems'* (P5/13).

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
Blind Spots, Snags, Hoodwinks & Triggers	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Replicating old/enabling new In/out of awareness Co-created 'Being Walter Raleigh': Rescuer/victim Gender Seduction/sexualization Unpredictability	P1/40, 42, 61, 62, 64, 101, 102,104 P2/ P3/9, 10, 27 P4/9, 13, 16, 17, 19 P5/13, 14 P6/48 P7/8 P8/179 P9/18, 19, 21, 24, 28, 33, 35, 36, 45 P10/36, 46, 56, 61, 65, 66 P11/40, 41, 45, 48 P12/75,76, 79,	*'Replicates back then'* (P5/19). *'We enable some new insight/experience to occur'* (P11/45). '*Blind spots'* (P1/62). *'Screwed around with her'* (P1/62). *'Snags'* (P1/60) *'Being hoodwinked'* (P1/104) *'Embroiled* and *enmeshed* (P9/36). *'Sticky net'* (P1/63). *'Bombing out'* (P1/98). *'End[ing] in an explosion of some kind'* (P1). *'Caught up in the mess of it'* (P9/36). *'I was really feeling sucked in'* (P9/28). *'I think based on my development as a therapist that can get missed by me. If I have not really considered it, worked through it, and know how I feel about it and understand it then I'll miss it'* (P11/41). *'Man to rescue them'* (P3/14). *'I got involved with her son's case and helped with it so it was a bad idea from the therapy point of view because I crossed boundaries and she began to respond to me in a dysfunctional way, in that old unhealthy way'* (P2/21).

Properties of this Category	Participants Contributing to Category	Dimensions of Category	Key Cross References	Indicative Quotes
				'I realized that I was getting enmeshed in the mess' (P9/36). *'Cure* or *get them well'* (P9/31) *'She would never have become sexual with this client but fell right into a co-transferential blind spot where she allowed this young women to just screw her around and stay in her house one night and sleep on her couch and cuddle up next to her and then filed a law suit the next day* (P1/62). *'Ruffling hair in seductive moments'* (P9/19). *'Lick chocolate on her coffee lid'* (P11/45). *'Ate* [banana] *after propping it up like an erect penis'* (P10/46). *'Really gruelling for me, hard difficult gruelling'* (P1/114). *'Fairly obvious manipulations like short skirt and buttons undone on her shirt'* (P9/21). *'Bombing out'* (P1/41). *'Ending in an explosion of some kind'* (P1/41). *'False suffocation alarm which fires off at the tiniest event'* (P9/24). *'At a moment's notice'* (P5/19). '*Easily triggered'* (P12/82). '*Pushed into one small intense area, which becomes dangerous'* (P11/48). '*She had the most beautiful, dark, waist length hair which she would often ruffle up in quite sort of seductive moments which I think would soothe her in ways that were not the ways in which I was going to soother her'* P9/19

Properties of this Category	Participants Contributing to Sub-category	Properties of Sub Category	Dimensions of Properties	Indicative Quotes
Shame	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12 While	Mutual process Acting out/Shame Isolation/in relationship High level/low level Clients shame Resistance Reducing shame 'Hairs breadth trigger' Narcissistic wound	P1/43, 63, 98, 100, P2/2, 12, 27, 29 P3/18 P4/4, 13 P5/6, 13, 18 P6/33, 48 P7/8, 10, 20 P8/159, 160 P9/44, 45, P10/44, 45 P11/52, 53 P12/31, 32, 33, 78, 82	*'Do you know The Little Prince? 'Why do you drink?'. 'Because I am ashamed'. 'And why are you ashamed?' 'Because I drink'. That cycle repeats itself in sex addiction. I had a woman client who was a sex worker who committed suicide and she used to say 'shame is to sex addiction is what oxygen is to a fire', and I have never forgotten it'* (P8/8). *'Someone who has a low level of shame is not going to do shameful things'* (P2/27). *'I am not a freak'* (P6/33). *'Knowing where the addiction comes from'* (P6/34). *'I think there's a lot of shame around and I don't think it's really named early on but it is always looming over the horizon. At some point in the therapy I usually will say to people, you know what this is, this is shame isn't it. This is a self wound and you can start doing some education work around it* (P10/45). *'Hair's breadth'* (P12/82). '*Explosions'* (P1/41). *'Wonder[ing] why they can't and that there is something flawed about them'* (P2/27). *'What I often find is that for many people who can't feel, dissociate and numb out, the first feeling is of relief when we honour it as something that kept you safe, rather than as something that defines you as being wrong or bad'* (P5/18). *'Female sex addicts can be deeply embarrassed if they have been particularly promiscuous'* (P2/11) *'Any emotion not effectively dealt with becomes a source of shame so the female sex addict will get a fix for the shame by getting someone else to care about them and give them love and admiration that they cannot give themselves'* (P2/12).

Category 5: Finding a Shared Frequency

Properties of this Category	Contributing Participants	Dimensions of Category	Key Cross References	Indicative Quotes
Entering Each Other	P1, P2, P3, P4, P5, P6, P8, P10, P11,	Having rhythm Getting underneath Getting inside Taking in Emerging and meeting Searching and exploring Finding, retrieving Avoiding exposure With permission, being Invited Allowed Depth/surface Bits at a time Entering therapist Being entered	P1/42, 43, 55 P2/12 P3/14, 15, 17, 20, 35 P4/12, 18, 22, 24, 28, P5/6,18, 26, 46, 54. P6/39, 43 P7/ None P8/167, 171 P9/28 P10/20, 37, 59, 60, 62, 63 P11/12, 43, 70, 77. P12/23, 36, 38, 47, 49, 52, 76	'*You are getting to know the person, your responses to her and her responses to you, both at a conscious and unconscious level. You are finding your way into the person* (P3/20). '*Deep between layers'* (P10/20). '*Trying to get in'* *'Opening up'* *'Getting up and underneath'* *'Back and forth'* (P11/ '*Bit by bit'* (P4/28). *'And you don't have to take me in as a whole, you can use bits at a time. Some you might use and some you might not. There are bits of Mother you liked and bits of Mother you did not* (P4/28).

Properties of this Category	Contributing Participants and Key References	Dimensions of Category	Key Cross References	Indicative Quotes
Locking In	P1, P2, P3, P4, P5, P6, P7, P8, P11, 12	Intentional/intuitive Absorbing Marking Early non-verbal, using eye contact proto-conversations, mirroring, facial expressions, prosody Unconscious/conscious Connecting/disconnecting Mother/infant Therapist as conduit	P1/22, 43, 70, 71 P2/40 P3/20, 21, 22, 29, 30 P4/12, 13, P5/17, 18, 26 P6/16, 39, 45, 48, 49, 50 P7/25 P8/170, 171, P11/56, 57 P12/48, 50	'*Addiction is like a merger experience'* (P7/25). '*Its intriguing because at one level I am doing this intentionally but at another I am not'* (P5/26). '*We are plugging into one another'* P4/14. '*On one level you are in the protoconversations with the client. I think as they look a you it is like babies/infants and mothers who are locked and so are we, we are locked in like this in therapy* (P6/49). *'If I do not stay engaged with my own process they do not stay engaged with me'* (P3/15). *'If I am not able to connect with my affect and my own bodily reactions with my sex addict clients whether it is disgust or it's excitement or it's my own eroticized rage, whatever it is, if I don't connect with it to some consistent extent throughout my work, clients either dissociate, they leave, they shut down or they act out'* (P1/43). *'I have to watch myself. I can also become too heady. I can get too cognitive'* (P3/14). *'From head to body'* (P7/176)

Properties of this Category	Contributing Participants and Key References	Dimensions of Category	Key Cross References	Indicative Quotes
Co-Regulating	P1, P2, P3, P4, P5, P6 P8, P9, P10, P11, P12	Repairing Role of Reparative other Modeling regulation Multiplicity/multileveled Dampening down/Enlivening Implicit/Explicit	P1/68,69,70, 73,74,75 P2/27 P3/20,32,21,22, P4/13 P5/17, 18 P6/13, 16, 35, 48, P7/ P8/20,179, P9/19 P10/30, 34, 59, 62, 65 P11/48, 53 P12/45,74	*'I practise what I preach, just as I regulate my emotions they see it in action'* (P2/ 27). *'Conducting an orchestra'* (P10/59). *'Softening', 'Calming'* and *'Dampening down'* (P6/35). *'Urge to reveal all'* (P5/18).

Properties of this Category	Contributing Participants and Key References	Dimensions of Category	Key Cross References	Indicative Quotes
The Unconscious Web	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Inside/Outside Therapist In/out of awareness Me/not me Fantasy, Dreams & Images Enabling shifts	P1/42, 48, 68, 72, 73, 74, 98 P2/12 P3/13, 32 P4/6, 15, 17 P5/17,18 P6/50 P7/15, 16, P8/20, 125, 176 P9/19, 20, P10/19, 30, 36, 41, 53, 65 P11/23, 43, 53, 54, 76 P12/ 41, 47	'*Addicts communicate through splitting so I know I am going to feel everything at some point they do not want to feel for themselves'* (P10/30). '*Very low level that I might not be aware of it'* (P1/41). *'Get your tits out…..making her come to therapy but not paying, or taking the money but not giving her therapy*' (P10/53). *'Something she wanted me to know unconscious to unconscious' 'Something to shift in me which did open up a different space for us in the therapy*' (P10/41). '*Looking at it in supervision and understanding what she wanted me to know unconscious to unconscious I think then shifted something in me which did open up a different space for us in the therapy'* (P11/41). *'She has either dreams about you or keeps asking to marry you, have sex with you, and so on. So it kind of works its way through to them saying I'm having dreams about my father, I want to be with my father, and bit by bit letting that go, so they can let the father go and go and have their relationship* (P11/27). *'Being drawn into a more intimate relationship with her, then opening up and allowing myself to be used more as a sexual object, the past sexual object. We can think about the experience together. That is where it really changed. Parts of me could be used as a part object to be thought about and to be drawn into dreams. We could then think about it and bring it into the relationship. So it is like bringing the sexual bits into the other. Now we can see something different'* (P11/42). '*Sexual masturbation fantasies'* (P1/42) '*Using my own system to regulate them'* (P1/68). *'You just put it on my unconscious web and leave it, then it resonates, then it will draw itself in naturally and just remain with it, with it the beyond approach of memory or desire as best you can. That's what I did, but I mean that insight enabled something to shift and draw me into a more intimate relationship with her and opened it up to let me be used much more as the sexual object'* (P11/43). '*I don't say it but I know it and feel it'* (P12/47). *'I had not understood the pain behind her destructiveness. Although I might have known it theoretically I had not until that point felt it to be located in me'* (P10/36).

Properties of this Category	Contributing Participants and Key References	Dimensions of Category	Key Cross References	Indicative Quotes
Body Whispering	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Umbilical Cord Somatic Ear Inside Body Observing Clients Soma Intersomatic Regulation Somatic Soothing Corresponding States	P1/38, 54, 68, 73, 74 P2/25 P3/8, 19 P4/33 P5/6, 18 P6/34, 35, 48, 50 P7/15 P8/20, 164, 167, 176 P9/19, 20 P10/19, 30, 36, 38, 58 P11/41, 43, 53, P12/41, 47, 68, 74	*'I think that sometimes this is what our brains were designed to do and what we do is mirror that. As an infant absorbs from the mother, so the mother absorbs from the infant. As an adult to adult we are co-communicating as well. I am absorbing from them and they are absorbing from me'* (P6/50). *'Absorb the client (affect) without being phased by it'* (P5/17). *'Listen to the client's body affect'* (P5/18). *'Somatic ear'* (P9/21). *'Sense*'. *'Intuition'*. *'Body intelligence'* (P5/20). *'My own body, my emotions, now that is the place where I have to look for the subtle work, particularly with very sexually anorexic, numbed, avoidant clients. There is no affect. There is nothing. No energy. No affect. There is very little going on. I notice my body feel a little colder and that is where I have to go for the much more subtle work. My breathing becomes very constricted and I notice my body get colder, my muscles are tightening – this person is very frozen I am sitting with* (P1/72–73). *'Their sense of body [having] been removed'* (P3/19). *'Because these women are so shut down, the talking therapies are not going to get us very far* (P1/74). *'Somatically charged at a moment's notice'* (P5/18). *'I am noticing somatic affect, emotional affect and I am looking at their faces and bodies, I am watching their whole being* (P5/18). *'I watch the posture, the way their shoulders are and I watch the breathing, very carefully watching their bodies you know gives me a hint about how where they are you know in terms of their tolerance'* (P12/74). *'I had to be very conscious of facial expressions and there was no way I was going to scan her body, as I would do with a man. I would just have to hope that I would see it out of the corner of my mind as she was crossing her legs, tapping her foot, anything that might give away a clue about how she was feeling.* (P10/21). *'I will try to find a sort of a way I might tick the heat up in the room'* (P1/74). *'So if they are telling me their story, their narrative, I can get a sense of their somatic affect, emotional affect – their affect bodies and know that this is going into a space where it is out of control and dissociative or re-traumatizing'* (P5/18).

Properties of this Category	Contributing Participants and Key References	Dimensions of Category	Key Cross References	Indicative Quotes
				'I stay measured I stay calm I look at what emotional state is probably going on inside of me as a reflection and then I try to use my system to regulate so that they can feel safe and anchored and then once the peak of it is come through then I'll have them sit and talk about it' **(P1/68).** *'And he was taking his business to the Court of Human Rights to get the smutty films shown and um, he had an anxiety attack right in the room in the second session. Doing all this kind of – and I just sat there. And the more upset he became, the more calm I became and I was amazed at this exchange because by the time he'd climbed back into himself after threatening to climb back out'* (P10/65)
Conscious Collaboration	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12	Being Collaborative Using explicit interventions: Verbal *into words* & Non Verbal *no words* Cognitive and implicit relating.	P1/15, 31, 76, 100 P2/12, 13, 28 P3/4, 8, 11, 12, 17, 22. 29, 42 P4/21, 25, 27, 28, 30, 33, 34, 38, 40, 46 P5/6,12,13,18, 21 P6/13, 20 34, 28, 34, 35 37, 41, 43, 44, 46, 48 P7/15, 16 P8/123, 134, 156, 168, 170, 174, 176 P9/20, 21, 53, 56, 60 P10/45 P11/52, 53 P12/39, 47, 46, 48, 89, 94	'*Hierarchy'* (P8/174) '*I try to facilitate them holding some of the power and jurisdiction round their own work with me'* (P5/21). *'Correcting misimpressions'* (P2/12). *'So basically, based on the idea of coherence and how someone relates to their past what <u>we are engaged in</u> is helping her relate to her past differently. To help her to learn to deal with her feelings in an effective manner so even if she is feeling anxious based on incorrect information or misinterpretation of what is going on there are still things she needs to do in order to deal with her anxiety'* (P2/12). *'Now that we have got her to the point where she is thinking more clearly'* (P2/12). *'Bringing beliefs into the conscious mind that are so deeply programmed in the unconscious mind'* (P2/12).

Appendix XIV
Example of Peer Checking: Transcript Excerpt Interview 5

Interview Transcript	Researchers Initial Codes	Peer Member Initial Codes
R/9: So how she lives sexually is quite different from how she fantasises about how that life would look……		
P/9: and everything is sexual – even how she relates is sexual. She doesn't know how to be.	Everything is sexual. Relating is sexualised. Difficulty not sexualizing everything. Openly discussing sexual tension in therapy relationship.	*Everything is sexual, doesn't know how to be not sexual*
When she sits with me there is a sexual type of tension and we have talked about that.	Openness about erotic energy. Sexualizing relationships. Sexualizing therapist	*Sexual tensions with her. They talk about it.*
I have just referred her to SLA and she says she identifies with everybody as they are talking as she is.	Having interpersonal difficulty. Referral to SLA Needing identification with others in group No knowledge of how to identify oneself another way. Having identification with others Using group	*Identifies with others with same condition*
Preoccupation and fantasy – little house on the prairie and fancies every man but it is all sexual – there is no….she doesn't know how to communicate about anything. She does talk about different subjects but can't do that with men.	Preoccupation. Fantasy Fantasy 'Little House on the Prairie'. Fancies every man. All sexual. All communication sexualised. No other way of being/relating.	*Idealized fantasy. Fancies every man. Out of control. Can only communicate sexually*
R/10: Only with women it would seem….		

Interview Transcript	Researchers Initial Codes	Peer Member Initial Codes
R/11: So in terms of those early relationships shaping early behaviour I guess the next topic is how you think early attachment relationship support of don't support affect regulation and styles of regulation and how affect dysregulation contributes to the problem of sex addiction?		
R/12: So when we talk about women using sex as an offshoot of an attachment disorder. Creating some sort of connection yet connecting from it, Um….there is anger acting out, anxiety about intimacy avoidance which might be too much so somewhere it sounds as if it is a compensating function in a regulating capacity. In terms of how you work with clients….would you focus or would it be a part of your work to use the relationship to support a new experience or a change to their style in how they regulate affect.		
P12: What I do is when they come to me and say I think I am a sex addict. Now what does that me for them have they read something. Sometimes they might come and have other issues and sexual addiction comes out at a later stage. What I tend to do first is educate them a bit. I think they need and education about sex. What it is what it means. What it means for them. They tend to be immature – emotionally immature…um ..not really a grown up. They do grown up thing but are not really connecting as a grown up. So we talk about that first and how they would like to be and look at is that real or is that fantasy. So we talk about the education really so where a lot of this may have come from. I do take quite a thorough sexual history. We start at the beginning and I say I don't just want to look at relationships with Mum and Dad and Siblings and its look at sexual history first and then look at what sex means. So you really go through that and that could take a few weeks.	Exploring clients meaning making of SA. Finding complexity in presentation.SA emerges later in work. SA can remain undetected until later in the work. SA emerges/presents spontaneously in the work. Educating SA clients. Using Sex Addiction education. Finding definition. Clarifying clients meaning of SA/experience. Exploring what clients reporting. Understanding clients perspective. Experiencing clients as emotional immaturity. Acting as grown ups. Not connecting as grown ups. Lacking inner cohesion. Working with consciousness of immaturity. Working with hope. Working with future self. Distinguishing between fantasy and fact. Using education. Linking past with present. Exploring causality. Taking thorough sexual history. Beginning with early family history. Exploring family relationships with client. Asking for sexual history first. Exploring what sex means for client. Being thorough. Taking time. Doing 'grown up' behaviours. No inner cohesion/split Creating possibility. Separating fantasy form reality.Thorough sexual assessment.Understanding the role of sex for the client. Thoroughness. Understanding what SA means for the client	*What she does when people say they are 'a sex addict'* *What do they mean* *All clients may have other issues. Sex addiction might come out later.* *Educates clients* *Tend to be immature. Not emotionally grown up.* *They talk about how they would like to be and assess if its real or a fantasy* *Take a thorough sexual history. From 1st relationship with parents to siblings. This can take a few weeks. It is from these relationships that their issues come.*

Interview Transcript	Researchers Codes	Peer Member Codes
P/17: Yea I can answer that. I think what we all do as therapist is that we replicate – I think I replicate almost like an ideal parent on that front. In other words I think of a little baby that screams and cries and has a tantrum it like the parent can absorb that, the parent is not phased by that, and as the therapist, I am not phased by that. the parent can respond to that with congruence and compassion and integrity and with boundaries.	Therapists replicating 'ideal' parent. Over-activated affect. Baby's affect. Seeking/needing regulation. Involving another. Parents absorbing infants affect. Parent un-phased. Parent regulates own affect. Parents respond with congruence and compassion. Having integrity and boundaries.	*As a therapist, she/he replicates an ideal parent.* *Like a baby having a tantrum, and parent absorbs over activated affect.* *Like the parent, the therapist is not phased.* *Containing as regulation.* *Response includes congruence. Using compassion* *Having integrity. Having boundaries*
Its like the parent can judge what the response needs to be. And what I think that does is it allows to happen is that the child is allowed to know that 'all that I feel and all that I can be – I can feel safe with that' ……..'I can be safe with all that I am, I can be safe with all that I feel'. I think this comes from a parents ability to be able absorb, to hold, absorb, reflect affect from the child. So to answer your question I think one of the benefits of my own personal work and training over the years is that I have been able to regulate my own affect and learn to do that in more wholesome efficient ways that means I am in a good position to absorb, to hold, to 'being with' another person in their affect.	Attuned parental responses. Special connection. Parent intuitively knowing. Assessing. Supporting child's confidence in own feelings. Child feeling safe. Strong sense of self. Coming form parental ability to absorb and reflect affect from child. Benefits of therapist's personal work. Passage of time. Personal journey over time. Personal work own style of affect regulation. Learning 'wholesome efficient' regulating strategies. Strong capacity to 'hold, absorb' clients affect. Capacity for 'being with' another and their affect.	*Means child can feel safe with all they feel. Parent can hold affect for child* *Feels her/his experience in personal work means she regulates her own affect. Wholesome and efficient ways.* *Personal work means she can be present and be with the affect of another. Take on a parental role*
So it taps into my philosophy - which I have always held which is my capacity and willingness and commitment to invest in myself, learn about myself and heal myself is a direct reflection of my capacity and effectiveness to be with another person. I have always held that and I do that and couple with that and marry that with sound foundation, knowledge and experience.	Personal philosophy. Valuing personal work. Seeing personal work directly reflected in effectiveness and capacity to be in relationship with another. Consistent value. Integrating personal with academic and clinical work.	*Having her/his personal philosophy. Believes in capacity of therapist to learn, invest and heal self. Capacity to heal self as direct reflection of capacity to help other. Enhancing capacity to be with others.* *Improving effectiveness.In combination with academic work and training.*

Interview Transcript	Researchers Codes	Peer Member Codes
R/18: So in terms of what you bring, you have own style of regulating? If a client comes for example, prone to hyper-arousal and overwhelm or those more hypo-aroused… they might look to you in therapy to get to know what they feel because they have trouble doing that perhaps….how do you work with this?		
P/18: Yea, yea, so how do I work with someone who dissociate or numb out or suppress or how do I work with someone who would almost go out of control…..Ok……well if I think about a person who will perhaps dissociate or numb out. This has happened a number of times and what I find quite effective….is that when ever someone is telling their story and I see them 'pop off' and dissociate or they report to me that they are not feeling anything I am numb, I am this or that….so affect……what I'll….the first thing I do is that I will say to them something along the lines of	Therapist bearing witness to clients opening up. Working with people who dissociate. Happens often. Affect suppressed. Almost. On the edge of loosing control. Precariousness. Getting clients to tell their story creates lens into affective state. Words and feelings together. Explicit revealing implicit. Effective intervention. Noticing when client 'pops off'. Client reports not feeling numb.	*Working with numbed clients.* *Affect is supressed.* *Using story-telling to reveal dissociated affect.* *Popping off.* *Client is not feeling anything.*
'so lets you and I just right now just honour that part of you that you would have you shut down as you remember that story' and then I am quiet. I am allowing the 'moment' with that so that they can connect with that.	Doing together. Guiding. Seeing how helpful past behaviours were. Working with defences. Respecting 'part that would have (client) shut down'. Understanding client's style of regulation. Numb clients do not know how they feel. Pushing them to know feelings triggers shame. Sensitivity to client's shame. Avoiding shame-based scripts.	*Saying 'let's honour that part of you'. This can be the first time this has been honoured as keeping them 'safe'. Safe rather than bad. Dissociative defence as involving shame. Working with shame.*
Rather than them going to, 'there is something wrong with me, why can't I feel this' and then put this expectation on me. I will make that intervention. And what I find is that often it is that many people who can't feel, dissociate, numb out or whatever…for them the first feeling of relief is the honouring of it as that which kept you safe, rather than that, that would define you as being wrong or bad.	Clients feeling shame about not experiencing feelings. Rather than triggering shame interventions create relief. Experiencing clients having first sense of 'relief'. Honouring/valuing client. Seeing defensive behaviour as safety not 'badness' or 'wrong'. Working with shame. Shame reduction. Understanding defences. Shame binds? Client self identity rooted in shame.	*Taking care to not re-enforce client's shame.* *Honouring defences that kept 'you safe'.* *Making meaning of dissociation.* *Seeing clients as relieved.*

I have witnessed that being an opening for people. I have witnessed people some people actually opening to their feelings in that acknowledgement. I see people sink back into their seats when we make that acknowledgement – when we pick that up – the relief is seen. And you know, and that then can take us in any direction. It can take us into a direction	Witnessing client response. Client opening up. Accessing client. Watching body. Client's relief expressed in body movement Sinking into seat. Making acknowledgement felt in body. Observed in body. Opens up many possible directions in the work.	*This can lead in any direction.* *Exploring how helpful behaviour might once have been* *Seeking to reduce shame.* *Taking us – going together* *Collaborative journey*
back there and then…lets see what happened to you, lets see what was going on that meant you needed to do that.	Exploring original function. Making new meaning of experience. Seeking to reduce shame. Avoiding re-enforcing shame.	*Understanding how past patterns are connected to current difficulties.*
Let's see how helpful that was to you back there then. So all the time you see I am seeking to reduce their shame rather than reinforce it by saying as a therapist "ok so hold on, what are you really feeling?" In other words not keep trying to push them into discovering what they are feeling because what that does is just reinforces the shame that "I can't feel and I should be able to" for some of them. Does that sort of answer that one?	Using a direct approach but not pushing client. Pushing client can trigger/re-enforce shame. Allowing clients feelings to emerge. Respecting client's process. Respecting clients pace.	*Wanting to help clients discover what they are feeling but concerned about triggering shame.*
Then at the other end of the scale, I had this recently actually people who are psychologically and somatically charged at a moments notice. The first thing that I am looking for is that they don't go into re-traumatization. So if they are telling me their story, their narrative and I am noticing somatic affect, emotional affect – their affect bodies. I am looking at their faces and bodies - I am watching their whole being.	Affect style on continuum. Hypo – hyper. In balance. Affect as integrated psychological and somatic experience. Like a 'charge'. Immediacy of emotional expression. No control. Prioritizing avoiding 're-traumatisation'. Not replicating back then. Using narrative. Hearing client's story. Affect in bodies. Noticing bodily held affect. Noticing emotional coherence. Watching. Noticing. Parts of body. Whole body. Noticing facial expression. Body. Watching whole being. Tracking signals of clients affect arousal.	*Understanding of spectrum.* *Clients who are somatically charged.* *Looking not to re-traumatize them.* *She/he notices their affect. Watching body/face*

If I have sense that this is going into a space where it is out of control and dissociative or re-traumatising I will firmly or gently intervene. I will just stop there and eye contact them for a minute, put your feet on the floor, look out the window, capture the image of the tree, see how the branches come around roots run to the ground to support it.	Working intuitively. Requiring her/him to firmly or gently intervene. Co-regulation. Stop/create pause. Setting pace. Stopping/slowing time as intervention Using nonverbal proto-communication. Making eye contact. Time. Re-embodying client. Reducing their arousal by; feet on the floor, look out the window, focus, notice the tree, visualise the branches, imagine tree rooting in the ground.	*If she/he sense going into 'out of control space' she/he gently/firmly intervenes.* *Grounds them to 'here and now'.*
I will bring them back into the room to try and stabilize them. So that is my immediate response if I think that is where it is going. And I will teach this to the client and will say to them, will teach them about how, about how, dissociation and re-traumatising and say "what we don't want to do in here in the work is to replicate what happened back there and then".	Back to present here and now experience. Stabilizing client. Re-embodiment. Immediate response. Immediate assessment. Teaching the client. Educating client about dissociation and re-traumatisation. Keeping client safe. Avoiding repeating old experience. Creating something new. Communicating understanding to client.	*Seeking to restore balance and stabilization for client* *Requires immediate action* *Teaching* *Creating new corrective experience. Avoiding repetition of old experience.*

Appendix XV

Consent Form

How do relational therapists work with affect regulation in psychological therapy with female sex addiction.

	Please Tick the Box
1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
3. I understand that the interview will be recorded on digital a digital recorder and transcribed.	☐
4. I understand that what I say will be confidential. Names will be coded and won't be used in any writing.	☐
5. I agree to take part in the above study.	☐

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Name of participant Date Signature

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Name of researcher Date Signature

Copies: 1 for Participant; 1 for Researcher.

Appendix XVI

Information Sheet

PROJECT TITLE
An exploration of how relational therapists work with affect regulation in psychological therapy with female sex addiction: A grounded theory study.

INVITATION
I am a trainee-counselling psychologist at the Metanoia Institute/Middlesex University and am currently completing the research component of my doctoral degree, a DCPsych in Counselling Psychology and Psychotherapy by Professional Studies. You are being asked to take part in a research study aiming to explore how you as a relational psychotherapist experience the therapeutic work with this clinical group.

The project has already been approved by the Metanoia Institute Research Ethics Committee).

WHAT WILL HAPPEN
In this study, you will be asked to participate in a semi-structured conversational interview exploring how you think about female sex addiction, how you understand affect dysregulation to contribute to this problem and how you work therapeutically with affect regulation as a therapeutic method with this clinical group. The interview will be recorded on a digital recording device and then transcribed by the researcher only. Both forms of data will be stored securely with a password on a Mac Book laptop and will not include any names or reference that will identify you. You will receive a copy of the transcript for approval.

TIME COMMITMENT
Each interview will take a approximately between 45 minutes to 90 minutes. You may be invited to participate in a follow-up interview which will be shorter in duration. The initial interview will be face to face with subsequent contact made by phone or email.

PARTICIPANTS' RIGHTS
You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn or destroyed.

You have the right to omit or refuse to answer or respond to any question that is asked of you.

You have the right to have your questions about the procedures answered. If you have any questions as a result of reading this information sheet, you should ask the researcher before the study begins.

CONFIDENTIALITY/ANONYMITY
The data collected will not contain any personal information about you and no one will link the data you provided to the identifying information you supplied (e.g., name, address, email). Following the writing up of the project data may be used in further works which will include presentations at conferences, training seminars and publications. Anonymity will be maintained at all times and client material excluded.

FOR FURTHER INFORMATION

My research supervisor is Professor Vanja Orlans who will be glad to answer your questions about this study at any time. You may contact her by phone at The Metanoia Institute ********** or by email on **********.

If you want to find out about the final results of this study please contact me directly on **********.