Men who identify as sex addicts – An IPA study

Maria Majeeda Ali

Middlesex University and Metanoia Institute

Doctorate in Counselling Psychology and Psychotherapy by Professional Studies

2021

Abstract

Sex addiction is the subject of much debate, as it was considered and then refused as an entry in the DSM5. Despite being referred to by different nomenclature, the most accepted definition is that it is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges, resulting in repetitive sexual behaviour over an extended period, that causes marked distress or impairment in personal, family, social, educational, occupational or other important areas of functioning. Research in the field has been predominantly medical-model based, focusing on symptomatology and correlates. There are fewer qualitative studies on the experience of the sex addict. This qualitative study uses Interpretative Phenomenological Analysis to explore six self-identified sex addicts' experiences of sex addiction. Participants were recruited through an open invitation to attendees of Sex Addicts Anonymous. Six participants came forward from different fellowships around the UK. Semi-structured interviews were carried out and analysis of the data revealed four major themes: Experience of the Self, Relational Dynamics, the Sex Addict and Addiction, and Recovery. The results were congruent with pre-existing literature, however new light was shed on the developmental perspectives and relational styles related to sex addiction, as well as reasons for acting out. Implications to therapy include understanding and addressing early relational ruptures and insecure attachments, grandiose self-statements, and enhancing intersubjectivity, not only focusing on symptom-management. The study also highlights the need for supervision, and researcher and therapist reflexivity. Future research should focus further on the role of early relational trauma, and on couple's therapy for sex addiction.

Keywords: Sex Addiction, IPA, Attachment styles, Narcissistic traits, Therapist reflexivity, Counselling Psychology

Contents

Chapter One: Introduction

Background to the Study

The term “Sexual addiction” was introduced into the Diagnostic and Statistical Manual of Mental Disorders (DSM3-R) in 1987 and was defined as

> “distress about a pattern of repeated sexual conquests or other forms of nonparaphilic sexual addiction, involving a succession of people who exist only as things to be used”
>
> (Kafka, 2010, p.378).

The term was proposed because of parallels to substance addiction – the preoccupation with sexual thoughts, escalating pattern of symptoms, and attempts to discontinue, resulting in dysphoria (Gold and Heffner, 1998). The term was removed from the subsequent DSM (DSM-4) but categorised as “sexual disorders not otherwise specified” (American Psychiatric Association, 2000). Hypersexual disorder was then proposed for the DSM-5, defined as a repetitive and intense preoccupation with sexual fantasies, urges, and behaviours, leading to adverse consequences and clinically significant distress or impairment in social, occupational, or other important areas of functioning (Kafka, 2010).

Excessive sexual behaviour has been clinically documented since the eighteenth century yet there is still disagreement regarding its nomenclature and aetiology (Berry & Berry, 2014). Hypersexuality is currently referred to as Sexual Impulsivity, Sexual Compulsivity or Sexual Addiction (Bancroft & Vukadinovic, 2004; Kingston & Firestone, 2008), yet these are not considered to be completely synonymous with the term Hypersexuality, as explained in the Literature Review.

The lack of consensus on what to call sex addiction, and what it entails has curtailed adequate conceptualization, diagnosis and treatment as well as research (Kingston and Firestone, 2008). The lack of agreement means that there is a lack of consistency in the research corpus. This is further complicated by the fact that the definition of sexual deviance is culture-bound and time-bound, and can change depending on shifts in moral values and gains in theoretical knowledge (Abel, Coffey and Osborn, 2008). Contrastingly, Berlin (2008, p. 624) iterates that although culture does shape human sexuality, “sexual desire is much more the product of biology than logic” and draws links between neuro-pathologies and hypersexuality. This polarization of attitudes towards the study of sexuality makes inquiry into hypersexuality more fragmented.

Hypersexuality is estimated to affect 6% of the general American population (Carnes, 2001), and also presents with comorbidities such as drug dependence, eating disorders and PTSD (Carnes and Wilson, 2002; Opitz, Tystsarev and Froh, 2009). Hence the number of people effected may be higher. There is no research on the UK prevalence (Griffiths and Dhuffar, 2014). The fact that it presents with comorbidities may be another reason why research is still lacking, as it will often be under-reported.

The most commonly reported manifestation of sex addiction is porn addiction (Hall, 2014). However, sex addiction can include a number of behaviours, namely compulsive masturbation, increased sexual fantasies, pornography use and promiscuous sexual encounters (i.e., casual sex, anonymous sex, several sexual partners). It is therefore more beneficial to conceptualize the problem as a construct, not an independent entity (Frances and Widiger, 2012), in order to facilitate therapists and researchers in working with the reality of the individual patient.

It is worth nothing that "increased" sexual behaviour refers to a comparison to the norm, rather than an increase within the person over time. This in itself merits careful consideration and questioning. How is normal behaviour defined? What makes it excessive? The literature review will tackle different definitions of "abnormal" and "excessive" sexual behaviour.

Purpose of the Study

It was proposed that Hypersexuality should be included as a diagnosis in the DSM-5, however it has been rejected primarily on the basis that there is not enough empirical research to warrant its inclusion (Kafka, 2010) (See Appendix 1 for Diagnostic Criteria). To date, "little is known about socio-demographic, psychiatric and psychosocial background of treatment-seeking self-identified sexually addicted individuals" (Wery, Vogelaere, Challet-Bouju, Poudat, Caillon, Lever, Billieux, & Grall-Bronnec, 2016, p. 623).

Diamond and Hueber (2012) note that the study of sexuality has been mostly limited to quantitative research, with the effect that experiential aspects have been overlooked and ignored. This appears to have happened with hypersexuality, as most literature pertains to its manifestations (Bancroft and Vukadinovic, 2004). When Hypersexuality was proposed as a disorder in the DSM–5 research was focussed on making generalisations and identifying clusters of symptoms (Kafka, 2010), and consequently, the subjective experience of the individual with hypersexuality appears to have been ignored. Measurement, definition and research on the

behavioural spectrum alone is insufficient (Kingston and Firestone, 2008), and there is a lack of emic enquiry (Morrow, 2005). There is therefore a need for idiographic inquiry, which would attempt to explore the uniqueness and complexity of the individual (Ponterotto, 2005).

Stein (2008) criticises current research for attempting to explain hypersexuality in terms of a single theory, pointing out gaps in its current nosology. He calls for inquiry which is not reductionist in its approach, emphasising the need for research on the phenomenology and psychobiology of hypersexuality. Such research could outline which therapeutic interventions would be effective.

According to Yardley (2000), "the decisive criterion by which any piece of research must be judged is, arguably, its impact and utility" (pg. 223). As detailed below, this research aims to provide a new perspective on hypersexuality, which will have both theoretical and clinical implications.

It has been argued that human existence is in the body, intersubjective and sexual (Cohn, 1997), however, the body and sex have not been the focus of phenomenological research as much as quantitative research (Fausto-Sterling, 2019). This dissertation is an inquiry into the phenomenological experience of sexual addiction. The aim of the research is to explore how men who identify as sex addicts experience sex addiction, and how they make sense of their identity and their relationships with others.

Contribution to Counselling Psychology

My experience as a therapist is what led to me first think about research gaps within Counselling Psychology regarding sex addiction. I became interested in it whilst completing my postgraduate studies in Sexual Health at the University of Sydney. I had an opportunity to be a co-facilitator in group therapy with sex addicts at a psychosexual clinic in Sydney, as part of my placement. The experience challenged my previous beliefs about sexual addiction, and it became apparent that there wasn't enough understanding or support about the experience of the sex addict. I felt that sex addiction was not discussed or portrayed with the gravitas it deserved, and that the distress it causes was not recognised.

As a sex therapist in Malta, I worked with a self-identified "sex addict" who had been referred to me for sex therapy by a well-respected figure in the Maltese psychotherapy community, because she felt that she didn't have enough expertise in the area and had been working with him for two years without much change. I struggled to find adequate supervision, and working as an individual

(rather than as a student member of a professional team) highlighted my need and desire to learn more about sexual addiction. I felt that my training had been restricted, and wanted to be able to explore other facets of the client's life, and not be limited to a cognitive-behavioural approach and I wanted to be able to work from a more integrative perspective.

Target (2007) argues that sexuality in general has been ignored in research possibly because of resistance amongst psychotherapists to accepting its centrality to identity. Several authors have emphasised the need for more research into hypersexuality, in particular with regards to developmental factors (Schwartz, 2008), the role of the family (Kafka, 2010 and Optiz, Tsytsarev and Froh, 2009) and attachment theory (Dewitte, 2012). Target (2007) points out that certain adult sexual behaviours are not dissimilar to mother-baby interaction such as kissing and stroking, but gaps in theoretical knowledge and research in this area may be due to its controversial nature.

Hypersexuality has been linked to dysfunctional attachment styles, and is considered to be an inability to form bonds and attachments in intimate relationships (Schwartz, 2008). Sexual addiction may compensate for an early attachment failure, therefore forming and maintaining attachments in a trusting intimate relationship is a therapeutic goal for hypersexuality (Adams and Robinson, 2002). Zitzman and Butler (2005) found that attachment played a significant role in the recovery of men's addictive use of pornography. Participants in their study attended conjoint couple therapy which facilitated attachment reparation. They concluded that conjoint therapy was more beneficial than separate therapy for the spouses, which implies that a relational aspect may be involved in hypersexuality.

Dewitte (2012) adds to this, stating that theories of sexuality and early developmental processes have developed in isolation. Recent publications have explored the sex-attachment link, yet this has been done from a number of different perspectives, and lacks an overarching, integrative theory. Furthermore, none describe underlying processes that maintain this link. This study will therefore aim to address this research gap, by attempting to gain further understanding of the lived experience of attachments of sex addicts.

More knowledge regarding therapeutic interventions for this population is required. Ayers and Haddock (2009) showed that therapists are reluctant to work with patients presenting with hypersexuality, as most feel they did not have enough training. They also found that the therapist's personal qualities (attitudes and beliefs) had a significant role in treatment approach. This study shows that more knowledge is required to inform training

programmes regarding therapeutic practices for hypersexuality, as well as greater awareness of the therapist's self in relation to a patient with hypersexuality.

Research Design

The research design will be addressed in greater detail in the methodology chapter, however, at this stage I will summarise my epistemological position with regards to the current research. My position is less concerned with the aetiology of sex addiction but mostly focussed on participants' lived experiences. Having employed a phenomenological research method, it is important to note that I acknowledge the possible biases within the research process itself and the final results which are, as McLeod (2001) explained, always influenced by the researcher.

Ensuing Chapters

The literature review will commence with exploring sex addiction from the medical model and essentialist perspectives. An exploration of social positions on sex addiction, porn and porn addiction will be given. I will explain why porn addiction is the main focus of the dissertation. I will then delve into psychological concepts related to sex addiction, and address therapy for sex addiction, and sex addiction in other populations. This chapter will provide an evaluative discussion of the literature.

In the methodology chapter, I will explain the chosen methodology and methods and justification for it. I will inform the reader of theoretical, ethical, and philosophical foundations that have informed the research process, including my ontological and epistemological stance. I will describe the research method and the reasons for choosing it, and I consider ethical issues and issues of validity.

The reflexivity chapter is placed before the findings and discussion, because it mostly (but not exclusively) relates to my process during the transcription and analysis phases, prior to writing up with subsequent chapters. It is a personal account of my reflexive process.

The next chapter will be the findings of the research. This chapter considers the findings of the research in relation to the central research aims. Data will be presented thematically across participants.

In the discussion chapter, I attempt to evaluate the results in light of the literature review by presenting additional literature that has been considered appropriate. The discussion connects the conclusion to the rest of the project including clinical and methodological considerations, limitations of the research and shedding light into the possibilities for future research in the area of interest. It should be specified that due to the limitations of space, the following sections do not reflect the content in its entirety.

Conclusion

This chapter briefly outlined the key concept of sex addiction and related nomenclature. I highlighted the professional influences that initiated questions about the nature of sex addiction, and explained the rationale for the study.

Chapter Two: Literature Review

Introduction

This chapter will give an overview of broader influences on how sex addiction is conceptualized – namely from the medical model, socio-cultural and political thought, and psychological influences. I will first present a broad outline of concepts from the medical model, regarding nomenclature and the impact this has on the field. I will then narrow my focus to discourse and influences of porn addiction, before moving to more acute, idiosyncratic factors. I chose to include these topics in my literature search and present them thus, as I feel this mirrors a "zooming in" on the client.

Historically, sex addiction was dominated by the medical model, with the focus more on symptoms, rather than the person. As a clinician, I believe that to understand a phenomenon, the context in which it occurs must be understood, as this shapes its presentation and precipitation. The role of the clinician then is to keep this in mind whilst being able to see the client as a subject, and not a "medicalized" object.

I will then present current research on therapy for sex addiction, sex addition in other populations, to explain why these have been excluded from the current study, and lastly, I will give the rationale for the study.

Medical Model Concepts

Epidemiology

Despite the lack of consistency on definitions, as well as assessments tools, some estimates have been calculated for the prevalence of sexual addiction. In a review carried out by Karila et al (2014), estimates range from 3% to 17% of men, and 7% of women. This is higher than the numbers given by Carnes (2001) and several others of 6% (Black, 2000, Muise et al, 2013). It should be noted that the discrepancy in numbers may be due to inconsistent use of measures. However, consistently, the prevalence in women is lower than that in men (McKeague, 2014).

Amongst patients with substance abuse disorders, the prevalence of sex addiction is as high as 25% (Stavro et al, 2013). To date, it is unclear what factors explain this correlation, however it is recommended that all substance abuse patients are screened for comorbid sex addiction (de Alarcon et al., 2019).

The numbers may actually be higher than those cited in official studies. Sex addiction may go undiagnosed, or be considered as a symptom of other disorders, for example, bipolar disorder, depression, Asperger's or PTSD (Klein, 2016). Sex addiction also frequently occurs with comorbidities, such as ADHD, impulse control disorders, substance abuse disorders (Kor, Zilcha-Mano, Fogel, Mikulincer, Reid and Potenza, 2014), and mood disorders (Tubino Scanavino, Ventuneac, Abdo, Tavares, Amaral, Messina, and Parsons, 2013). Reid, Cyders, Moghaddam and Fong (2014) iterate that the prevalence of comorbidities makes it ambiguous to discern if sex addiction is a distinct construct, or a manifestation of existing pathology. It is therefore necessary to screen for comorbidities when clients present with out of control, high frequency sexual behaviour.

Psychobiology of Sex Addiction

Krafft-Ebing was amongst the first to write about sexual dysfunction having both somatic and psychological causes, and added that sexuality would have an impact on the person's psychology (Oosterhuis, 2000).

Toates, (2009, p.188), submits evidence of psychobiological pathways involved in sex addiction, and adds "biological and social-constructionist theories of human sexuality should not be seen as rival accounts but as capturing processes that can coexist".

Sexual motivation is modulated in the limbic forebrain, which is also associated with attachment (Codispoti, Bradley and Lang, 2001). In sex addicts, neuroimaging shows that sexual motivation is dissociated from pleasure gained from the acquisition of a reward. Instead, the images show that they are more likely to display extrinsic motivation (the reward is external, such as money or recognition) (Kor et al, 2014).

Diagnostic Status

Sex addiction has been operationalized under many terms, including compulsive sexual behaviour, sex addiction, sexual impulsivity, hypersexual behaviour or hypersexual disorder, and out of control sexual behaviour. I will briefly outline these terms, before providing a critique of the term sex addiction, and why I chose to use it for the purpose of this study.

There is a lack of consensus on sex addiction – if it exists, what it entails, and how it should be defined (Berry, 2013). Currently, sex addiction does not fit under any classification in the

Diagnostic and Statistical Manual of Mental Disorders (DSM). Coleman (2015) suggests that under the current DSM (DSM-5), sex addiction fits best under Impulse Control Not Otherwise Specified, and describes it as including sexual urges, sexually arousing fantasies and sexual behaviours that are recurrent, intense and cause distressful interference.

Other nomenclature exists to describe the same phenomenon, and a brief description of each will be given below:

Obsessive Compulsive Disorder

SA is commonly classified as lying on the obsessive-compulsive spectrum (Bancroft and Vukadinovic, 2004). However, Gordon (2002) argued that Obsessive Compulsive Disorder (OCD) pertaining to sex is different. In marked contrast to most sexual fantasies, the sexual ideation in OCD is extremely unpleasant and upsetting. The person with OCD does not to want to act out the thought; instead he or she wants to stop thinking about it. Sexual obsessions in OCD are not part of one's sexual script and rarely produce sexual arousal, but induce guilt and anxiety. Contrastingly, sexual thoughts in sex addiction are described as arousing or pleasurable. They may include graphic details of a fantasized sexual script.

Impulse Control Disorder

Impulse control disorders (ICDs) can include different behaviours, and the previous DSM classified compulsive sexual behaviour (CSB) as an Impulse control disorder, not otherwise specified, (American Psychiatric Association, 1994) which was described as 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). Sex addiction was considered an impulse control deficit because of the associated increase of the behaviour in response to stress, the inability to delay sexual gratification, and impulsive decision-making with regards to sexual activities. However, most people with sex addiction report spending excessive amounts of time planning and coordinating a sexual event, and having to go through elaborate means to keep it secret (Carnes, 2001). This amount of planning and forethought is inconsistent with an impulse control disorder. Goodman (2001) argues that if sexually out of control behaviour can be considered an impulse-control disorder, then equally substance abuse can be considered an impulse disorder. He concluded that 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).

Impulsive/Compulsive Sexual Behaviour

Impulsive/Compulsive Sexual Behaviour (ICSB) is described as sexual urges, sexually arousing fantasies, and sexual behaviours that are recurrent, intense and a distressful interference in one's daily life (Coleman, 2015). It is driven by a need to reduce anxiety (de Alarcon et al, 2019). As a definition, it is useful because it allows for multiple pathological pathways and treatments (Braun-Harvey and Vigorito, 2016). Bothe et al (2019) conclude that to date, there is not enough evidence to suggest that impulsive and compulsive features are mutually exclusive vis-à-vis sex addiction and problematic porn use.

Out of Control Sexual Behaviour

Davies (2017) defines "Out of Control Sexual Behaviour" as a "sexual problem of consensual sexual urges, thoughts, or behaviours that feel out of control for the individual". The focus is on sexual health, rather than sexual symptoms. He suggests that assigning a label allows clients and therapists to avoid difficult emotions when talking about sex.

Hypersexual Disorder

Defined by Kafka (2010), Hypersexual disorder is characterized by recurrent and intense sexual fantasies, urges and behaviours, aimed at alleviating dysphoric moods. Criteria also included failed attempts at controlling the behaviour. The criteria were proposed for inclusion in the DSM-5 (Appendix 1), however it was not included on account of there not being enough evidence (Braun-Harvey and Vigorito, 2016).

Sex Addiction

The phrase sex addiction was first used by Carnes, and defined as a pathological relationship to a mood altering sexual experience that the individual continues to engage in despite negative consequences (Carnes, 2005).

For the behaviour to be classified as sex addiction, Carnes (2005) specified that the following criteria must be met:

- Compulsive Behaviour: A pattern of out of control behaviour over time
- Efforts to stop: Repeated specific attempts which failed
- Loss of time: Significant amount of time lost doing/recovering from the behaviour
- Preoccupation: Obsessing about or because of the behaviour
- Inability to fulfil obligations: The behaviour interferes with work, school, family and friends

- Continuation Despite Consequences: Failure to stop the behaviour, despite legal, social, relational, physical or occupational problems arising from it.
- Escalation: Need to make the behaviour more intense, frequent or risky
- Losses: Losing, limiting or sacrificing values parts of life
- Withdrawal: Stopping the behaviours causes considerable distress, anxiety, restlessness, irritability or physical discomfort

Sex addiction has been categorized into different levels based on which behaviours are involved (Carnes, 2001). Level 1 behaviours are normative behaviours but are engaged in at such frequency that the individual begins to isolate from others, and include masturbation, compulsive relationships, anonymous sex, pornography consumption and paying for sex. Level 2 behaviours, which include exhibitionism and voyeurism "are sufficiently intrusive to warrant legal sanctions" (p. 49). The behaviours can be harmful however they are not considered as dangerous as level 3 behaviours. Level 3 behaviours involve rape, incest and child molesting, where the "most significant boundaries are violated" (p.58). It should be noted that this study pertains to Level 1 behaviours.

These descriptors are in line with current guidelines which recommend that atypical sexual preferences are distinguished from mental disorders by firstly establishing if the behaviour causes distress to self or other (Wylie, 2015). Therefore, for example, with Level 1 behaviour, isolation from others may cause distress to the self, or to partners. Frequently engaging in masturbation is not a criterion in itself.

Cohn (2014) argues that although the term sex addiction has no nosology, it has three features similar to other addictions - tolerance (over time more stimulant is needed for the same result), withdrawal (distressing reaction follows discontinuation of use), and progression (gets worse over time). The debate on semantics ensues (Coleman, 2015), however, sexual addiction does seem to reflect the sense of powerlessness that characterizes other addictions (Butler, Meloy and Call, 2015), and more people are presenting to clinicians seeking help for it (Coleman, 2015).

Kraus, Sturgeon and Potenza, (2018) conclude that before sex addiction can be given "disorder status", more research is needed on comorbidities, the role of negative emotionality, tolerance and withdrawal, and differentiating between addiction and excessive drive.

Social and Political Concepts

Critique of Sex Addiction

From the labels above, two are more commonly used – Sex Addiction and Hypersexual Disorder (Braun-Harvey and Vigorito, 2016). They converge on the following criteria: an activity which interferes with functioning and becomes a preoccupation, repetitive but unsuccessful attempts to control the behaviour, the behaviour is often in response to dysphoric mood states, and it leads to impairment in important aspects of life. The Addiction Model also states that the person will experience withdrawal symptoms if s/he does not engage in the behaviour, and that they become tolerant to the effect of the stimulus.

Of the two concepts, sex addiction appears to be the more popular, according to several authors (Berry, 2013). Sevclkova et al (2018) attributes this due to the increasing attention that behavioural addictions have received, mainly due to the publication of the DSM-5. The revision introduces "Substance-Related and Addictive Disorders" as a new category, with subcategories "Substance-Related Disorders" and "Non-Substance-Related Disorders". Sex Addiction was not included as a stand-alone diagnosis due to a lack of evidence to date (Sevclkova et al, 2018). However, before adopting the phrase, it merits discussion as to whether it represents the condition, and what connotations it brings with it.

Weeks (2011) states that the term sexual addiction implies a post-traditional culture over-saturated by sexuality, but which cannot agree on normally acceptable behaviour. Moser (2011, p.288), specifically criticizes using as a criterion personal distress or impairment associated with the frequency and intensity of these sexual interests. He asks,

> "Whose distress? Is it the individual's distress? Is it the distress of the spouse, who is dragging the 'patient' to a psychiatrist for engaging in too much masturbation, pornography viewing, cybersex, etc? Is it the distress at being blackmailed (''stop or I am divorcing you'')? Is it the distress from living without the type or quality of sex actually desired? Is it the distress at not being able to live up to societal expectations?

This reminds practitioners to evaluate the individual's presentation contextually. Is the "problem" actually a problem? How so, and for whom? Society, scholars, spouses, or the individual?

Braun-Harvey and Vigorito (2016) critique the use of the phrase sex addiction. They posit that although shifting focus from moral judgement to the medical model allows people to seek treatment and empathy, the use of a medical label is detrimental. It reinforces the social disapproval of specific sexual behaviours. Any behaviour that is different to normative or

conventional practices risks being labelled as a sexual disorder, and non-consensual sexual behaviour risks being wrongly labelled under sexual addiction.

Another criticism of use of the term “addiction” is not to do with its applicability as a definition in medical terms, but to do with the consequences of using such language. Addiction suggests uncontrollability, which absolves responsibility (Tyler, 2010). This is in line with findings by Briggs et al (2017), who interviewed five men who identified as sex addicts, and four men with high frequency sexual behaviours who did not identify as sex addicts. The former gave descriptions of loss of control, similar to those used to describe the progression of a disease, which enabled the participants to adopt the “sick role”. Berry (2013) suggests that there is a risk of losing sight of the person, and focusing on the disease instead.

Braun-Harvey and Vigorito (2016) suggest that it would be more helpful if practitioners were to conceptualise sex addiction in terms of deviance - culturally acceptable behaviour, nuisance sexual behaviour and dangerous behaviour. These categories describe levels of risk, not addiction. Behaviours are viewed through the lens of cultural norms and violation, legal consequences and risks, and victimization. One advantage of such an assessment is that it is more grounded in reality, rather than theory. Clinicians and clients are able to work on real therapeutic goals. It also advocates responsibility for change, rather than using the term addiction as a way of suggesting uncontrollability.

Derbyshire and Grant (2015) concluded that before formalizing use of the phrase sex “addiction”, more research is required on the role of comorbidities, and on differentiating it as an addiction or a state of excessive drive. Furthermore, more research is required on the role of negative emotionality and tolerance and withdrawal.

Sex and the Internet

As technology advances, social interactions and sexuality will change. Stern and Handel (2001) argue that sexual content on the internet is harder to control than on any other medium (and is more popular), because of properties specific to the internet. Namely, the internet is vast and difficult to regulate, compared to the distribution of DVDs. It also provides a multi-media platform, and not just still photography, or written word. Material is often free and always readily available, with new material emerging constantly. It is also interactive, which could imply that the user is drawn in further than with other experiences.

Carnes (2001) argues that porn consumption and cybersex (watching a person perform live sexual acts online) are accelerators of sex addiction, because it may be easier to rationalize and

minimize compared to the other behaviours. People are more likely to assume that the behaviour will not harm their spouse, or that it does not constitute as infidelity, because there is no physical contact. Furthermore, it is easier to project feelings of intimacy onto a virtual sex partner, and there is less likelihood of being rejected.

Porn has become a means of entertainment, sexual stimulation and a source of information. Increased use of porn is associated with an increase in the number of sexual partners, and a younger sexual debut age (Træen, Nilsen and Stigum, 2006), which in turn was more likely to lead to sexual problems that were more resistant to change (Southern & Cade, 2011).

Increased use of Internet-based pornography has led to more sexual variance and some predatory sexual activity, and has led to changes in the nature of clients seeking sex therapy. The proportion of clients with more pervasive and chronic sexual problems increased while the proportion of clients needing education dwindled. Cybersex and porn is being conceptualised as a both a means of coping with, and a means of causing intimacy problems (Edwards, 2012).

An online survey which was carried out with 15,246 respondents in the USA, showed that men who viewed porn were more critical of their partners' body and less interested in actual sex than those who did not (Butler, Meloy & Call, 2015), and it gave them unrealistic expectations of sexual relationships.

In a review conducted by Manning (2006), pornography consumption was reported to be associated with increased risk for sexual deviancy, committing sexual crimes, and experiencing difficulty in one's intimate relationships, accepting rape myths, and behavioural and sexual aggression. These findings were replicated by Weitzer (2013). In another study, men who viewed porn more frequently were less likely to achieve orgasm with a partner than other men, and showed less awareness of the problems it created with their partner (Stein, Black, Shapira & Spitzer, 2001).

Other research has revealed that apart from affecting relationships and sexual functioning, consumption of porn also had occupational consequences as the most common time to access porn is 9am to 5pm (O'Brien, Marshall and Marshall, 2008). This may reflect an uncontrollable need to view porn, a disregard for work regulations, or a fear that watching porn at home may lead to discovery by a partner. In a survey of 40000 adults, 20% reported engaging in online sexual activity whilst at work, spending an average of 2.5 hours a day in online sexual activity during work hours (Cooper, Scherer and Mathy, 2001).

The internet allows men to build new social identities through sexual expression and consumption. The anonymity provided by the Internet provides a place for some men who may not have the power to do so in real life to live up to the hegemonic masculine ideal (Becerra, Robinson & Balkin, 2011). Perhaps this may be both beneficial and disadvantageous.

An often-ignored advantage of porn is that it can be a platform for the sexual interests of "marginalized" groups, whose romantic and sexual needs are traditionally ignored or have limited options, for example the chronically ill, the disabled, and those with alternative sexual interests. Porn and the internet can create a communal hub for people to engage in exchanges about their interests (Cooper, Scherer and Mathy, 2001). Furthermore, both partners consent and feel comfortable, porn is sometimes used as a joint activity for a couple, used to increase sexual arousal, and is sometimes recommended to couples attending psychosexual therapy (Klein, 2016).

Porn Addiction

It is unclear at what stage porn-use becomes an addiction (de Alarcon et al, 2019). Porn addiction is the most common behaviour for men with sex addiction, and it is often prompted by distress, experiential avoidance or relational withdrawal. It can lead to emotional and cognitive dysregulation, and impairs capacity for intimacy, which need to be repaired in order for healthy intimate relationships (Fraumeni, 2019).

However, not all porn users are porn addicts, and as described above, frequent porn consumption is in itself, not enough to be considered porn addiction. Despite this, increasingly, men seek help for problematic porn use. They seek help to control the amount of porn they consume, and are usually motivated by various factors such as religious beliefs, or relational problems as a result of porn consumption (Ley, 2015). Humphreys (2018, p.387) reports that the extent to which participants believe they are addicted to porn "was predicted not so much by their behaviour, but how strongly they felt that their behaviour was morally wrong". This shows that cultural and personal disapproval rather than objective assessment, has a significant influence on how comes forward for help, and consequently, what is defined as diagnosable.

Sniewski and Farvid (2019) coined the term Self-perceived problematic porn use (SPPPU), differentiating it from sex (and porn) addiction. It is when an individual believes they have a problem with controlling the amount of porn they watch, and that this is having a negative impact on various domains of everyday life. Negative consequences of porn use, rather than frequency of consumption is a better predictor of SPPPU. The perceived lack of control is detrimental to the

person's self-agency. This highlights the importance of having objective, clinical measures for sex addiction, as well as the importance of understanding what might lead a person to find porn use problematic.

Labelling high-frequency, distressing porn-consumption as porn addiction is a complex matter, subject to bias (Ferree, 2002a). Braun-Harvey and Vigorito (2016) identify many difficulties clinicians face. Firstly is the lack of clear diagnostic guidelines. There is also a lack of training regarding the issue, and clinicians may have their own historical, sexual difficulties that may make it difficult to process another's sexual issue. Several studies also show that clinicians' religiosity influences the therapeutic process (Klein, 2016), with clinicians who score on religiosity being more likely to judge porn use as pathological if the client is married, or judge a woman's porn use as atypical even when it was the same frequency as male counterparts (Hertlein, 2004). Ferree (2002b) found that within a faith-based context, the continuum is ignored. A minor "sexual transgression" might elicit the same response as full-blown addiction. The addiction is viewed as a moral failure. This shows how deeply ingrained cultural messages are, and the far-reaching impact they have on behaviour and subsequent diagnoses.

Also these sources of bias and error point to a need for clinicians to understand the phenomenon better – what influences sex addiction, and what influences them in treating it.

The Politics of Porn

Porn is not produced and consumed within a political and social vacuum. To understand it, the industry itself and the intention of producers have to be examined (Tyler, 2010). However, the amount of porn content is massive and vast, therefore providing a critique of porn as a "total" would be impossible. In this section I will discuss various views on porn, with the caveat that they do not represent and fully capture the nature of all porn content.

MacNair (2013) argues that the need to control and pathologize porn use is to counter the sexualisation trend in modern societies and a reaction to gender politics. Porn is a way of asserting hetero male dominance (in particular, porn that is violent or degrading towards women). According to MacNair (2013) controlling porn consumption is a feministic rhetoric to reverse this power dynamic. However, I would argue that some feminist perspectives call for changing porn content (Synder, 2008), rather than controlling consumption. Porn has been heavily criticized for its treatment of women (Boyle, 2010). In its mildest forms, it gives unrealistic expectations of women's bodies. However, Klein (2016) suggests that women's insecurity about their bodies is

what fuels “panic” about porn consumption. I would argue that the problem then is not merely in porn (although it contributes to it), but in the lack of honest education about sexual expectations and body confidence for both men and women.

At the more extreme end, some porn depicts women being degraded, and even violence towards women. Some content shows women enjoying this, with consumers forgetting that porn shows sex being performed, and not experienced (Boyle, 2010). It can perpetuate the dangerous myth that “No” means “Yes” and that women enjoy their own degradation, humiliation and abuse. Tyler (2010) argues that if actresses do not show distress, and are making no attempt (on film) to stop the abuse, then it isn’t really violence. Furthermore, violent porn is becoming more mainstream, according to Adult Video News (as cited in Boyle) - a print publication aimed at porn producers to disperse information regarding the industry, including trends, legal notices and reviews. Since the seventies, feminist scholars have been criticizing porn for perpetuating these images (Coveney, Jackson, Jeffreys, Kay and Mahony, 1984), however since then, it appears that porn has become both more violent and less violent. Voss (2015) argues that in response to this criticism, new genres of porn content were created.

This change in content however, led to a new dilemma for Easton (1994), who noted that women’s enjoyment of porn negates (at least partially) that it is harmful to them, however, in my opinion this does not necessarily follow. A problem faced by anti-porn campaigners is the difficulty in proving that porn is incitement to violence against women and sexual hatred.

The seventies anti-porn movement was also in part responsible for more gay and lesbian porn to become available and mainstream (Edwards, 1994). Despite changes in content, porn has been and remains predominantly heteronormative (Voss, 2015). It shows the “consequences of dominance of men, white people and wealthy First World people” (Jensen, 2010, p. 106). According to Jensen, a porn researcher who studied trends in porn production and consumption, “the patterns of misogyny and racism remained the same, only with a noticeable intensification of both” (p. 106). He adds that men would not be able to be aroused by such material if they routinely empathised with the female performers. MacNair (2013) echoes this statement, adding that not only do porn consumers not empathise with the actors, but they increasingly objectify them, and are more likely to objectify other women (seeing them only as a sexual object, losing their humanity).

These arguments are not enough to suggest that watching all porn is bad, or that in fact porn addiction exists. However, I believe they are pertinent to formulating a clinical position as a therapist, and to understanding the experience of the porn addict.

Ley (2015) reminds us that porn content is not homogenous, it is not all violent towards women - it also depicts women enjoying sex. He argues that the term sex addiction has been created to vilify behaviours that oppose dominant, conservative norms. Porn use itself isn't bad, and can be beneficial. It is an outlet for sexual interests and curiosity that cannot be played out in real life, it is beneficial when couples or an individual have inhibited sexual communication (for solo masturbation, and as something the couple can watch together. Porn consumption makes previously marginalised, subordinate or invisible sexual categories more visible (MacNair, 2013).

Psychic Concepts

Psychological Theories of Sexuality

The American Psychological Association recommend that psychologists rely on diverse theories of sexuality, rather than depending on one unified concept (Tolman and Diamond, 2014). The guidelines suggest this because

> "sexuality (along with race and gender) is one of those domains in which the status of scientific facts is particularly suspicious and important. … Sexual facts have profoundly important consequences in a culture that grants special status to scientific knowledge as the basis for ethics, ideology, and social policy and rigorously regulates sexuality. Hence, responsible scientific practice, in our opinion, requires an open and honest reckoning and wrestling with one's own theoretical perspective, whether implicit or explicit; its implications for research practice; and its implications for the interpretation and dissemination of research findings"
>
> (Tolman and Diamond, 2014, p. 23)

The guidelines propose a number of theories, however I shall briefly outline theories that inform my thinking on sex addiction.

Reward and Conditioning Theory

Reward and Conditioning theory is in itself an integration of essentialist and social constructionist principles. Pfaus, Kippin and Coria-Avila. (2012) found that the neural systems that govern sexual response are intrinsically plastic, designed to respond flexibly to different environments and to

learn—through basic processes of reward-based conditioning—what people desire. (According to Attachment Theory, these learning experiences are firstly with the primary care-giver). Innate predispositions are forged into stable patterns of relating through the individual's ongoing experience with sexual reward and with the process of linking reward with specific sets of cues over time.

Attachment and Sexuality

Sexuality is intricately linked with attachment, since it is an experience of being intimately aware of the self through the other (Ferree, 2002a). Attachment and sexuality are considered to be two overlapping, motivational-instinctual systems, which can at times work antagonistically (Eagle, 2007). Sexual experiences in turn also impact attachment styles and behaviours.

The purpose of the attachment system is protective, to ensure proximity to others. A secure attachment means that during distress, a support response will be elicited from the "other". This experience generates a positive view of self and other (Mikulincer and Shaver, 2007).

The needs of the sexual system are more likely to be fulfilled when the need for protection is satisfied. However, herein lies a dilemma. For someone to become an attachment figure, they must be predictable and familiar. Novelty and unpredictability are incompatible with forming secure attachments (Eagle, 2007), and yet, sexual attraction depends on novelty and unpredictability (Perel, 2006). Adults in secure relationships manage this contradiction, relying on closeness, self-disclosure and interdependence to create a positive foundation for sexual relationships. Secure adults are less concerned about their sexual performance, and are more focused on intimacy. They are less likely to engage in sexual relationships outside of an intimate relationship (Mikulincer and Shaver, 2007).

People with insecure and avoidant attachment are less likely to integrate attachment and sexuality (Mikulincer and Shaver, 2007). Hyper-activating strategies are likely to be adopted by anxiously attached individuals with negative models of self, unsatisfied attachment needs and worries about rejection and disapproval, which involve more effortful and mentally preoccupying attempts to have sex. These sometimes go on to become coercive attempts (Eagle, 2007). Individuals overemphasise the importance of sex and view it as a means of garnering attachment and support, and become hyper-vigilant to signals of arousal, attraction and rejection. Individuals with anxious attachments use sex to fulfil unmet needs for security and love, gain acceptance and reduce fear of betrayal and abandonment, but have trouble focusing on partner's needs. Sexual pleasure is less intense (Mikulincer and Shaver, 2007). They will associate genital arousal with feelings of loneliness, using sex as a means for connection (Schwartz, 2008).

An avoidant person may use other strategies which include viewing sex as separate from intimacy, distancing from one's partner (if the person is in a relationship and feels rejected sexually), and narcissistic attempts to elevate self-image through sex. This can occur without enjoying sex (Eagle, 2007). Their lack of comfort with closeness and negative model of others may interfere with sexual intimacy and develop a more negative construal of sexual activities, leading to them engaging only in non-intimate sex, devoid of feeling and connection (Mikulincer and Shaver, 2007), to maximize control over a partner or for social prestige (Schwartz, 2008). They are more likely to approve of multiple relationships, limited involvement and commitment, and the use of sex for fun, rather than an expression of intimacy (Eagle, 2007).

Peloquin et al (2014) studied attachment patterns, sexual satisfaction and caregiving behaviours in 126 cohabiting couples from the general population, and 55 couples who were attending therapy together. They found that avoidance was negatively correlated with self and partner's sexual satisfaction for both distressed and non-distressed couples. Caregiving behaviours (perceiving partner's distress, seeking proximity when partner is distressed) are related to sexual satisfaction. However, influence may be bi-directional. Sexual satisfaction may encourage sensitivity to one's partner, which consequently promotes positive sexual interaction and greater relationship satisfaction. Partners reporting higher avoidance also reported less proximity behaviours when their partners are distressed. For men, caregiving proximity was less strongly correlated with sexual satisfaction, which the authors interpret as men placing less importance on having emotional needs being met.

Attachment, Trauma and Sex Addiction

Several authors have established a connection between early attachment trauma and sex addiction (Cox and Howard, 2007; Carnes, 2016, McKinney, 2014, Efrati and Gola, 2019). Craparo (2014) suggests that emotional neglect, may have a traumatic impact on emotional development. Sex addicts who have experienced trauma or neglect often have a sense of worthlessness, a consequence of the belief that their parent(s) could not have been capable of harm, therefore blaming themselves for the trauma they experienced (McKeague, 2014). The sex addict is more likely to have experienced powerlessness and as a child, whereas the partner is more likely to have experienced neglect, and compensates for this by caring for others and neglecting the self (Turner, 2009).

Early neglect can lead to failure to recognize emotional information (Katehakis, 2009). Emotional content is therefore stored in implicit memory, which when activated results in a state of physiological hyperactivity that can lead to compulsive behaviour (Ross, 2013). Sexual behaviour

becomes self-medication for somatic memories of recurring trauma (Brewer and Tidy, 2019). Porn sites and masturbation become a sexual cover aimed at modulating painful emotions (Craparo, 2014).

Dissociation weakens affect regulation and strengthens impulsive-compulsive need to engage in behaviour, in order to increase pleasure and to reduce hyperactive states. The memory of pleasure (ego-systonic) and ritualization of reducing pain (ego-dystonic), reinforces the addictive experience (Craparo, 2014). Therefore, sex addiction is considered to be an invasive, uncontrollable need that is repeated compulsively to regulate unmodulated emotions that were not mentalized in early (traumatic) relationships with care-givers.

Other than being a compulsive need to regulate traumatic memory, sex addiction can also be a re-enactment of early insecure attachments, an attachment to a bad object.

> "For some people, when it comes to sex, even knowing someone's real name can feel suffocating, let alone experiencing a relationship or love. We might think about this in relation to early experiences of being intruded on, and misattuned to, with early bodily contact perhaps having been about the other's need for tough rather than a response to the infant's desire"
>
> (Wingfield, 2007, p. 60).

This makes anonymous or cybersex more appealing than sex within a relationship. As more research emerges on the role of attachment and sex addiction, it is important to consider that sexual addiction is likely to be primarily driven by a combination of opportunity, attachment styles and trauma (Hall, 2014). Reducing sexuality to object relations dynamics alone would desexualize it (Fonagy, 2008) and would present a biased and incomplete account.

Male Sexual Identity

Several authors (Jensen, 2010, Jackson, 1984) write that heterosexual male sexuality is based on asserting power by making the other weaker, or by rejecting the other. This starts from a young age, when boys are pressured into a defensive separation from their mother. If they are considered to be not masculine enough, or too attached to their mothers, they are teased for being a "mama's boy" (Schwartz, 2007). Feelings of weakness are externalized through dehumanizing the other, or are projected onto others who are perceived to be weaker (typically women) (Purnell, 2007). There is a subtle coercion to reject the mother. This can force boys into

a “relational vacuum, leading to a tendency towards avoidant attachment, making for a tendency towards relationless sexuality in adult life” (Schwartz, 2007, p.52). Denying and repressing their relationship to their mothers, the most important early attachment relationship, shapes men to become pleasure-seeking (Schwartz, 2008), and them vulnerable to developing an unstable sexual identity (Purnell, 2007).

Philaretou, Mahfouz and Allen (2005) argue that men are socialised into suppressing emotional expressiveness, and needs for intimacy. These are considered to be conflicting with the image of masculinity. This can start to create a divide, and the inability to tolerate both intimacy and its absence. Men may start to rely on alternative means of having intimacy needs met. They become socialized to find male domination and female submission arousing (Jenssen, 2010). Male sexuality is seen as socially controlling or simply as power over women in the form of sexual dominance and violence (Edwards, 1994).

Shame

Shame is an oft-cited concept related to sex addiction (Briggs, Gough and das Nair, 2017). High sensitivity to shame is a risk factor that contributes to porn addiction. Furthermore, shameful desires that cannot be met in real life may drive a person to seek stimulation online. Porn use will exacerbate shame, which the individual regulates by consuming more porn. This perpetuates a cycle of dependence (Chisholm and Gall, 2015).

> “For addicted individuals, shame serves as both a trigger and consequence of sexually acting out behaviours. When an individual experiences a distressing emotion, such as shame, he or she may engage in a sexual act to produce feelings of pleasure that temporarily dispel the negative affect. As a result of sexually acting out, individuals experience self-loathing, shame and despair, which initiates the addiction cycle once again”
>
> (Woehler, Giordano and Hagedorn, 2018, p 155)

Shame is the negative appraisal of self, whereas guilt is the negative appraisal of a specific behaviour, and both have contrasting roles in sex addiction (Briggs et al, 2017). Gilliland, South, Carpenter and Hardy (2011), found that high levels of guilt are correlated with motivation to change and engaging in preventative behaviours. However, high levels of shame impede progress in therapy. Shame reinforces secret porn use, consequently making it highly erotic. Simultaneously, shame can cause feelings of hopelessness and lack of control over one’s

psychological, relational and sexual life, as well as denial and avoidance of sexual issues (McCarthy and Ross, 2018).

Turner (2008) found that shame-based attachments between care-giver and infant are common in sex addicts. There is typically a familial pre-conditioning of abandonment through neglect or abuse. In the adult, shame has a role in impeding the development of stronger attachments (Opitz, Tsytsarev and Froh, 2009), and perpetuates the addictive cycle. It separates the self from others, intimate connections are lost and this creates a greater dependence on the behaviour as a way to regulate negative affect (Adams and Robinson, 2002). Individuals who have learnt to anticipate abandonment, rejection, unfairness and conflict are more prone to feelings of anger, hostility and helplessness. They fear overt display of such feelings, therefore find a covert way of acting out and self-soothing (Schwartz, 2008). Sexual gratification becomes soothing, and hence merges and becomes associated with shame, anger, sadness and loneliness (Adams and Robinson, 2002), which exacerbates the need for the behaviour to remain covert (Carnes, 2001). At the neurobiological level, Gerhardt (2015) explains that the experience of shame increases the dispersion of cortisol, however this then returns to normal with affect regulation. A young child depends on an adult to regulate affect but in the event that this does not happen, the child's sense of shame is prolonged, and cortisol levels continues to rise. The child therefore remains in a state of increased arousal (Gerhardt, 2015).

Therapy

There are various therapeutic approaches to working with men who experience sex addiction. This section gives an overview of different common approaches.

The Twelve-Step Program for Sex Addiction

The Sex Addicts Anonymous (SAA) program offers a spiritual solution to sex addiction, without requiring adherence to any specific set of beliefs or practices. It involves attending meetings with other addicts who are in various stages of their recovery. Together, the group works on the 12 steps (or guidelines) to recover from sex addiction. The steps aim to interrupt and alter the addictive cycle, and build and restore the capacity to engage in meaningful relationships. Recovery is aimed at achieving sexual sobriety, which is refraining from a personalised list of compulsive sexual behaviours (Sex Addicts Anonymous, 2021).

The following are the 12 Steps adapted for Sexual Addicts:

1. We admitted we were powerless over addictive sexual behaviour - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood God.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked God to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God's will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to other sex addicts and to practice these principles in our lives.

(Sex Addicts Anonymous, 2021)

SAA groups are found to be effective in lowering levels of sexual-related sense of helplessness, avoidance, and compulsive sexual behaviour (Efrati and Gola, 2018). The programs have been criticized for not catering to non-believers, however, 12-Step programs do not require that participants believe in God. They encourage participants to reach spiritual understanding of themselves (Hornbacher, 2011). Tonigan et al (2002) found that believing in God is not necessary to benefit from 12-Step programs, however, atheist and agnostic clients were less likely to seek treatment in such settings.

Sevclkova et al (2018) interviewed 18 SAA participants, all of whom reported an improvement in their mental health which they attributed to attending the group and meeting others who had been sober long-term. They also found it helpful to structure their day with activities they found meaningful, which helped distract them from having thoughts about the addictive behaviour.

Therapy for Sex Addiction

Currently, research on therapy for sex addiction is lacking, mostly due to the multiple definitions which leads to a lack of consistency in the field. For example, it is unclear how many people are treated for sex addiction, and which approaches are better-suited to which patients. There is a lack of Randomised-controlled trials (RCTs) for 12-Step programmes, as well as cognitive behavioural therapy (Shepherd, 2010). Another reason is that to date, there is a lack of clinician training on the topic, which means that there is a great discrepancy in how it is dealt with (Coleman, 2015). From a methodological viewpoint, this limits the conclusions that can be drawn from treatment studies. Another criticism is that patients tend to be white men, therefore applicability of treatment to other populations is uncertain (Nacify, Samenow & Fong, 2012).

National data for the UK were collated by gathering feedback from the 58 Mental Health Trusts (MHTs) regarding treatment of sexual addiction. Only five MHTs reported having treated patients for sexual addiction in the past five years prior to the study. Various reasons were cited for why sexual addiction is not treated, such as that it was not within the trust's remit, that the term was considered "too narrow" (Griffiths & Dhuffar, 2014, p. 565), and therefore no information could be given, that the trust did not have the specialists to provide therapy, and that no patients presented with sex addiction. However, it was found that some trusts provided therapy if the patient had an Axis 1 or Axis 2 comorbidity. In fact, (Carnes, 2001) stated that sex addicts often present for therapy because of another issue, such as suicidality, depression or anxiety.

A study was carried out to examine the efficacy of CBT for sexual addiction (Shepherd, 2010). It was reported that increasing awareness of thoughts before the behaviour was important to reduction. Other factors that were considered beneficial included increased awareness of decision making process and of impact thoughts and feelings on behaviour, and recognising unhelpful thoughts. The principles of acknowledging ambivalence, rolling with resistance, and identifying the patient's perceptions of the advantages and disadvantages of changing are illuminating and essential. The study recommends that case conceptualisation could potentially change interventions used, and it is important to have a case concept that accurately reflects the client's presentation.

Therapeutic Principles for treating Sex Addiction

Ley (2015) states that the goal of therapy for sex addiction should be harm reduction, rather than abstinence. This definition gives the flexibility to create goals that suit the client. For example, if the client is not in a committed relationship, decreasing the frequency of masturbation may be an adequate goal. If the client is in a committed relationship, they may wish to only engage in sexual behaviour and masturbation with their partner.

If the client is in a relationship, therapy should involve the partner because the addict's partner is part of the system that sustains the addiction (Carnes, 2001, Turner, 2009). There is a risk that the partner may view sex as a means of controlling the addiction, rather than as a positive aspect of the relationship. Controlling the addiction is to remain the client's responsibility. The partner's role is to support and adopt a non-shaming approach. Couple's therapy would also focus on integrating eroticism and intimacy into the relationship (McCarthy and Wald-Ross, 2018). Some addicts and their partners may refuse to engage in such therapy, because it would mean working on a bond that may feel irreversibly broken (Turner, 2009).

Infidelity is often reported to be difficult for couples' therapists to work with. Brewer and Tidy (2019), iterate that disclosure or discovery are traumatic events for the partner, therefore they need support. Vossler and Moller (2014) carried out semi-structured interviews seven experienced couple's therapists and found that therapists' language included implicit moral judgement, and all therapists experienced difficulties with balancing different needs. Initial work involves creating a safe space to build trust and expression of emotionally charged material, in order to allow a move from irrational "hurt child" to a more "adult-to-adult" dialogue (Vossler and Moller, p.432). Both partners have to learn that the addiction was a means of coping with something unbearable, and they will have to discover what that "something" is as meaning is assigned to the behaviour (Cohn, 2014). The addict will have to learn to empathise more, and the partner trust. Different sources of excitation and inhibition could be identified as a hierarchy, and therapy could also focus on strengthening inhibitory control in response to unhealthy sexual arousal (Toates, 2009). Understanding and regulating emotional contents which precipitate sexual compulsion would help the person to represent states of arousal differently - managing sensorimotor, emotional and cognitive information, increase the ability to understand one's own and others' mental states (known as mentalization or reflective functioning), develop the capacity to identify and explore traumatic memories and assign language and affect to them, work on

painful mental states, and develop the ability to be in one's body (to handle sex drive) (Carparo, 2014).

The next stage involves modulating affect and learning social skills, which is an advantage of attending group therapy. Addicts will learn to understand more on boundaries. Therapy requires increased mentalization skills and processing of traumatic memories (Carparo, 2014). In the advanced stages of therapy, a stronger sense of self is consolidated, the addict and the partner take on more responsibility and learn to relate intimately (Turner, 2009). In cases where the addict is in a relationship but the partner does not attend therapy, these issues should still be focused on. The aim is primarily to establish safety and to reach a diagnosis, understand the factors involved in precipitating and maintaining behaviours, and to understand the relationship dynamics as well as work towards a new sexual relationship model (Cohn, 2014).

Therapy should challenge a sadomasochistic sexuality that denies the other their subjectivity (Schwartz, 2008). In a good-enough attachment, there is an experience of intimacy as a relationship between two people, intersubjectivity, rather than a fear that connection with the other's mind and body will lead to "merger" or abandonment. This represents a shift from one-person sexuality (subject-object) to two-person sexuality (subject-subject) (Wingfield, 2008).

Braun-Harvey and Vigorito (2016) suggest an approach to therapy that focuses on sexual health, and attempts to change the sexual patterns that lead to unwanted consequences. Therapy should promote wellbeing, a philosophy in line with the WHO, based on six principles:

- Consent: mutually positive sexual experiences
- Non-exploitation: not using a power dynamic to their advantage in order to receive sexual gratification
- Protection from unwanted health consequences
- Honesty: being honest with self and other about desires and boundaries
- Shared values: between client and partner, to build a relationship based on mutuality

As an approach, this moves away from pathologizing. To do this, Braun-Harvey and Vigorito (2016), stress the need for building a strong therapeutic alliance, and challenge the practitioner to question any personal discomfort with sexual diversity.

Benfield (2018) interviewed six sex therapists who had more than five years of experience working with clients with sex addiction. All participants iterated that clients crave connection yet find it

overwhelming, which places them in an impossible space. In order to overcome this, therapists have to proceed slowly with building a therapeutic attachment. In order to be a secure base, therapists work at relational depth, including managing eroticization. Therapy also addresses isolation, not just vis-à-vis the therapeutic relationship, but by encouraging reaching out to others, partners, and group work. Therapists also emphasized the need to process trauma, and eventually moving to affect regulation. This work therefore requires therapists to address clients' attachment styles as well as their own attachment deficits. However, Faisandier, Taylor and Salisbury (2012) identify several obstacles. Firstly, the therapist may be unwilling or unable to engage with their own attachment deficits, or may have discomfort exploring sexual behaviours. Another obstacle is resistance from the client. Sex addicts are likely to have difficulty asking for help, and may use seduction instead. When the client experiences shame, s/he may use objectification as a means of protecting her or himself from disapproval or rejection.

Chisholm and Gall (2015) emphasise the value of spiritual interventions with sex addiction, because of their emphasis on self-loathing, and improving self-compassion. Increasingly spirituality-based therapies (both group and individual) are found to be effective with people who are already "spiritually-inclined", but may not be a good fit for those who are not spiritual. The core principles of these therapies are acceptance, addressing automatic thoughts, developing a greater sense of self, values and committed action. With regards to faith-based groups such as SAA, research indicates that participants who are not spiritual, still benefit from attending (Efrati and Gola, 2019).

Sex Addiction in Other Populations

Sex addiction has been studied in women, and gay and bi-sexual men. Differences in presentation between these populations and straight male populations have been reported, and will be highlighted below.

Heterosexual Women Sex Addicts

Significantly more research has been carried out on male sex addicts than on women and although research does suggest some overlap, there are gender differences in presentation. Early research suggests different etiological factors for men and women, which concurs with Sexual Strategies Theory, which states that men and women have different motives for engaging in sexual behaviour, Gender disparity in social roles, position and power may also change the experience of sex addiction. According to McKinney (2014), sex addiction is a response to socio-patriarchal oppression to gain a sense of control through sex. This complements McKeague

(2014), who states that it is also a response to trauma, an attempt at mastering trauma, to regain a sense of control.

Maternal deprivation also influences gender differences in sexual behaviours of sex addicts. Women were more likely to engage in self-injurious behaviours, whereas men were more likely to be aggressive towards partners. They conceptualized sex addiction as a strategy to stop feeling numb from dissociation, or as a way to regulate overwhelming affect. These responses are an attempt at self-cohesion (Schwartz and Southern, 2017). Men tend to show a greater number of symptoms (Kuzma & Black, 2013), and focus more on sexual gratification (Black, 2000), whereas women's sexually addictive behaviours are more relationally motivated and tend to present with comorbidities of eating disorders and Borderline Personality Disorder (McKeague, 2014). Women tend to have more sexual encounters perpetuated by feelings of pain, fear, loneliness and desperation (McKinney, 2014), whereas men tend to use porn more (Oberg Hallberg, Kaldo, Dhejne, and Arver, 2017).

Gay and Bi Men Sex Addicts

Sex addiction disproportionately affects gay and bisexual men (Weiss, 2002). Although foundational intervention guidelines for sex addiction are the same across gender and orientation, Weiss (2002) highlights additional issues that need to be addressed in therapy with gay and bi sex addicts. These include childhood repressed homosexuality, internalized homophobia, stigma and potential rejection and trauma from external homophobia, and AIDS grief. The rates of comorbid drug abuse are also significantly higher than heterosexual male sex addicts. Smith et al (2018) found that, from a sample of 942 bisexual male adults, higher rates of compulsive sexual behaviour correlated to higher levels of homophobia and bi-negativity. This supports the hypothesis that perceived isolation and stigma can have a role in sex addiction.

Carnes, Green and Carnes (2010) found that gay and bi sex addicts did not present the same issues and symptoms as heterosexual men, and the differences merited different therapeutic groups and assessment tools.

Lesbian Sex Addicts

Not much research differentiates straight female sex addicts from lesbian sex addicts. Most of the research pertains to the context, rather than the presentation of sex addiction, and suggests that lesbians face even more oppression and stigmatization than straight women (Ziegler, 2000). They are more likely to present with psychiatric co-morbidity, internalized and societal homophobia, co-

dependency (Ziegler, 2000), internalized oppression (the absorption of negative cultural stereotypes), the lack of cultural support for lesbian relationships, homophobia, the oppression - avoidance syndrome, typical sexual difficulties in lesbian relationships, subculture dynamics, and the coming out process (Kasl, 2002).

Based on the differences in aetiology, comorbidities, numbers and presentations, gay and bi men, and straight and lesbian female sex addicts will not be included in the study.

Rationale for the Study

The most common behaviour in sex addiction is porn addiction (Kor et al, 2014). For this reason, the study will focus on porn addiction, recruiting participants who consume porn compulsively. Participants who engage in additional behaviours (as well as compulsive porn use) will be included. The discrepancies in numbers in various populations suggested that there may be possible differences in the experience of SA, from its aetiology, which behaviours manifest, what consequences it brings, as well as the context in which the addiction started and continued (Freedman and D'Emilio, 1990). Therefore, the study excludes participants from different populations and focuses solely on heterosexual men who had porn addiction.

An overview of the literature shows how controversial and vast the topic of sex and porn addiction is, with conservative and liberal societies aligning and being predominantly "anti-porn" for different reasons (Klein, 2016), a lack of consensus within feminism regarding its stance (Easton 1994), and a lack of consensus regarding its status as a diagnosis. Despite this, the experience of living with porn and sex addiction is not well understood. Boyle (2010), called for more qualitative research, specifically men's view on experiencing porn.

Despite some scholars arguing that sex addiction doesn't exist (Ley, Klein, Davies), and giving it different nomenclature, the number of people seeking help for this phenomenon continues to increase (Hall, 2014). Therapists and researchers have to keep in mind their values, their client's, and the broader context in order to assess if distress is "justifiable", if it is having a significant impact on well-being, and what the therapeutic goals should be. There is a risk to be organized by the debate, and lose sight of the client.

It has been argued that human existence is in the body, intersubjective and sexual (Cohn, 1997), however, the body and sex have been ignored by phenomenological research (Finlay, 2006). This research is an inquiry into the phenomenological experience of sexual addiction. It aims to explore how a person with sex addiction perceives the self, the other and sex addiction. The study will

focus on the nature of the addiction, how this developed, how it is managed and how it impacts self-perception (and vice-versa), and relationships.

Diamond and Hueber (2012) note that the study of sexuality has been mostly limited to quantitative research, with the effect that certain aspects have been overlooked and ignored. This appears to have happened with the phenomenon of sex addiction, as most literature pertains to its manifestations (Efrati and Gola, 2018).

Boethe et al. (2019) criticise sex addiction research for attempting to explain sex addiction in terms of a single theory, pointing out gaps in its current nosology, emphasising the need for research on the phenomenology. Such research could outline which therapeutic interventions would be effective. More knowledge regarding therapeutic interventions for this population is required. Ayers and Haddock (2009) and Braun-Harvey and Vigorito (2016) showed that therapists are reluctant to work with patients presenting with sex addiction, as most feel they did not have enough training. They also found that the therapist's personal qualities (attitudes and beliefs) had a significant role in treatment approach. This study shows that more knowledge is required to inform training programmes regarding therapeutic practices for hyper-sexuality, as well as greater awareness of the therapist's self in relation to a patient with hyper-sexuality. Significantly, Mollen, Burnes, Lee and Abbott (2020) found that very few Counselling Psychology programmes offered comprehensive training in sexuality, and from these topics covered included sexual development, sexual orientation and gender identity, intimacy, sexual trauma and abuse. Sexual expression and sex therapy principles were unlikely to be covered. This points to a deficit not only in theoretical training about sex addiction, but also a missed opportunity for counselling psychologists to develop clinical conceptualizations of sexual expression, and to develop proficiency and ease when working with sexual issues.

This present research aims to address some gaps in the research on sexual addiction, as well as inform clinicians about the experience of sexual addiction, and which will enhance therapeutic practice.

Conclusion

This chapter started by addressing broad concepts pertaining to sex addiction, starting from the medical model, and current research on the applicability of different clinical nomenclature. I then drew on social concepts on sex addiction and specifically porn addiction, since is this the most common manifestation of sex addiction. In the following section, I discussed research on

attachment, trauma, shame and male sexuality, and how these relate to sex addiction. A review of current therapeutic practices for sex addiction was then included, followed by the rationale for the research. Ultimately, this chapter reflects the debate with Counselling Psychology and wider society on sex and porn addiction.

In the forthcoming chapter I will be looking at the overall rationale for the qualitative methodology I have adopted for this study. I will begin by discussing the wider research paradigm, including my ontological and epistemological stance, then discuss the philosophical foundations that underpin the research (i.e. phenomenology), and consider issues relating to validity.

Chapter Three: Methodology

Introduction

This chapter highlights the philosophical underpinnings of the current study and my approach to research, discusses methods I considered for this study, and provides an overview of the study design and methods employed to collect and analyse data. Finally, I consider how my own professional and personal influences positioned my role within the research.

Philosophical Influences

My philosophical underpinnings for research are based on concepts that attempt to answer "What is Being?", "What is Knowledge?" and "What values influence seeking knowledge?" I believe that "Being" and how it is known, or studied, will then define "Reality", however, as a researcher, I must be transparent about the process of defining that reality.

Epistemology

Epistemology is the study of the nature of knowledge (Schwandt, 2014). There are various views on what constitutes knowledge, and these shape how knowledge is sought. Empiricism and Positivism suggest that there is only one reality, which can only be known through measurable observations, namely quantitative methods (Forrester, 2010). The researcher aims to collect objective data (McLeod, 2001), such as to establish the incidence of specific behaviours in people who meet the criteria for sex addiction.

Qualitative methods lean towards a subjectivist approach, stating that it is not possible to quantify the nature of feelings, thoughts, and behaviours because knowledge is subjective and contextualised (Langdridge, 2007). Nietzsche (1873/1962) posited that knowledge is relational, and objective truth cannot be known. Moreover, the researcher's interaction with participants has an impact on the research, and vice-versa, (Richardson, 1994), which is based on the principle of mutuality and intersubjective processes taking place within and between people (Buber, 1921). My understanding of knowledge is that it can never be fully, objectively known. It is subjective, bound in the meaning ascribed to it by the subject. This falls under a relativist approach, which recognizes that knowledge is context-specific and influenced by the perspective of the perceiver (Lyons, and Coyle, 2015).

Ontology

Ontology is the study of being (Crotty, 1998), regarding the form and structure of reality and the nature of being in the world (Willig, 2009). As a researcher, I am influenced by post-positivist paradigms and specifically critical realist views which state that reality is more than what can be observed (Guba & Lincoln, 2005). Furthermore, although reality is only partially accessible, multiple constructions of reality exist, according to the constructivist paradigm (Clarkson, 2003 and Ponterotto, 2005). Reality can be known through consciousness and social interaction to create meaning (Denzin, 2007). This is congruent with Hollway and Jefferson's view (2013) that knowing and understanding a phenomenon are different. My stance as a researcher aligns with my practice as an integrative, relational psychotherapist.

I agree with the Social Constructionist perspective, which suggests that language is crucial to constructing reality (Burr, 2003). Rogers (1961) stated that our perceptual field is reality - to this I add that our perceptual field is the closest understanding we have of reality. This definition suggests that there are aspects of reality which we cannot or have not yet perceived. Therefore as a researcher I feel more confident using a qualitative approach for this study because the results will not be presented as "reality" but a representation of it, as perceived through the participants and myself as the reporter of the findings. I believe this is more ethical than presenting the findings as the "truth", and not my understanding of the truth.

In an attempt to integrate clinician and researcher perspectives, I am interested in what the experience of Being is. What is the sex addict's experience of Being who he is? Existence is always "in the world … in the body … intersubjective" (Cohn 1997 pg.13). This seems particularly relevant to a study of the self as expressed and manifested through sex.

Axiology

Axiology is the study of values and ethics. Positivist approaches define a clear distinction between fact (knowledge), and values. Facts are objective, whereas values are subjective and emotive, and therefore a source of bias. The role of the researcher is to remove all potential sources of bias in the research from its conception stage, till reporting of results (McLeod, 2001). However, according to Heron and Reason (1997), to know or experience something, always implies valuing it in some way or another. Under interpretivist approaches, axiology requires making the researcher's values explicit, and stating how these influence the interpretation of knowledge (Lehman, 2011).Therefore the role of axiological inquiry is necessary to qualitative methods. Considering the researcher's values as part of the research process is necessary towards

understanding how those values shape the research (Deurzen, 2002). My own viewpoint fits more with an interpretivist stance, therefore to increase transparency, I will make my values known, and how I believe these influenced the study. These will be tackled in the Reflexivity section and Ethical Considerations sections, below.

Phenomenology

Phenomenology is concerned with the essence of experience. Husserl (1936) stated that inquiry should focus on the intentional relationship between what is experienced and how it manifests in consciousness (Smith, Flowers and Larkin, 2009). Phenomenology challenges the view that reality is objective, and values understanding as means of acquiring knowledge (Moustakas, 1990).

Phenomenological inquiry is based on Heidegger's concept of "Dasein", or "being in the world"- the belief that engagement with the world is always through interpretation. It recognizes the role of consciousness (as made accessible through language) in the perception of experience (Heidegger, 1953). Consciousness is intentional and relational to an object outside the self (Giorgi, 1997). Language, thinking and being are considered to be one, and only through language could being-in-the-world be accessible (van Manen, 1990). Intersubjectivity (a concept closely related to mentalization) is central to Heidegger's work. Subject and object are interrelated, not separate (Moustakas, 1990).

Husserl (1936) stated that inquiry should involve 'epoche' and 'phenomenological reduction' - the processes of bracketing assumptions about investigated phenomena to be able to grasp and describe them in their 'totality' (Willig, 2008). However, Heiddeger stated that assumptions can never be fully distanced from inquiry. For this reason, phenomenology has been criticized as "unregulated" speculation (Moran, 2000: 14). However, Meades (2019) suggests that phenomenological research mirrors psychotherapeutic practice, whereby rather than suspending and distancing inquiry from assumptions, there should be a process of exploring implicit, underlying meanings in dialogue and considering the significance of what often goes unsaid. The aim of phenomenological research is to give detailed description in order to understand how meaning is created through embodied perception (Sokolowski, 2000).

Therefore, phenomenology has the advantage of drawing upon the researcher's past knowledge, as both a bias and a source of information. It makes explicit the influence of the researcher on the research and asserts that the phenomenon can never be fully understood from the view of

the participants (Willig, 2001). In my opinion, this is a more ethical stance, because the reader is informed of potential bias. Furthermore, it allows the researcher to be more questioning of the research process (Finlay, 2008). A distinction is made between the phenomenological analysis of an event as it presents itself to the researcher, and the phenomenological analysis of an account of a participant's experience. The participant's account is that which the researcher engages with (Smith and Osborne, 2008).

Eliciting meaning is the scope of phenomenological research. It involves phenomenological reduction to arrive at salient themes (Moustakas, 1990). Merleau-Ponty's (1945) work adds to the above, mirroring the value-laden axiological and relativist ontological assumptions of qualitative methods: it assumes the contextual and intersubjective status of reality and truth. According to Merleau-Ponty, interpretations of reality are grounded in embodied consciousness. This leads to the next component of IPA - the interpretative, or hermeneutic element.

Hermeneutics

Phenomenological epistemology aims to produce knowledge about the subjective experience of the participant. Phenomenological literature appears divided between a descriptive and an interpretive phenomenology, with Husserlian phenomenologists concentrating on a detailed description of experiences and bracketing of personal assumptions while existential/interpretive phenomenology are interested in hermeneutics - the phenomenology of interpretation. An interpretative phenomenological epistemology can be thought of as stepping outside of the reported account and reflecting upon it in its wider social, cultural, and theoretical context (Larkin, Watts, and Clifton, 2006, p.104). Gadamer argued that people are embedded in a wider context of history and culture that has shaped their consciousness (Honderich, 2005). Gadamer (1960) proposed that nothing exists except through language. He considered language, understanding, and interpretation as inseparable from being-in-the-world. IPA is based on an interpretative (or hermeneutic) phenomenological epistemology (Larkin and Thompson, 2011).

In seeking to generate knowledge about participants' lived-experiences and the meanings within individual social and cultural contexts, as well as considering these experiences theoretically in relation to the literature, I align myself with an interpretative phenomenological epistemology. A purely descriptive approach would require that no interpretation is given when presenting results, however, this is incongruent with my epistemological beliefs that meaning is created intersubjectively.

Hermeneutic phenomenological research is based on the concept that hermeneutic consciousness exists when the researcher is open to restructuring pre-existing knowledge of phenomena (Larkin and Thompson, 2011). This is a cyclical process of starting from pre-undersanding or pre-knowledge, moving to a state of not knowing (finding what is unknown from that which is known). What becomes known then revises what was pre-known (Finlay, 2011). In this case, it means that I am challenged to hold, yet question the pre-knowledge on sexual addiction, in particular published quantitative data, which had a limited view of the individual, and also my clinical knowledge, which may have been biased by my inexperience, lack of adequate training, as well as personal and cultural beliefs.

Furthermore, little research exists on the subjective experience of hypersexuality. Apart from the reasons highlighted above, I therefore consider Phenomenology suited to the research question, because it aims to "describe … the intentional experience as uncontaminated by foreknowledge, bias and explanation" (Cohn, 1997 pg.11). Moreover, this stance respects the context in which the experience occurs, as opposed to merely objectifying and quantifying it (Faulconer, 2005). I am not interested in the behaviour of sexual addiction per se, but in the intersubjective context in which it takes place.

Choice of Research Methodology

Interpretative Phenomenological Analysis

As highlighted above, an interpretive approach considers interpretation as an unavoidable part of description. I shall elaborate below why Interpretative Phenomenological Analysis (IPA) was chosen. IPA focuses on the relational processes between participant and researcher, seeing them as necessary to creating meaning. Personally, this mirrors my psychotherapeutic practice, where co-creating narrative and meaning are an essential part of the therapeutic process. Frie (2010), suggests that the split between self and other in psychotherapy, or subject and object/researcher in research, should be replaced with a hermeneutic exploration of the subject's world, within the context of how he/she relates to self and others. IPA is congruent with this stance, therefore it was an appropriate choice for the study.

IPA involves attempting to understand a person based on the question, what is an experience like? (Pietkiewicz & Smith, 2014). IPA has been extensively used to study addiction because it is able to address psychological accounts of addiction that are seldom studied (MacMahon, 2019). The aim of this study was to explore how a person experiences himself, others and relationships,

when living with sex addiction. What is the experience of sex addiction like? The study also aimed to explore the meaning attributed to sex addiction, as most research to date has been quantitative (Kafka, 2010). Contrastingly, IPA focuses on individual accounts, and can lead to insight for psychotherapeutic practice (Vasilliou, 2016). IPA is based on the principle that the same phenomenon (e.g. sex addiction) can be experienced in different ways, and that meanings attributed to the experience are influenced by broader contexts.

The aim of IPA research is to capture the quality of an experience and to explore self-reflection on the experience (Reid, Flowers and Larkin, 2005). It aims to give detail about the process through which participants make sense of their experiences, by looking at the participant's account. The experience is described in its own terms, rather than predefined categories (Smith, Flowers and Larkin, 2009). Hence IPA was adopted for this project. It is descriptive, idiographic (focusing on the individual, rather than nomothetic, which focuses on the larger scale) and inductive, considering the participant to be the expert, rather than imposing an a priori hypothesis about the participant's experience. It is not committed to making claims about larger populations (Brocki and Wearden, 2006). This contrasts with most research into sexual addiction thus far which has investigated participants' experiences in terms of diagnoses.

Interpretative phenomenological research focuses on meaning in human experience, embedding it within a larger framework through theoretical interpretation (Wertz, 2005). Thus, it is a double hermeneutic, the researcher making sense of the participant's sense of a phenomenon (Smith, Flowers and Larkin, 2001). This is based on Heidegger's hermeneutic phenomenology, and asserts that is impossible to gain direct access to the participant's world (Langridge, 2007). It is therefore concerned with "exploring experience in its own terms" and subjective reports rather than reducing it to "predefined or overly abstract categories" and objective accounts (Smith et al 2009, p. 1), which has been the case for research on hypersexuality.

Interpretative Phenomenological Analysis (IPA) developed as a procedural framework for conducting qualitative analysis. It is influenced by symbolic interactionism, which iterates that meanings emerge from reciprocal interaction between a person and the world (Aksan, Kisac, Aydin and Demirbuken, 2009). The researcher is making sense of how the participant makes sense of his or her experience (Smith, 2004).

Social constructionism has also influenced IPA, in that it makes explicit the role of the researcher's interpretation, and requires a consideration of the context in which the research took place. IPA

acknowledges that interpretations are bound by participants' abilities to articulate their experience, and by the researcher's ability to analyse (Brocki and Wearden, 2006).

Participants are selected in order to elaborate on the phenomenon to be explored. In IPA, samples are homogenous with regards to experience of a particular phenomenon (Dunworth, 2008) and this allows for more acute focus on the research question, rather than random sampling so as to achieve broader representativeness (Eatough and Smith, 2006a). IPA prioritises more in-depth description of the individual's experience, rather than general explanations, therefore a small sample is required.

As a critical realist method, IPA assumes that reality cannot be directly experienced. It looks at how access to reality is made available through a person's understanding of their experiences at a particular time in their specific context (Forrester, 2010). IPA is also considered to be suitable for the study of sex and sexuality and areas that are still under-researched (Smith, Flowers and Larkin, 2001 and Levering, 2006)

IPA is based on the assumption that verbal responses reflect cognitions. However, it also recognises that a person's thoughts are not directly transparent in an interview transcript, hence the need for the researcher to interpret and engage in an analytic process, in order to make sense of the participant's words (Smith, Jarman and Osborn, 1999). This interpretation leads to new insight for the researcher, and this is a key aim of IPA. Through achieving new insight into the experience of hypersexuality, links can be drawn between the existing literature and that which is still unknown.

This study is influenced by relativist ontological philosophy, an interpretivist epistemological positioning and my own values and ethical conduct, grounded within the guidelines of the British Psychological Society (BPS, 2014). I will explain how IPA fits within these paradigms. IPA is grounded within phenomenology (the philosophy of experience) and hermeneutics (the philosophy of interpretation).

Critical Appraisal of IPA

Understanding the limitations of IPA is a necessary process, as these limitations will inform considerations regarding quality and validity of the study. One of the primary criticisms of IPA is that the research is constrained by the language of the participant. The participant has to be able to articulate thoughts and experiences (Willig, 2012). To this I would add that participants must

also be able to reflect on those experiences. However, Meades (2019), counteracts this, stating that analysis can also include what is not said.

Another criticism is that IPA is solely focused on individual experience, ignoring the social context within which the phenomenon occurs (Kaptein, 2011). However, as has been demonstrated, IPA's strength is that it requires the researcher to be sensitive to the social context of the participant. This in turn leads to another limitation, which is that IPA does not clearly make explicit the reflexive process, there is always some ambiguity regarding the researcher's impact on the study (Willig, 2012). However, IPA does not claim to find objective facts, and clearly states that the findings are an interpretation of the participant's experience (Smith, Flowers and Larkin, 2009).

A further criticism of IPA is that it is lacking replicability (Giorgi, 2010). However, Smith (2010), addressed this by explaining that evaluation criterion for qualitative studies are different to those for quantitative.

Other Methodologies Considered

Other methods were considered for the research. In this section I will explain which other methods were considered, and the basis for which they rejected.

Thematic Analysis aims to identify and organise themes (King, Horrocks and Brooks, 2018). In Braun and Clarke's (2006) paper, thematic analysis is described as not being bound to any theoretical framework. There is loss of depth and complexity, in order to accurately reflect content that is prevalent throughout the entire data set. Contrastingly, IPA is bound within phenomenological epistemology (Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2003), which gives experience primacy (Holloway & Todres, 2003), and is about understanding people"s everyday experience of reality, in great detail, so as to gain an understanding of the phenomenon in question (McLeod, 2001). I chose IPA because it places greater emphasis on identity and meaning-making, and felt it would better suit the research aims.

Grounded Theory and IPA share similarities in their approach and underpinnings. Both aim to identify linked themes and categories that can be clustered into master themes, so as to capture the essence of the phenomenon being studied. However, Grounded Theory aims to study social processes, by offering a sequential guide to qualitative fieldwork and is more suitable for research where the focus is not primarily psychological. The aim is typically to generate a theory and is used for causation-type research by drawing on convergences within a larger sample to support wider conceptual explanations, whereas IPA is more focused on describing and interpreting

experience through microanalysis and not causation or concepts. IPA is considered to be a more creative methodology than GT, in that it does not follow a rigid protocol (Brocki and Wearden, 2006), which allowed for the study to focus on emergent content.

I also considered Discourse Analysis, which is based on the principle that shared use of language creates meaning and defines social roles (Murray, 2008). For this particular project, it would have been interesting to explore how participants describe their experiences. However, the aim of the study was to explore how sex addicts make sense of their experiences and not the ways in which these experiences are narrated based on socially available discourses.

Research Design and Methods

This section will cover the procedures taken throughout the research, as well as ethical issues and a discussion of how validity and trustworthiness were ensured.

Sampling

IPA studies require small, purposive sample sizes, with the aim of generating in-depth, detailed data for deep idiographic analysis of experience and meaning-making (Smith, Jarman and Osborn, 1999, and Smith, Flowers and Larkin, 2009). A small sample size made it possible to have an in-depth anaylsis of the data (Brocki & Wearden, 2006). A purposive sample allows for more depth (rather than breadth) to be collected from the data (Langdridge, 2007).

Potential participants were invited to take part in the study if they identified as porn addicts. I did not specify what I meant by porn addicts, as I wanted to recruit participants from whom the label had a meaning, rather than based on what meaning I gave it. According to Delmonico and Griffin (2002), social online sexual behaviour (such as chatting) and solitary online sexual behaviour (masturbating to porn) are related. Ferree (2003) notes that online sex addiction does not typically occur on its own, therefore sex addicts who engage in this behaviour and other manifestations of Hyper-sexuality were also invited to participate, as well as men who are addicted to porn but do not show other behaviours associated to hypersexuality.

It was important that the participants identified as porn addicts, rather than screening them to ascertain if they fell under a particular classification of sex addiction or Hypersexuality. If participants felt that they had problematic use of porn which was impacting their life, then they were eligible to participate. This is in keeping with my approach as a clinician, to give more power to the person experiencing the phenomenon, and to move away from labelling and stay focused on the experience of the person.

Recruitment

During the planning phases of the project, I had informally contacted Sex Addicts Anonymous (SAA) intergroup, which is the central contact for all SAA groups in the UK, and asked if in principle they would agree to disseminating the recruitment material. They agreed, stating that their ethos was to allow their members to make their own decisions, rather than to decide for them (SAA, 2021).

After I received ethical approval from Metanoia Ethics Committee, I contacted SAA and it was agreed that they would disseminate my invitation and a copy of the Participant Information Sheet (PIS) (Appendix 2 and 3), was also disseminated, together with a consent form to their groups. Members were also invited to contact me beforehand if they were not sure about participating.

The information sheet included details about the study, as well as organisations and individuals who potential participants could contact for further information if they had any queries or for support. An explanation of how the study maintained an ethical stance was detailed (see below).

Informed Consent was achieved through ensuring that participants read and understood the information outlined in the information sheet, including the purpose of the study, how the research would be carried out and what would happen to the data, who I was and which university I was affiliated with.

Potential participants were made aware through the information sheet that all identifying data would be removed from the transcripts. This was reiterated before the interview, with an emphasis that even though quotes would be used in the presentation of results participants would not be identifiable.

It was also made explicit that although no risk was evident in participating, participants may have found talking about their experience distressing. Participants were therefore given a list of contacts they could refer to if they felt distressed during or after the interview. They were also informed that they could stop the interview at any time, and did not have to answer questions which made them feel uncomfortable.

Participants who contacted me via email were given more information on the study, and reminded of consent issues, anonymity, and confidentiality. This was an opportunity to address any concerns the participant might have about taking part in the study. This was also done so as to achieve symmetry between the researcher and participant (Eatough and Smith, 2006a).

The ethical issues and information sheet were repeated prior to the interview. It was also emphasized that participants were not obliged to take part in the study. The participant was then asked to sign the consent form and the interview began.

Six potential participants came forward and since they fit the criteria they were interviewed. This is in accordance with Smith et al.'s (2009) recommendations. This provides enough cases to examine similarities and differences between participants but not so many that an overwhelming amount of data would be generated. SAA has separate groups for women, and members of the LGBT community. The recruitment letter was only sent to groups for heterosexual men. IPA requires a small, homogenous sample, and as highlighted in the literature review, research has pointed to several differences in aetiology, power struggles and oppression, stigmatization and co-morbidities amongst gay and bi men, women and lesbian sex addicts.

All participants were given a pseudonym to ensure confidentiality. The table below gives brief background information on the participants.

Pseudonym	Age	Marital Status	Problem Behaviours	Time Elapsed since they last engaged in behaviour
Adam	75	Divorced	Excessive Porn use Paying for sex	Over 3 years Occasionally masturbates, but does not use porn
Brian	48	Married	Excessive Porn use Masturbating at work	7 months
Colin	34	Divorced	Excessive Porn use Masturbating at work	8 months
David	69	Married	Excessive Porn use Paying for sex	2 years
Eli	48	Divorced	Excessive Porn use Chat rooms Paying for sex	6 months
Frank	47	Divorced	Excessive Porn use Strip Clubs Paying for sex	4 years

Data Collection

It is possible to use data from different sources for IPA analysis, such as diaries, personal accounts etc., however in-depth semi-structured interviews are recommended (Smith, 1996). Other methods were considered for this study, such as use of a diary, however this idea was discarded because as a researcher I would not be able to ask follow-up questions. Furthermore, the written word may be more "edited" and "biased".

Interviews took place in a hired consulting-room within a counselling service. The building had a receptionist at all times. Typically in IPA, one interview is carried out with each participant (Smith et al. 2009). I prepared the schedule (Appendix 4) for the semi-structured interview based on pre-identified gaps in the literature, my clinical experience as well as guidelines set out by Smith et al (2009). Interview questions were open-ended and served as cues for the participants to explore their experiences, rather than to lead the interview into a particular topic. Probes were written in advance so as to gain more depth and additional information. The more generic questions were at the start of the interview, whereas more difficult questions were placed later, so as to establish a rapport and trust before tackling difficult issues, and also because the participant would be more primed (Smith et al, 2009).The interview lasted one hour to ninety minutes.

A semi-structured interview aims to address specific issues but should primarily follow what the participant considers relevant, rather than what is dictated by the schedule, and remain emergent (Eatough and Smith, 2006a). Phenomenology aims to return to the phenomenon itself, by bracketing what we may already know about them. Having worked as a clinician in the field, there was a risk that I could delve into particular questions because of an a priori knowledge about hypersexuality, and this would have detracted from learning about the participant's experience. Husserl applies phenomenological reduction in order to bracket past knowledge and be fully engaged with the topic. Therefore a semi-structured interview was used because it would allow flexibility, be led by the participant's account, and ensure that the interview focussed on the research question (Ayala and Elder, 2011).

Transcription

Reflexive notes were taken after each interview, which were referred to when carrying out the final data analysis. These included information on eye-contact, punctuation, questions and comments made prior and after the interview, etc. Interviews were transcribed verbatim and given line numbers. Kvale (2007) notes that the transcribing process from oral to text is in itself an interpretative exercise. It requires the transcriber to make the participant's story accessible to

readers, and whilst every effort will be made to ensure that it is an accurate representation, the text will not fully capture nuances of nonverbal communication that occurs during the interview. This provided information regarding transferential dynamics, which I reflected on and discuss in the Reflexivity chapter.

Each transcript was checked in order to verify for accuracy. Data was anonymised at transcription and participants were given pseudonyms.

Data Analysis

Gadamer (1975) differentiates two forms of interpretation, “pointing to” something and “pointing out” the meaning of something. As a practitioner learning to integrate researcher and clinician role, I believe that both forms of interpretation are necessary, and during the process I endeavored to maintain both.

Eatough and Smith (2006b) suggest that the researcher should move between description of data and different levels of interpretation and differentiate between the two, giving enough information for the reader to discern the fit between the participant’s account and the researcher’s interpretation. As elaborated below, analysis involved a description of the content given by the participant, as well as my interpretation (Creswell and Creswell, 2018).

Smith, Jarman and Osborn (1999) described the process of data analysis in IPA as a step-wise recursive process of interpreting and coding the data. The first transcript was read several times so as to become immersed in the data. This is in keeping with Yardley’s criterion for “good” qualitative research of “Commitment and rigour” (2000, pg. 221) (discussed below), which involves in-depth engagement with data and depth and breadth of analysis. After several readings, the transcript was coded. The first step in coding was to write comments on chunks of data (Pietkiewicz and Smith, 2012). Comments could be:

- Descriptive - focusing on content
- Linguistic - how language is used, repetition, fluency, metaphors, pauses
- Conceptual - focusing on participant’s overarching understanding, abstract concepts and implicit knowledge

A keyword was then assigned to each comment to represent what the participant was discussing (Creswell and Creswell, 2018). Each keyword was “tested” by asking if it is relevant to the

experience. Does it contain a moment of the experience that is necessary and sufficient for understanding it? Is it possible to abstract and label it? Expressions not meeting the above requirements were eliminated. Overlapping, repetitive, and vague expressions were also eliminated or presented in more exact descriptive terms (Moustakas, 2011).

Keywords were then collated and emergent themes were elicited. Related keywords were listed chronologically and grouped into clusters. Similar themes were identified and grouped together (abstraction). Alternatively, an emergent theme could be a super-ordinate theme in itself, and other themes related to it were grouped within it, a process known as subsumption. Polarization is the process of searching for opposing themes and contextualization is the identifying of contextual or narrative elements. Themes were then analysed for how frequently they appear in the transcript (numeration), and were explored for their function within the transcript (function). A table of themes and sub-themes was drawn for the transcript. In this way, data was organized into abstract information. Efforts were made to use the actual language of the participant (Creswell and Creswell, 2018), so as to increase authenticity.

At this stage, themes were connected from material available in the text, rather than analyzing through a theoretical lens. Verbatim extracts from the transcript and a summary of the key themes was presented. In this way, while recognising analysis is unavoidably an interpretative process, transparency is attempted by making explicit to the reader the levels of interpretation, and by offering a summary of the resultant narrative, before a theoretical viewpoint is superimposed.

Smith, Jarman and Osborn (1999) suggest attending to one transcript at a time, finding emerging themes, drawing connections between them then grouping these coherently into themes and sub-themes. These steps were done for each transcript before moving on to the next so as to follow an idiographic approach, eventually building to a more general categorisation. When this was done for the six interviews, a list of themes for the group was drawn, themes were clustered and a master table of themes was generated for the six participants by cross-referencing for similarities and differences.

This process follows Creswell and Creswell's (2018) guide of moving from inductive analysis in order to establish a set of themes, to deductive analysis, where the researcher looks back on the data from the themes to determine if the themes are supported by the evidence presented, or if more information is required.

Ethical Considerations

Ethical guidelines of the British Psychological Society, UK Council for Psychotherapy, Metanoia Institute and Middlesex University, were followed. Furthermore, due to the nature of the study, further ethical considerations regarding sexual addiction were adopted, based on practices in the therapeutic setting (discussed below).

Ponterotto (2005) asserts that the lived experience and values of the researcher cannot be removed from the research process, particularly as the constructivist position requires "immersion" in the data. Therefore a self-reflective journal was maintained from the initial planning stages of the study until completion, in order to document experiences and thoughts throughout the research process. This process was carried out with the aim that assumptions and biases would emerge and become clearer (Morrow, 2005). This might be particularly relevant to working with sexuality and sexual addiction, as therapists (and possibly researchers), are more prone to "blind-spots" (Target, 2007, and Griffin-Shelley, 2009).

Potential participants, via Sex Addicts Anonymous (outlined below), were presented with information regarding the study, the aim, overall research question, what the study involves, and the purpose of the study. This was done to ensure that all participants could give informed consent (BPS, 2014). According to Yardley's (2000) criteria, this addresses the power imbalance between researcher and participant, and shows sensitivity to context. This document also explained that participation in the research would be anonymous: no information that could be used to identify a participant would be presented in the results. Participants were also informed that they had a right to withdraw from the study prior to publication of the results.

Since keeping the self-reflective journal and on discussing the project with peers, I realised I was reluctant to work with people who had committed sexual offences, and I initially considered setting this as an exclusion criterion, reasoning that it would simplify matters on confidentiality. The reluctance to interview people who committed sexual offences may have been a shaming reaction on my part, which is common when working with sexual addiction (Carnes, 2001). Furthermore, Delmonico and Griffin (2002) note that some sexual addicts may commit sexual offences, hence excluding people who have committed such offences could dilute the pool of possible participants.

In order to include such participants but not breach ethical guidelines regarding confidentiality and harm to others, the BPS Code of Human Research Ethics (2014) were consulted. Based on guidelines stipulated in this code, it was decided that the information sheet would explain that

confidentiality would be breached in the circumstance that the participant admitted to committing a sexual offence. Potential participants knew of this condition on first receiving information about the study. Furthermore, during the initial contact with the participants, and again at the start of each interview, this was highlighted verbally.

As discussed in the "Participants" section above, participants had to be attending SAA meetings at the time of the interview. This criterion was set based on the assumption that participants would have previously processed difficult material, and would be less likely to become distraught by it during the interview. Furthermore, should difficult material arise, they would already have a support network in place.

Participants were also invited to share any concerns about the interview or research in general, at any stage during the research (including after the interview had taken place). Debriefing also took place via email, where I re-iterated the above to the participants and asked about how they felt by participating in the interview. It should be noted that none of the participants informed me that they had any concerns.

Validity and Trustworthiness

Traditionally, standards for assessing the quality of qualitative research borrowed concepts from quantitative methodologies, however the growth in qualitative research has led to a number of discussions and guidelines regarding validity and trustworthiness (Smith, 2009). As well as the measures taken below, I have referred to Tracey (2010) and Creswell and Creswell (2018) as check-lists for qualitative research (see Appendix 5 and 6).

IPA requires that the researcher works with what emerges throughout analysis. Therefore assessing validity has to be flexible, in order to allow for this idiosyncratic process (Smith, Flowers and Larkin, 2009). Assessing the quality of qualitative work varies according to the project, however there are general guidelines that should be followed (Ballinger, 2006).

Transparency is important in establishing trustworthiness, and this can be achieved in different ways (Yardley, 2000). Firstly, the researcher's view on ontology and epistemology should be made explicit from the outset of the project (Ponterotto, 2005), and has been outlined above. I have made explicit my position as a researcher, and included a section on reflexivity, where I discuss factors that may have impacted how I analysed the data (Tracey, 2010). The researcher has to account for how data is accessed. An audit trail (Smith et al 2009) was also carried out, whereby the entire research process was tracked and documented. There is evidence of how the

research was carried out at each stage, and regular feedback with my supervisor also ensured accountability.

Furthermore, “trustworthiness” was ensured through thick description (Morrow, 2005). Thick descriptions give a detailed account of the participant’s experience and context in which the experiences occurred, therefore this has to be reflected in the interview schedule. Enough detail about the participant’s context should be given, so that readers can formulate their own conclusion about the study (Tracey, 2010). Appendix 7 and 8 are the list of key words and the subsequent table of the emergent themes for Adam (Participant 1), included in order to ensure transparency.

Trustworthiness also has to be a part of the participant-researcher relationship (Bond, 2004), as it builds a rapport and facilitates the participant’s ability to talk about their experience. Care will also be taken not to cause the participant avoidable distress during the research process (Bond, 2004). This is a salient point for researching sexual addiction, as participants may bring up traumatic events/attachments (Griffin-Shelley, 2009), and care was taken so as to alleviate any distress caused in this case. This was done by reiterating before the interview that the interview could be stopped at any point, or questions could be skipped if participants didn’t feel comfortable, and maintaining an empathic and respectful stance throughout

The credibility of the project also depends on researcher reflexivity (Morrow, 2005), which requires being aware of what is influencing internal and external responses, as well as of the researcher-participant relationship (Etherington, 2004). Sartre (1943) suggested that only through knowledge (of the self) and understanding can connection with an Other be realised. I believe that this is essential to the research process, and that a reflexive stance from the researcher is crucial. Researcher subjectivity is considered to be a “contaminant” in quantitative approaches (Ponterotto, 2005), however, reflexivity allows the researcher to open “a space between subjectivity and objectivity where the distinction between content and process becomes blurred” (Etherington, 2004, p.47). A journal was kept throughout the research process from the initial planning phases. Thoughts and reflections on the research content, as well as personal reflections were recorded in the journal.

Researcher subjectivity is necessary and Yardley (2000) suggests the researcher has an understanding of pre-existing theory and research regarding the topic, as this will allow for an in-depth analysis of the results. A literature review of current research and clinical data on sexual addiction was carried out prior to the interviews.

Sensitivity to context is another of Yardley's (2000) criteria for assessing quality of qualitative research. It involves learning about the participant's socio-cultural context and taking it into consideration when interpreting results, together with existing literature and theory. This criterion was demonstrated through the reference and use of theory discussed throughout the research. I also endeavoured to meet this criterion by asking about the participant's context, reporting it, and inquiring as to how this might have impacted the interview process. Attention was paid to possible power issues between myself and participants, even from the pre-recruitment stage, for example by not excluding people who may have committed sexual offences. I have also aimed to demonstrate sensitivity by conducting and describing an in-depth analysis, and made use of verbatim extracts to support my arguments.

Commitment and rigour (Yardley, 2000) involves in-depth engagement with the material, and ongoing developing competence in the method used. I attempted to demonstrate this through attentiveness to participants during the interviews and attentiveness to analysis. I have carried out previous research studies using IPA, and had an on-going commitment to furthering my skills in this approach by reading a number of published studies that used this approach. This was not limited to those in the field of sexuality. Rigour refers to depth and breadth of analysis, which can only be achieved through thorough data collection. According to Tracey (2010), rigorous researchers must ask, how much data is enough? This leads to decisions about how many interviews to carry out. Tracey (2010) suggests that with rich line-by-line analyses, few data sets are required.

Conclusion

This chapter provided a theoretical and methodological account of the research process, focusing on philosophical principles, as well as research methods and ethical considerations and measures taken throughout the study. IPA was chosen based on its utility in answering the research question, "What is the experience of sex addiction? How do men who identify as sex addicts make sense of their identity? The addiction? Their relationships? The study aims to explore the phenomenology of sex addiction, and what it means to identify as a sex addict, and how this impacts relationships.

Chapter Four: Reflexivity

Introduction

The practice of reflexivity is regarded as an important ethical measure, particularly in qualitative studies (Lazard and McAvoy, 2017). In this chapter I aim to outline how it affected my research, and became not just an exercise in good (ethical) practice, but a medium through to which to deepen my theoretical and clinical knowledge, and also as a form of self-care.

This chapter was initially based on my experience of carrying out the research, from the initial proposal stages to writing up the analysis. During this time I married my partner and had a son, and got divorced shortly after my son turned one. The physical and emotional changes that took place in my personal life had a deep impact on how I carried out the research, and I will discuss this further, below.

My work is based on the values of Counselling Psychology, which aims to integrate theory, research and practice into a coherent whole (Giovazolias, 2005). Similarly, in this chapter I aim to integrate the roles of researcher and therapist. Adams (2014, p.63), states,

> "Therapists find symbolization … through the development of a vocabulary and a structured narrative, to give meaning."

The same can be said for researchers. I refer to literature below that pertains to therapists, however, I believe that the same holds for researchers, whilst acknowledging that there are differences in the nature of the work. This is perhaps even more pertinent in areas to do with sexuality. As Watson and Vidal (2011, p.27) argue:

> "Morality cannot be separated from sex, we have felt it necessary to examine our own beliefs towards prostitution and examine how they influence our practice".

Therefore it was crucial for me to analyse my own feelings regarding the research, from its inception.

Sexual Other, Sexualised Object

At the time of proposing my research question, I was a third year doctoral student. I was a qualified sex therapist and I had carried out research in areas pertaining to sexuality, however not in sexual addiction. I shall discuss how, as a researcher in sex addiction, I became a sexualized object, not only to some of the participants, but also to peers. This process, I believe also repeats itself as a

therapist working in sex addiction, where the therapist is first an object before becoming an "Other" with whom the client can relate and see as an individual with needs (Fuchs, 2013).

When first presenting my research proposal to peers, it was met with some doubt, concern, and even ridicule. I was advised to dress conservatively, I was asked how my partner felt about my researching the topic. One student also told me that it was voyeuristic. I felt that the underlying message was that perhaps I was a "voyeur", and hence, deviant. This feeling re-emerged when another student who was ahead of me by some years in the programme and whom I was collaborating with on another research project asked "Does that mean you're a sex addict?"

These reactions, whilst commonly reported by sex researchers and therapists (Hammond & Kingston, 2014; Vidal & Watson, 2011), planted seeds of shame and doubt in my project. I felt that my professional and personal integrity were being questioned. It made me curious about the experience of disclosure for sex addicts. Where they ridiculed, ignored, or shamed into silence? Could the fear of such reactions prevent them from seeking help? Considering sex addiction from a relational perspective, with history of humiliation-based attachments, could such ridicule further aggravate the addict's shame, perpetuating the dependence on sex to alleviate such feelings?

Furthermore, researching porn could sometimes be seen as legitimizing its use (Voss, 2012). As a woman, it is assumed that I am betraying feminist anti-porn rhetoric, which posits that porn is degrading to women. Firstly because of the acts involved in porn, which may show women as less powerful than men, and that women are responding to male desire, not initiating themselves, and it is also criticized by feminists for unrealistic depictions of women's bodies, perpetuating an impossible ideal of what women should look like (Webber and Sullivan, 2018). However, not all porn is necessarily demeaning to women (Klein, 2016). I had to question my stance on porn when carrying out this research, and also as I thought of how I would move forward in terms of my therapeutic practice. I believe that some porn is demeaning, especially that which is non-consensual. However, I also view porn as a product of human sexuality and fantasy – it has elements of power, desire, connection, pleasure, pain, fear and beauty. Porn use can be problematic if it takes over aspects of a person's life, and if it is used as a "rule book" for sex, rather than seen as a work of fiction.

> "To say that porn demeans women is to deny some women's passion, lust and desire"
>
> (Klein, 2016, p.66).

This attitude gives power to men and perpetuates relational asymmetry, rather than mutuality, which is what I would work towards in therapy.

On another level, I was also different (and "deviant") as a bi-racial immigrant in the UK. I realized race may have also impacted the nature of the research, and that perhaps the participants would have answered differently if they had been interviewed by a British white male, and similarly, a British white male researcher might have responded differently to them than I did. After the interview, Brian called me "exotic", a term I associate with stripping "exotic dancing". Other researchers also report being likened with prostitutes (Kingston and Hammond, 2014). Race is an inherently social and political issue (Lago, 2006), but with that one word, it also became fraught with sexual connotations. As outlined above, sex researchers are often perceived by their participants as sexually available (Voss, 2012), and this may have been more so in my case as a bi-racial woman.

> "The black female embodied the notion of uncontrolled sexuality".
>
> (Hammonds, 1999 p 95)

"Uncontrolled sexuality" is precisely what I wanted to research in men. Was I attempting to redirect a power dynamic? Or was I denying the notion of uncontrollable female sexuality by focusing on males? I experienced the word "exotic" as deeply shaming and chose to ignore that it happened. Defensively, I rationalized that my choice was right given that it was a research setting, and the purpose was more to record and observe rather than process relationally. I now feel I missed an opportunity to be curious about his experience. I could have asked how it feels for the participant, and I might have shared my reaction. From a therapeutic perspective, this would have been a chance for the participant to express sexual interest and it not be denigrated, or intimidating, as well as allowing him to see how it is received by the Other. This was beyond the original scope of the research question, however it would have enriched the research if I were able to ask about how the participant experiences being in an interview with someone he perceives as "exotic" and meaning he attributes to his reaction. Reflecting on this incident was a valuable learning experience on how my shame can be paralyzing at times, to the detriment of the work.

Shame stands in the way of creativity

As therapists, we should ask ourselves, what attracts us to our client group? Was I attempting to circumvent my own conflicts in order to convince myself that I was more "integrated" than the participants (Adams, 2008)? Was I, as had been suggested, a "voyeur"? In order to carry out the

research ethically, I had to answer these questions for myself, otherwise I would be at risk of misrepresenting the participants. However as professionals we are not above avoiding difficult material in order to maintain a more comfortable view of ourselves (Adams, 2008). My husband was not a sex addict, but often told me that he found monogamy “unnatural”, and the threat of infidelity was predominant in our marriage. Perhaps I wanted to understand men who cheat on their wives, but there was the risk that I might interpret the results from the lens of the hurt party.

Shortly after I started the analysis, I became pregnant with my son and decided to take time off from research. This made practical sense, and also presented a good way for me to “excuse” myself for not engaging with the research and not acknowledge that it was emotionally difficult. At the time I did not link my reluctance to engage with the research (with its themes of infidelity), with the dynamics in my marriage. It was much later that I would admit that I disengaged from the research in order to protect myself emotionally. However, as time passed, I found myself in a double bind. I felt more ashamed of the research. Ashamed that I had started a project on sexual addiction, with all its implications, ashamed of my marriage disintegrating, and ashamed that at the same time I was unable to complete the project.

> “Those whose work explores issues surrounding sex and sexuality [face] being viewed as an illegitimate, thrilling or taboo topic, as a joke, or as an unworthy study, all of which result in loss of professional status, present barriers to career progression and leave researchers open to inappropriate remarks, personal abuse, and being regarded as not very bright and sexually available”.
>
> (Hammond and Kingston, 2014, p. 332)

The loss of professional status was further impounded by maternity leave, as I was no longer actively engaged in therapeutic work. The role of new mother, at home with a baby meant that I was no longer an active member of a professional community.

The therapist’s (and researcher’s) shame is a sign that something needs to be uncovered. It impedes creativity in the process. The material was heavy with both the participants’ shame and mine, on many levels. Shame to do with sex, shame to do with addiction, shame because of failed relationships. During the initial stages and data collecting phase, shame made me sometimes lose confidence in my ability as a researcher, and as my marriage deteriorated, I lost all faith that I would be able to complete. I felt overwhelmed by the task ahead and by shame.

Adams et al. (2015, p.40) describe it as

> "By telling stories – often vulnerable stories – about aspects of our identities and experiences, autoethnographers purposefully open themselves up to criticism about how we've lived… Autoethnographers make these choices … to all attention to the vulnerabilities, questions, injustices, silencing and shame that others might endure"

Adams (2014) warns that shame in fact can drive us underground. In particular, I struggled with the image of facing colleagues and lecturers at Metanoia and stating that I was divorced – feeling that this admission would make me lose more credibility. Therapy is based on relationship-building, therefore how can I be a therapist if I allowed the most important relationship to disintegrate? This erroneous thinking could be the result of my background – divorce was only made legal in Malta in 2011, and it is considered to be a personal failure. For a therapist to go through a divorce in Malta, there would be personal and professional implications. A therapist and researcher also needs to be objective, which I might not have been able to if I was consumed by my own sadness. One possibility was to complete without disclosing my experience, however this would have gone against my values as a researcher and a clinician of authenticity, and there would have been a greater risk of projecting my material onto the participants' (Yalom, 1980 and Adams, 2014). I was therefore, stuck.

Physician Heal Thyself

For quite some time I disengaged from the research, and would briefly read the transcripts when I felt ready to face it. In the mean time I started the legal process of divorce, went back to work earlier than expected, and moved into a new home. I eventually contacted the Head of Programme after she had tried to establish contact with me, and admitted that I was struggling, and what my reasons were. We agreed on a timeline for completion, and she encouraged me to reach out.

The act of speaking to the Head of Programme was therapeutic and mobilized me to speak to others, as well as read literature on the experience of the therapist during a time of stress. I spoke to my clinical supervisor about the project, and she shared that she too was going through a divorce and that as therapists, we are perhaps more attuned to pain in others, and drawn to it. Her stance on my divorce was more empathic than mine, and this gave me more motivation to face my shame and start moving forward.

Slattery and Park (2007) discuss Slattery's experience when her daughter was hospitalized after being suicidal. Themes of shame, self-blame and disbelief intertwine, "I'm a therapist, I shouldn't

have let this happen". Other therapists also report similar experiences when going through their own trauma. However, with the right support, these experiences can be formative and crucial to our development as therapists. For example, Slattery was able to draw on her experience as a client in family therapy to appreciate that sometimes as therapists we see clients over-reacting to seemingly trivial matters, but for the client they may be laden with meaning. It also gave her a deeper sense of empathy towards clients.

Murray (2017) discusses her experience of being a therapist working with men who have problems with online porn, whilst her husband had the same issue. She notes the risk in identifying with her client's partners, of falling on anti-porn rhetoric, and of being her clients' "moral compass". For me, this would mean taking a punitive stance and condemning the participants' use of porn as well as their actions in their marriage. To avoid this, Murray asked herself repeatedly how she felt with the clients, what her role was with them, and being curious about the intensity of her experience when with clients. In particular, I found it informative to use the intensity of my reaction to reading the transcripts. This provided the impetus to start thinking from a relational aspect, and what the clinical implications might be (as I shall explain further below).

Prior to starting this programme, I held the "Infallibility Fallacy", the belief that therapists did not have personal problems. To end the programme with the demise of my marriage was to say I am not a worthy therapist. This was echoed by my husband repeatedly asking me "How can you be a therapist?" Basescu (2009) reflects on how the therapist's divorce shatters the image of the idealized therapist. If processed, this can be a reparative experience for the client. However, in order to do so, the therapist must be able to process it with themselves first, and then with the client. Similarly, I saw that I must first process it, and then process the transcripts.

Basescu (2009) argues that dissociative defense could be useful or pathological. To some degree temporarily dissociating from the research was useful because it would have been painful to read the transcripts. Furthermore, I wouldn't have been able to do the work justice, I'd have interpreted it through the lens of a hurt partner, and would have likely fallen into a punitive, shaming stance. There was also the risk of being "seduced" by the participants' narratives, and shifting the blame on a pathology – which is what the participants did when they spoke about their behaviour as "it", speaking about the addiction as something outside of them. Through my previous therapy, I know that I tend to rely on the Medical Model to conceptualise pathology, and I know I justified my husband's behaviour in terms of his childhood history. I therefore had to learn to walk a fine line between not being blaming, and not being seduced, and staying with the experience of the participant.

As therapists, we are not immune to trauma, or to divorce. As my supervisor shared, we perhaps are more susceptible to being drawn towards people with pain. Southern (2007, p.287) suggests that unless therapists are able to "maintain a balance of vulnerability and confidence" , we are at risk of contact trauma, depression and burn-out as well as distortion of clients' material. Adams (2014) highlights the importance of acknowledging the therapist's unresolved issues and how these manifest in the dyad. Through accepting our vulnerability and being authentic, we are able to connect with or clients and participants, and the material. As I started to empathise more with my vulnerabilities, I was able to connect more with the participants and think about their experience.

Becoming a mother is in itself a challenge to a woman's boundaries, (Waldman, 2003). Taking maternity leave gave me distance from the material which allowed me to reflect on it (Hammond and Kingston, 2014). When I resumed the research, on a practical level, I had to manage time boundaries between being a single parent, working, and engaging with the research. However, Walden (2003) argues that expanding boundaries also happens at an intuitive level, the therapist develops a more acute attunement to visceral needs. I believe that as I started to manage my multiple identities, I was also becoming more able to understand the material from an affective perspective.

Beyond Transference: Therapeutic Thinking

Adams (2014) calls on therapists to be attuned to the transference/countertransference dynamics. This prerequisites self-awareness, and then the confidence to process the dynamics that occur with the client. To do this, there has to be a good rapport. From a research perspective, my research was structured in such a way that a strong rapport could not have been built given the short time frame. However, I could build a better rapport with the narratives, by processing any negative feelings towards the participants as they arose when engaging with the research.

> "It is through the resolution of the transference/countertransference struggle that our patients reframe their view of the world and themselves".
>
> (Adams, 2009, p.x).

Feelings about clients can suggest something of their intrapsychic and interpersonal experience (Southern, 2007). I believe the same is true with researchers and participants. There were several instances during the interviews and again on reading the transcripts when I found myself feeling annoyed with the participants. This happened with different participants, at different times,

particularly when I felt I had been lied to, or they had lied to a loved one, or when they showed a lack of empathy towards someone, or when they spoke with a sense of entitlement. My initial reaction was to deny what was happening, however, the fact that this dislike occurred frequently and intensely was a trigger to reflect on what was eliciting such a response from me. It led me to start thinking about the participants' character types. Therapists often report clients with narcissistic traits as being unlikeable (Smith Benjamin, 1998). As I read more about this transference reaction, I was able to conceptualise certain patterns in the texts as indicative of narcissistic traits. This in turn, had an impact on me as a researcher and a therapist. I understand narcissistic traits as a result of and a compensation for repeated, narcissistic injuries (Johnson, 1994), and I therefore became more curious about this history of my participants (and other sex addicts), in particular about relational trauma. This clinical curiosity became more of a therapeutic care.

Another "counter-transference reaction" that is of note is the particular way I was dressing for the interviews. Although the interviews were carried out with some weeks apart, I realized that I was always wearing the same dress – a large, grey dress which I don't like and felt "unattractive" in. I noticed I didn't shower the morning of the interview with the fourth participant. Retrospectively, I was curious about what sort of response the participants were eliciting from me. Was I trying to counter being objectified? Was I trying to create boundaries? According to Johnson (1994), this is often a reaction to people with narcissistic traits. Although I wasn't aware of it at the time, I could have also been impacted by what colleagues told me a year earlier – to dress conservatively. This highlighted to what extent the research had an unconscious and visceral impact on me.

Parallel processes

My process of self-empathy and then reflecting on my feelings towards the participants, led to reflecting on parallel processes between myself and the participants.

Hammond and Kingston (2014) report that their research in sexuality was not taken seriously, they were undermined as professionals, and they were stigmatized and had to manage whom they told what about their research. They reported that the association to the topic overshadows other aspects of their identity. Similarly sex addicts have to manage whom they tell about addiction, and reported the experience of it taking over other aspects of their identity.

Facing shame was also a parallel process, necessary to moving forward. Divorce is a process of mourning and shame, and also individuation and integration, it involves a loss of control,

humiliation, inadequacy and existential loneliness, much like therapy. (Basescu, 2009). For me it started when I spoke to the Head of Programme, I was able to start addressing my personal difficulties, this in turn helped me seek literature on therapist's trauma, specifically divorce. Reading that other therapists got divorced and described it as traumatic had a mobilizing effect. My shame was not as paralyzing as it had previously been, and I was better able to empathise with myself and recognize my strengths. I was raising a happy child in a loving environment, and I was a good-enough therapist, and so perhaps I could also be a good-enough researcher. This gave me more confidence to re-immerse myself in the material. Previously I had found reading the transcripts painful, a double-layer of reminding me of some of the dynamics in my marriage, and feeling that I wasn't good enough to analyse the material without my personal getting in the way. Similarly, by reaching out to others for support, the participants were able to start facing their shame.

To some degree, there may have been a parallel process of relational trauma. The role of relational trauma is yet to be fully understood in sexual addiction, and this may be an area of future research. As discussed above, divorce can also be considered a form of relational trauma (Basescu, 2009). Van der Merwe and Hunt (2019) carried out a study on vicarious trauma in 102 researchers who conducted fieldwork in the field of trauma. The majority of researchers showed symptoms of vicarious trauma. Care of the researcher should therefore be considered as an ethical requirement when researching sensitive material.

In order to stay with the phenomena as experienced by the participants, I followed the IPA practice of idiographic analysis of a series of cases, with each transcript analysed independently and in its entirety before cross-case analyses were conducted. This ensured that the phenomenological content as expressed in participants' own words was coded before any interpretation was undertaken.

Furthermore, during the analysis and write-up, I frequently reflected on what affective response I was having to the material, if I was able to concentrate, or if I was losing interest or finding it challenging. This was a gauge to understand if my own material was being elicited. At points when I noticed these changes, I would discuss this with my therapist.

Conclusion

Knowledge is context-specific and affected by the researcher's biography (Hammond and Kingston, 2014). I have argued that there were several nuances particular to this research that would have had an impact on the knowledge generated from the study. The process of reflexivity,

allows for the reader to make their own assumptions about the research, but also enrichened the research. This could only come about by asking myself difficult questions, such as when I was uncomfortable or distressed, and what the real reasons were when I didn't want to engage with the material.

By going through this process I have more empathy for the participants, their partners, and a deeper understanding of how therapists might get caught in enactments with them. The interview and post-analysis, not just in terms of transcript, but also vis-à-vis how I felt, gave a lot of information on potential dynamics that could arise in a therapeutic context.

I started with the intention to outline how reflexivity impacted my research, but the practice became more looking at how I was impacted on the research, and how that influenced my analysis. My experience as a researcher became part of the research process itself. Acknowledging and reflecting on similarities with my experiences in my marriage, and on parallel processes occurring at an affect level, deepened my understanding on the experience of sexual addiction, people in relationships with sex addicts and for their therapists.

Chapter Five: Findings

Introduction

This chapter considers the findings of the research in relation to the main research aims and questions. It gives a comprehensive description of the phenomenological experiences of the participants.

Theme Codes were chosen that most closely reflected the content of data as it was presented to me by the research respondents. The master themes are illustrated with verbatim extracts from the interviews. The themes are presented in such a way as to provide a logical narrative of the findings rather than the order being indicative of their importance. The themes are interdependent and not mutually exclusive. My intention in this chapter is to provide insight into the participants' experiences and share my reflexive interpretation of how they appeared to make sense of their experiences of sex addiction. A selection of relevant extracts that illustrate each theme are given. Further analysis and deeper interpretative work on the findings are in the discussion chapter, where I draw links with current literature and clinical practice. The presentation of the master themes and their sub-themes forms the basis of the rest of this chapter.

Participants' Background Information

At the time of the interview, Adam is a 75 year old white male, born to two European refugees. He reports that his addiction started when he was a teenager, he would masturbate daily but initially not "compulsively". At 19 he started visiting brothels. He has been married twice, both marriages ended after his wives found out he was frequenting brothels. He has 3 children, a daughter from his first marriage with whom he has no contact, and an adult son and daughter from his second marriage. Apart from viewing porn online his behaviours included visiting massage parlours, watching porn during sex and paying for sex. In his sixties he had Eye Movement Desensitization and Reprocessing (EMDR) and then joined the SAA. He has had two relationships since then but was single at the time of the interview and reports that he still masturbates but does not use porn.

Brian is a married father of 3, in his mid-forties. He was the fifth of six children, and said that there is a history of sexual deviance from the mother's side of his family. His brother is also a porn addict, and his uncle and cousin both were incarcerated for sexual abuse of a minor. During his early twenties Brian became a missionary. His addiction started by masturbating to images in magazines, but it was reportedly under control when he was a missionary (due to unavailability

and lack of privacy). He started watching porn online years later when he was completing his second masters. This eventually increased and he had to get a separate internet account, and it was creating conflict with his wife. He had an affair whilst living abroad for a few months, and his wife found out about it some months after it had ended. This prompted them to attend couple's therapy however he then decided to attend individual therapy as he was still watching porn daily, sometimes at work, and was consequently falling behind on work. His therapist then recommended SAA and Brian experienced this as a form of rejection. At the time of the interview he hadn't used porn for seven months.

Colin is a divorced 34 year old white British male, who reports that he started watching porn when he was 18, away from home at University and he didn't have much of a social network. This gradually increased, and he started watching porn every chance he could, and looking for opportunities to watch it. He got married after two years of being with his partner, whom he describes as a co-dependent, and with whom he would watch porn. At the peak of the addiction, he would start as soon as he woke up in the morning, and was masturbating six times a day, spending hours doing it, and "forgetting to eat". He eventually started "watching" his female students whilst giving lectures and touch himself. He also started looking at male students to see if they had erections. He started watching live shows on the internet, and going to strip clubs. He joined SAA when he was trying to reconcile with his wife but this didn't work out so he stopped attending meetings and went back after eight months, when he suspected he might be HIV positive. He also started therapy and went to a psychiatrist who prescribed anti-depressants and at the time of the interview had not used porn for eight months.

David is 69 year old, married, Jewish man. He reported that he always had "addicted" behaviour, however he said that this was initially to do with sports when he was younger. He started buying porn magazines when he was a teenager, however he said that his sex addiction started at age 45. He started buying magazines more frequently, and bought videos. He then started watching videos online. At age 60, he was on holiday in Bangkok and had paid sex with a prostitute in a brothel. On returning home he kept frequenting brothels until he was found out by his wife six years later. He did a 12 Step programme in America, and attended local SAA meetings when he returned. He has not watched porn or been to brothels in 2 years.

Eli is 48 years old and a divorced father of 3. His wife left him after their 20 year old son discovered photos of a woman he was having an affair with, (who was the same age as him). Eli started masturbating at a "young age", and was buying porn magazines when he was a teenager. As an adult he travelled often for work and would watch porn in hotels, and he once got fired from his

job when he handed in a hotel bill which included 17 hours of porn. Eventually his addiction developed online to live chat rooms, and he also frequented massage parlours. He was demoted from another job when a client filed a sexual harassment complaint against him. He was spending substantial amounts of money on his addiction, and eventually started SAA sessions and individual therapy, which he later stopped claiming it was an expense. At the time of the interview, he hadn't been frequenting strip clubs or using porn for six months, and he wasn't in a relationship. Eli was the only participant for whom financial issues were a concern, and the primary motivation for controlling the addiction. At the suggestion of his ex-wife, he started anti-depressants.

Frank is a 47 year old divorced British white male, the youngest of four children, which is significant to his narrative, as he was "unplanned" and born 8 years after his older brother, and his older sisters were 11 and 12 years older. His mother suffered from depression, and he felt he was left to look after her. He started looking at pornographic magazines when he was 7. Throughout his life, wanting to appear confident was a predominant theme, he became more successful and confident at work, however use of porn and his sexual behaviour were becoming out of control. He was watching porn DVDs in his car when he was waiting for clients, and slept with clients a few times. He was eventually fired for this reason, and he was out of work for a few months. He decided to attend CBT group therapy for depression and took anti-depressants and porn use almost stopped completely, and he found another job. Eventually Frank started seeing a woman whom he later married. During this time he still watched porn but it was under control. Frank's behaviour increased again after his wife had a miscarriage. During this time he started going out and getting drunk, and avoided going home. He also started having sex with women he met in bars. After his wife left him, he started frequenting strip clubs and massage parlours. He sought help again after he had an accidental overdose on coke. He attended individual therapy, and a specialist residential programme. After that programme, he attended SAA meetings for six years, and hasn't been to strip clubs or massage parlours or used porn in four years.

The Master Themes

Themes were interpreted through a careful analysis of the interview data that resulted in the identification of four overarching master themes, and respective sub-themes, represented in TABLE 1 below:

Master Theme	**Sub-Theme**
Experience of Self	Aloneness
	Self-Perception
	Double Bind
	Sense of Entitlement
Relational Dynamics	Dynamics of Family of Origin
	Messages about relationships and sex during childhood
	Romantic Relationships
	Sex vs Intimacy
The Sex Addict and the Addiction	Perception of the Addict and Addiction
	Powerlessness
	Rationalization and Deception
	The Purpose of Addiction
	The Nature of Addiction
Process of Recovery	Turning Point
	Benefits of the Group Setting
	Personal Therapy
	Sobriety and Change

Table 1: Table of Themes and Sub-Themes

Experience of Self

This section is titled “Experience of Self” to show that the participants are not just giving descriptions, but have reflected and made sense of experiences and relationships that were formative and have shaped their identity and way of being in the world. Participants made sense of these experiences and relationships and interpreted them to mean something about who they are. It appears that different experiences brought them to similar ways of seeing themselves.

This theme was divided into Aloneness, Self-Perception, Double Bind and Sense of Entitlement. The sub-themes spread across their lifespan, with the majority of experiences described being from childhood. The sub-themes are linked because underlying each is a negative affective state. Furthermore, they are each pivotal in how the participants make sense of their identity.

Aloneness

I chose the term “Aloneness” to refer to a state of being, not just of being alone, but because of an underlying affective state of sadness that was common to all participants. Participants described experiences of feeling alone, or isolated throughout their lives, and suggested that this state was not (only) due to circumstance, but because of who they were, and their way of being.

All participants (except Eli) shared the experience of not having had many relationships, however, they also all report other times in their lives in different contexts, where they felt isolated and alone. Interestingly, these experiences were not always directly related to sex or sex addiction. Furthermore, they all reported feeling isolated prior to having a problem with sex addiction, typically reporting that they felt this way from childhood.

Adam saw everyone as the “enemy”. For Adam, the state of aloneness was a constant in his life.

> “The whole world is against you, nobody really likes you and they are probably right”. As a child, he felt that his cat was his only friend, and later as a young adult, “I would go to parties and I would be so shy I would go and sit on the toilet in order to avoid any sort, people looking at me, not being any good at things, and not really knowing anybody. It is a really desolate existence.”

Despite coming from a large family, and being part of a large religious community, Brian felt very much alone, precisely because of these two factors. Being one of many children meant that his parents were not very involved.

> “You know how some people have that sort of relationship, where if something goes wrong, they’ve got a good family behind them? I never felt that, it was always felt very much alone. Our family was the religious community, and that was too big and too anonymous”.

He also adds that apart from this, he was very shy and never really had friends he could talk to. Whilst Brian had a large family, Colin was an only child, yet still they shared the experience of aloneness. Colin commented that he was lonely as a child, had no siblings and wasn’t close to friends, and had “no one to share stuff with”.

> “I was very awkward and shy at school. I was super tall, and a ginger, so that didn't help. So yeah, it was quite lonely. … I didn't have that many friends to begin with, I was quite insular ... I always felt like I didn’t really belong anywhere. I think being an only child does that… I always had the sense of being out of place”.

When he had a group of friends, he was “on the fringe”, and lost touch when he went to university. He also discussed the isolation as a result of the addiction saying that because of it he “hadn’t kept up with friends in years, hadn’t maintained a relationship with family”.

Similarly, David also felt that the addiction isolated him

> “My life had become more unmanageable because of the symptoms of it was that I was becoming more isolated, emotionally”.

David also said that he felt alone as a teenager, particularly as he “didn’t have a fantastic adolescence when it came to sex”. Although he does not say this explicitly, there is a sense of “aloneness” within his marriage. David and his wife did not talk about important things, for example, he was not aware that his youngest daughter was diagnosed with depression and being seen at the local CMHT.

The sense of “aloneness” was also relevant in Eli’s narrative. Eli felt a lack of acceptance from significant people in his life. “Probably I’ve been aware of how missing it was, right from the start, because of my dad”, and also from his children “feeling that I’ve disappointed my children, my parents. I’ve set myself up to be around people I will never please”. His children and wife abandoned him when they found out about his affair, and cut off contact. He also feels he was also cast out by his own mother. He expected her to be more understanding, since he describes her as also being a sex addict. He expressed disappointment and sadness that she saw him as a failure because of it.

When Eli's mother became ill with cancer, his ex-wife (a doctor) called him to ask about her, and during the conversation suggested to Eli that he starts taking antidepressants to help treat the sex addiction. Eli said that she called because she and his mother were close, which could imply that he didn't think she called to see how he was doing. He does not comment on her suggestion of antidepressants, and he does not say if it could have been a display of care and support from his ex-wife. This interaction may suggest that Eli missed a moment of connection, which could have helped counter being alone, particularly as he felt abandoned by his ex-wife when she found out about the addiction.

For Frank, feeling alone was an important part of his narrative.

> "I remember my sisters telling me things were better before I came along. I was the youngest, the unplanned child, the one who created problems at home. I always had that role, and I was always very aware of it".

He also reported feeling alone after his addiction had become more pervasive. Of his wife, he said "She couldn't be with me anymore", and about his sister:

> "I had stopped speaking to my sister, and she was the one person who was showing me any form of care or concern. So I was pretty much alone".

For Frank, aloneness left him with a feeling of anger towards those who had abandoned him.

Loneliness is a prominent subtheme, as it was prevalent from childhood for all the participants, and some of the participants reported that it contributed towards their sex addiction, as sexual behaviour became an antidote for it. In turn, it was then further perpetuated by the addiction. It overarches with other subthemes discussed below, as it manifests in different experiences such as a lack of intimacy in sex, lack of emotional intimacy within relationships, and feeling abandoned and alone when others found out about the addiction.

Self-Perception

Interestingly, all the participants described themselves in relation to others, their ability or style of relating to others, or within their role as husband, son or father. Significantly, all the participants saw themselves in an overall negative light. A few of the participants were able to identify things they were good at (such as their job), but they do not seem to incorporate this as an integral part of their identity.

The participants' self-perception appears to have been negative prior to the sex addiction. They all believed that the two were related, however, they do not make explicit that they believe their negative self-perception led to sex addiction. Rather, most of the participants focus on how their interest in sex (prior to developing sex addiction), was central to shaping their self-perception.

As a child, Adam saw himself as a "ferocious little fellow" and very insecure, which suggests that his acting-out behaviour as a child may have been an attempt to hide vulnerability. As an adult, he felt sorry for himself and expected to be rejected by others. This became a self-fulfilling prophecy through his behaviour. He retrospectively recognized how he was in relationships and realised that his behaviour led to him being alone. "Being loved by a sex addict wouldn't have been very productive" and:

> "I wasn't participating in family life. I was isolating. I didn't want to see friends. Because I closed off in myself. This was my universe, in here. As a result, I wasn't a very nice person to be with, I was horrible".

This could suggest that he believes he was unlovable. It also shows awareness of how his way of being affected his wife and children.

However, Adam is the only participant who then adds that he is a different person now. At the end of the interview, he said "I'm becoming the person I was meant to be - I'm a nice person. I think I'm ok". The phrase "I think" may suggest that he is tentative about this, which is common in addiction therapy, to see the work as ongoing, and never complete.

Brian's self-perception presented him with a dilemma. Firstly, he feels that he has not always been a good person, and that this is incongruous with being a good father. His thinking is very judgmental and black-or-white. He doesn't hold the possibility that "good people" can do "bad" things (such as have affairs), or that previous mistakes mean that he cannot be a good father. "Being a good dad when you've not always been a good person is tougher than I thought it would be." He also shows this rigid pattern of thinking with regards to being masculine and being vulnerable. During the interview, Brian became slightly tearful when talking about becoming closer to his brother. At this point, he stopped himself and said that it was not masculine to cry. My understanding is that he found it incongruous to cry and be talking about more "masculine" things such as porn use. This interaction was an example of a split, or rejection of a vulnerable part of the self, because it could be seen as the antithesis of masculinity.

Male sexual identity was very much directly and indirectly linked with the participants' self-perception. For example, Colin, Eli and Frank reported trying to appear confident despite feeling unsure of themselves. Adopting a false self with women was necessary because they measured success and self-worth on the basis of women finding them attractive and showing interest in them. To do this, they believed that they had to appear confident, or risk being rejected.

Having a one-night stand changed the way Colin saw himself as a man.

> "I left feeling that I'd done well somehow, that I somehow did what I was meant to do as a man. I wanted to tell friends about it… but I had no one to tell. I sort of felt proud of myself, which I know might be a strange thing to admit in this case".

Similarly, he felt proud that the woman he slept with wanted to meet him again.

> "That made me think that I was something, or that a night with me left her wanting more. Which now I know seems big-headed, but I really did think that she must have had a very good time if she wanted more of me then."

In fact, he said that his sexual behaviour "used to make me feel, I suppose you could say high, or powerful almost, it definitely used to make me feel more confident". Colin's interpretation of having a one-night stand and his wife (girlfriend at the time) wanting to be with him were evidence of his worth.

On the other hand, Brian's sexual interests made him feel that he wasn't normal from a young age. At the age of 10, he believed that the extent of his curiosity about sex was pathological. It is important to note that this was his subjective experience, and might not be fair or accurate. His belief that it was pathological becomes more evident throughout the interview as he repeats the word "deviant". It suggests that perhaps he was overly critical, and not able to find self-empathy.

Similarly, David's sexual behaviours made him feel bad about himself, but what helped him was knowing that he had been a good provider and hence, father for his family. His criteria for being a good father was based on being able to provide. He does not take into account being emotionally available for his children (he later says he didn't know his daughter was depressed).

Eli also described himself in terms of his parenting. "As a father, I'm not the best but it was worse with my father", but he does not share any reflections on this, or what that entails. Eli revealed more of how he perceived himself by drawing comparisons with his mother.

> “She was successful, and tough, and didn't show any signs of weakness. She wanted us to be like that too… I grew up driven to succeed. I think it was partly because I wanted to impress her. Maybe it's a male ego thing, I wanted to be a successful man and impress her. It was also the way to impress my father”.

He saw himself as successful, and achievements were central to his self-perception. As explained further under the Addiction theme, Eli saw his sexual behaviour as necessary to sustain his performance at work, therefore by extension, it was an integral part of his identity. However, it led to being rejected by others, therefore presenting a double bind, showing how the different sub-themes interweave.

The Double Bind

The participants spoke of situations where they appeared to be in a double bind. It was included as a sub-theme under Experience of Self because it represents a conflict within the self that seemed to stem from, or effect, how they experienced their sense of self.

As adolescents, all respondents reported the difficulty of being interested in sex, wanting to experience it and learn about it, but being taught that sex was “wrong”, and subsequently feeling inhibited and awkward in pursuing sexual relationships. When sexual needs and curiosity cannot be expressed in a safe way, it appears that then there is a drive to seek alternative ways of having them met, rather than quash the needs.

There were other experiences of being in a double bind, common to all participants and pertaining to sex, namely, engaging in behaviour that was inconsistent with their moral values, which led to difficulties in accepting and integrating an element of the self which was incongruent with their self-perception.

For Adam, this was when his girlfriend wanted to sleep with him:

> “I didn’t want to deflower a virgin because as a Catholic that would be the wrong thing to do. So this was a contradiction – this panting mass of desire for sex and this inability to have sex with a lovely warm human being who was offering it”.

It is also interesting to note that when sex and love where from the same woman, Adam had difficulties being with her. It was easier for him to sleep with women when he didn’t have feelings for them.

Religion was difficult for Brian, because although it was important to him, it made him feel he didn't belong in his family.

> "Our family was the religious community, and that was too big and too anonymous. So you felt that you had this big family, and you were meant to consider yourself privileged for being in it, but at the same time it brought so much confusion with it, because it was what was keeping my family apart, and it was too big for them to really notice the individual members".

Religion presented another double bind for Brian because it gave him structure and values, but was a source of conflict vis-à-vis his sexual behaviour.

As discussed above, Brian also presented the dilemma of being a good parent and a sex addict. This would merit deeper reflection in therapy, questioning on how and why one would exclude the other. It also calls for a broader conversation within society about how we view sex addicts. Brian's behaviours were not pathological to the extent that they impacted his ability to participate in family-life, the way it did for Adam, David and Eli, therefore his dilemma would require further exploration.

For Colin wanting to go out was a double bind.

> "At first I was lonely and really wanted people to invite me, but when they did, I would avoid parties and social situations. I felt that I was not going to have a good time anyway."

Colin retrospectively identified a double bind through therapy, "I hated myself yet I was only interested in serving myself". Colin understood this as a contradiction, rather than as an attempt to reject the false self and seek gratification and comfort.

Frank experienced a double bind with regards to his sister. "At first I was angry, because she was the one who upped and left me when I was very young, and she was also the one to say that things were better before I was born, so I guess I was always angry with her, but really wanted her to be around at the same time". During the interview, Frank stated that his mother was not emotionally available, therefore the anger towards his sister may have been because it repeated being abandoned by his mother, or perhaps because his sister was a surrogate maternal figure to him. Being angry was a reaction to being hurt by her, and yet simultaneously wanting to spend time with her could be an attempt to repair the attachment rupture.

Unlike the others, David felt that he was in a double bind after therapy and working on his addiction, "I'm much happier now without the addiction, but I also had to grieve the loss of the

addiction". However, being able to express this difficult truth suggests that he is coming to a more realistic and empathic understanding of his needs, and his experience, and a more coherent sense of self.

These double binds were a source of inner turmoil for the participants, and a possible way of coping with them was to act out with sexual behaviour, which reinforces dependence on the behaviour. In cases where the conflict was about the sexual behaviour, it put the participants in a more difficult position because with time, they were reinforcing the addictive cycle. They engaging in behaviours that offered immediate and temporary fixes, but subsequently this would leave them feeling worse about themselves. To alleviate distressing thoughts or poor mood, they would engage in the behaviours again, and thus the cycle repeats itself.

Sense of Entitlement

This was another central sub-theme, as it seemed to be underlying addiction behaviours and interaction with others. It over-arches with the sub-theme of Rationalization (under the theme of Addiction), discussed below.

All participants indirectly displayed a sense of entitlement when speaking about their sexual behaviour. They felt they deserved to use other people, but contrastingly, they felt undeserving of relationships. They all showed little consideration as to how their behaviour would affect their partner. Brian commented that he was using the woman he had an affair with, and Colin reported that he "Could get away with harassing students". Eli "ordering girls". Such language is suggestive that both felt entitled to do what they were doing.

Adam directly admitted

> "I wasn't interested in people. I was interested in what was going on inside me only. That was my life. Only me…It was sin, an offence to God, but not to my wife and children. Totally selfish".

It points to the discrepancy in value that he places on committing an offence towards his wife, and committing an offence against God. One reason for this could be that he was indoctrinated from a young age to revere God, but relationships were not given any importance. His role models for relationships (discussed later), did not demonstrate mutual respect.

Similarly, David also explicitly admitted that he was selfish. "I was so self-centred, life revolved around me". David's sense of entitlement is also evident when he refers to the woman he had an

affair with. She was a call-girl he met through an escort service, and started a relationship with. He eventually ended the relationship with her after his wife found about the addiction, but he wanted to meet her on her birthday. She refused, so he went through the website and paid to meet her. This shows a sense of entitlement, because he is not respecting her wishes, and is instead manipulating her into meeting against her will.

This incident, which could be considered coercive, jars with David's statement that he believed he loved her and could have married her. He added that he had always paid her for their meetings, even when they were in a relationship. It is unclear if David's financial status gave him a sense of entitlement, this could be the case as he did talk about financial success being important to him, however, the extract points to how he sees relationships. He considers it a relationship, even though there is a monetary transaction involved. This will be discussed further under the theme Relational Dynamics.

Relational Dynamics

This section concentrates on participants' views of significant relationships in their lives, how others experienced the participants, and how they (the participants) experience the Other. It also incorporates attitudes towards sex, where the role of the Other was more as object, rather than subject. It presents a "time-line" from childhood to adulthood, explaining how these perceptions develop throughout their lives.

This theme is also noteworthy for what is not said. None of the participants mention a positive relationship in their lives. Two participants mention that they became closer to a sibling during their recovery, however, it appears that for all the participants there was a lack of a secure base throughout their life. It highlights their isolation and could be a reason why they turned to sex addiction.

Dynamics with Family of Origin

Family of origin dynamics were the initial source of "information" about how to relate with the Other.

All the participants reported that their parents were not affectionate or very involved, to varying degrees. Significantly, nearly all the participants had a parent who had depression. Whilst this

generalization cannot be made for all sex addicts, it is worth noting here, as all participants noted that their parents were not emotionally available.

Adam's upbringing was perhaps the most traumatic, not only because of the war, but because of witnessing domestic violence between his parents. After his parents split up he didn't see his father. He recalls feeling that his mother "was the most wonderful woman in the world and everybody loved her" but that she never cuddled him, even when he was ill. As a child, Adam therefore was presented with the fact that his mother was a wonderful woman, yet she didn't care for him. This would have been traumatic not only because of the abandonment, but more so if he concluded that his mother's behaviour was a reflection of his worth, rather than to do with her own history and way of being. He added,

> "I remember my parents never visited me. I once wanted to telephone my mother. You had to tell the operator, and you waited for the call back. So I sat in a cold room in the dark waiting for hours for the call back and it never came. I was alone and miserable. I'll probably start crying if I think about it."

In therapy, this could have been an opportunity to explore this further, what would it mean for him to cry, what feelings it evoked. However, given the setting, I did not feel it ethical to ask more, in order to respect Adam's wishes not to discuss it further. However, it did appear to be a significant moment during the interview. He went further to recall that when he was 28, his mother killed herself and this had a profound effect on him

> "I was left wondering why didn't she say goodbye and after that I thought did she really love me?"

Again, this is doubly traumatic, because he interpreted her behaviour as a reflection on him. He does not posit that it could have been due to her mental state.

Brian did not single out any incident, but experienced an ongoing form of rejection, as his parents weren't interested in him or his siblings.

> "Everything was about portraying ourselves a certain way, and we didn't bother with how we were doing as a family".

As children, there was a lot pressure to comply with the teachings of their religion, and to appear to be good members of the church. This could have been the start to learning that needs will not be met, and therefore shouldn't be expressed. It may have also implicitly encouraged Brian to adopt a "false self".

Eli had more to say regarding his relationship with his father and how it affected him.

> “You can't call it a relationship, because he wasn't really there. And when he was it was on his terms, always in and out of our lives, or our mother's lives. We fit around him, and his holidays or plans or whatever it was. Like we had inconvenienced him. And of course as a child you believe this. And you go along with it because you don't know any different. I used to believe that if I did so and so differently then he would be proud and come again but he didn't. He'd be in and out and that was it he was gone for months. I don't think about him so much anymore”.

As happened with Adam, Eli interpreted his father’s behaviour as a reflection of his worth. In response to this, he committed himself to being a high-achiever, as a way of gaining his parents’ love.

Frank’s family dynamics and his position within the family were relevant to his narrative. After his birth, Frank’s mother became depressed, and his sisters told him he was unplanned, the “unwanted child” and things were better before he was born. His siblings left home when he was a teenager, and he describes that time thus “I was so sick of worrying about upsetting my mother by then. I was alone in the house with the two of my parents, and it got tiresome. I don’t think I really cared much at that point. She was always so morbid, everything so catastrophic with her, she couldn’t handle anything. It’s like she never really got out of the post-natal”.

After his sister moved to another continent, his mother felt she was

> “being abandoned and that nobody loved her. The thing was, she was abandoning us, or probably had long before we grew up and left home, which is what people do anyway. She was a miserable woman in every way. She didn't eat, and she was very small. I think she did it so that we would encourage her to eat, and look after her.”

He talked about the effect it had on his father:

> “They were in a miserable relationship, but were fine with that. … My father wasn’t interested in looking after her anymore. He’d had enough, but he wasn’t a bad man”.

He suggests that he felt abandoned by his mother, and possibly manipulated into looking after her, because of her behaviour and because he was the only left at home. He felt resentful towards her.

Messages about relationships and sex during childhood

All the participants discussed childhood influences and sources of information on relationships and sex that shaped their attitude towards sex (and sexual behaviours including masturbation). These messages were from their family, friends or school. They were not always the result of direct discussion, but they were also messages understood implicitly. Significantly, all the participants reported having been exposed to sex-negative messages, and did not have conversations with their parents about sex.

Adam discussed his parents' relationship. Apart from being violent, Adam reported that his father repeatedly cheated on his mother. He went on to say that he wasn't sure if his father was a sex addict. He did not elaborate how this influenced him, but it can be hypothesised that he viewed infidelity as acceptable, or a "normal" part of relationships.

Adam reported that he felt shame and guilt for masturbating in boarding school. "The manager of the dorm said "these are the most disgusting sheets I've ever seen". The message from school was:

> "Boys should not masturbate… boys should not have sexual relations with girls until they are married. … I was told that masturbation, which actually was my only consolation and pleasure in life, was wrong, sinful and I had to stop it. That was a problem".

It created conflicting feelings towards sex, and he felt singled out and that something was wrong with him for wanting to masturbate.

Brian's interest in sex started at the age of 10 when he noticed nude pictures in tabloids. He repeated that he was "deeply curious", and believed that his interest was not normal. Whenever he was alone at home he would look through the lingerie section in his mother's catalogues.

> "I didn't understand it but I found it very arousing. Maybe not sexual, or I didn't make the link but I found it exciting. I was too young to realise it was destructive and harmful. But I knew it wasn't right, because I kept it a secret. My parents were very strict. Almost Orthodox. Especially when it came to nudity."

A 10 year old could not have made the distinction between something being "not right", and his parents not approving of it. Brian believed that interest in sex was not right, and his parents would be angry if they knew. Brian reported that his obsession with sexual images "robbed him" of a normal childhood.

> “I don't think that it was OK to be doing all that. And I wonder why my parents didn't talk to us more about sex, why they made it so dirty and secret. I think that did it for me. I don't blame my parents but I think they made a very big mistake with how they brought us up, and to some degree, I do think this was their doing”.

He added that when he was the same age, his parents requested that Brian does not attend sex education classes at school, and he was the only one of his peers who wasn’t allowed to attend. Like Adam, Brian felt humiliated and singled out, and he adds that this had the detrimental effect of making him more curious about sex.

Brian also added that there was a history of “sexual deviance in the family” His gay brother is also a sex addict, and he reported that his mother was sexually abused by her step-father. He added,

> “My cousin served time in prison for having sex with a minor (he was in his 30s, she was 12-13). My uncle also served a number of years in prison for committing sexual abuse to a minor. All from my mother's family…it was this really really awful shameful thing that my family didn't want to talk about. So it just kept conditioning sex as being bad. And that in a way, it was normal to be obsessed with sex, and to be deviant, because it seemed like my whole family was”.

This quote demonstrates Brian’s ability to conceptualise his behaviour from a developmental perspective, but he does not go further and is mostly descriptive. He shows a combination of understanding and simultaneously externalizing by blaming his parents and family.

Unlike Adam and Brian, Colin didn’t view sexually explicit material until he was 18, however he noted that he had “less than positive messages” about sex when he was growing up. He recalled his father getting angry with him after he had a wet dream, and said that he felt awkward and disconnected from his father. He then recalled at school when he was 11 years old a student got her period and he said “I remember being totally disgusted by the whole thing … With my male friends we talked about it and there were those who knew what periods were and those who didn't and I definitely was in the group that didn't know. Then one of the teachers at school gave us a lesson about it all and they made it part sexual education and part anti-bullying, so I remember thinking this was a waste of time and not really paying much attention. So yeah, I think the messages we had about sex were... It was all a bit disgusting and it was something to laugh about with the boys that was the only thing I can think of that somehow made it positive. Then as we grew older it became something to compete about.”

This extract shows how the experience influenced Colin's beliefs about sex, and how these messages became part of his male sexual identity. As an adult, he was fuelled by wanting to compete with other men for female attention.

Eli's family didn't communicate much and "sex was a particular no-go area". Despite not talking about it, he feels he was very much influenced by his mother regarding sexuality and identity. Eli described his mother as a sex addict, but it is unclear what facts he based this on, he only offers that she had sex with her partners in the home frequently. He did not say that she had multiple partners simultaneously, however, she would sleep with his father when he visited (even if she was in a relationship at the time). He views this positively, saying that his mother was a successful business woman, which was impressive for the seventies, and even more so that she was a single mother. He understood sex to be a "reward" for hard work, and part of her identity as someone "strong". He does not make it explicit, but he suggests that this influenced him in seeing sex as separate from emotional attachments, and that casual sex was not only acceptable but rewarding.

Their family history led both Eli and Brian to wonder if there is a possible genetic component in the aetiology of sex addiction. Interestingly, they do not suggest that family dynamics and observations of their parents' relationships may have formed part of their implicit understanding of how romantic relationships work, and how they view infidelity.

Romantic Relationships

Participants noted how they perceived romantic relationships or themselves in relationships, and in particular, their marriages, which were inevitably impacted when their spouses found out about the sex addiction. However, some of the participants discussed other matters within the context of their marriage, not directly related to the addiction.

For Adam, romantic relationships were very difficult. "When I eventually met a girl I was paralysed. I couldn't speak to her. I couldn't talk to her. I couldn't be normal. It was awful. I remember being on a sofa at a party with girls. I couldn't move. I couldn't say a word to the girl who liked me. I couldn't express myself. I couldn't have relationships at all". This paralysis influenced how he saw himself, and led him to further separate fulfilling sexual needs and romantic relationships.

As he grew older, he recognised how his partners might have perceived him. "I was impossible to be married to and to talk to. I was always right. … I was completely incapable of having a relationship with anybody". However, this statement is not to do with sexual addiction, he states that he was difficult to be with because of a particular character trait. This could show that he did

consider the addiction to be having an impact on his relationship, or that he saw additional elements of himself that were difficult.

Brian only spoke of his marriage and the affair as his relationships. He reported having a good relationship with his wife at the time that he started watching porn more often. Despite this, Brian reported that he had difficulties opening up to her about a number of things. For example, Brian never told his wife that his uncle and cousin were sex offenders, his mother told her at a later stage. Brian preferred to withhold this information, rather than be vulnerable and share something potentially shaming, perhaps out of fear that she would reject him.

Colin did not mention relationships, other than with his wife. He said that she was also a porn addict and had a dependent personality, and that the addiction was the glue of the relationship. There wasn't a strong attachment between the two from the start of the relationship, yet they stayed together, because it helped him feel more confident. There is a sense that it was not a relationship based on mutuality, but was ego-centric, with Colin focussing on what it gave him, rather than his feelings for his wife.

> "I was slowly starting to realise that I could have other women also, like students at university so that meant that I was freer of the relationship than she was… We were scared of being alone, she depended on me, whereas I was finding a new confidence in myself, but at that point, it was still linked to her interest in me."

David also felt that his wife had a dependent personality but seemed to have reflected further on the nature of codependency. He said that the power in their relationship wasn't balanced, and that prior to therapy he looked down at her at times "I might demean her with a nasty look". It is interesting that he recognises and acknowledges the power imbalance between him and his wife, but he does not acknowledge the power imbalance with his girlfriend, by paying for her services. One possible reason for this is that he might have felt more comfortable discussing his relationship with his wife during therapy, rather than his affair with a prostitute, and hence, had more insight into the former.

Eli only spoke about his relationship with his wife, and of this he said that "she was too busy to attend to what I needed", "she wasn't keen on anything anymore, particularly not on me". He felt that it was a good thing for her that he slept with other women, as it "meant less work for her". This shows the lack of value he placed on fidelity, but also perhaps that he had felt rejected by his wife.

> “It made me realise that my marriage wasn’t what it appeared to be and that using call girls might not have been as bad as I thought it was.”

When he reached this realization, Eli could have chosen to address the situation by talking to his wife and tell her how he felt, but instead he chose to start “using call girls”. This could have been raised in therapy, as to why he chose to go down one route instead of the other.

Frank spoke about his relationship with his wife in terms of what he got from it “I got a high from being with a woman who was so confident, because it made me look confident.” When she had a miscarriage at 4 months:

> “She was very low and depressed, didn’t want to do anything, and it was difficult to be around. Me, I want to be around people who boost me, not bring me down…I just wanted to feel good about myself, and not have to worry about my wife”.

He did not support her when she was depressed, perhaps because this would have repeated his attachment injury of caring for his depressed mother. However, he expected her to be there for him when she found out about his addiction.

> “It’s a bit of a sham, the vows you take, in sickness and in health and all that, and then a sickness comes and you disappear, I understand, that she, her pride was hurt, stung, and she didn’t trust me anymore, but that’s not what in sickness and in health means”.

He drew a similarity between his father and his wife. His father struggled with his mother’s illness, but didn’t leave her. However, Frank’s wife left him when she found out about his sexual behaviour. This was a shock to Frank “I was stunned and I still am, because she never said anything - she never said she was unhappy with me, or that she wanted something different. If she'd said something before I might have been able to do something, but to just leave, that was another knock to my confidence.”

Significantly, all the participants were aware that they hurt their partners, however, none of them said that hurting their partners caused them distress. In therapy, this would be important to explore. Is this because it didn’t hurt them to see their partners hurt? Alternatively, was this a defensive process? What would it have meant, if anything, to say that they hurt their partners? Would it have changed how they see themselves?

It was worth noting that 4 of the participants reported difficulties communicating and connecting with their wives prior to them learning about the addiction. For Adam, this was because he always had to be right. Brian did not feel he could share information about his family, and Eli felt she was

not interested in him, and it can be assumed that David and his wife didn't communicate much about important matters, because he had reported that he didn't know his daughter was being treated for depression.

All participants expressed the desire to be in romantic relationships again, and that they hoped they would be different and make changes.

Sex vs Intimacy

This sub-theme follows from Romantic Relationships, as all the participants made a clear distinction between sex and emotional intimacy. I chose the word "vs" to imply that they did not see sex and intimacy as good bedfellows.

All the participants had been married, and spoke of their marriages and relationships in such a way that indicates a lack of intimacy, mutuality and reciprocity. Even in other relationships, mostly with the women they were cheating with, such relationships are marked as being for sexual purposes.

For Adam, the separation was clear.

> "I never sought to express or fulfil love through sex. It was just about orgasm. There was no intimacy, it was just mechanical".

He added that later on in the marriage he was watching porn to get an erection to have sex with his wife, because he was no longer attracted to her. He also said "I just wasn't able to develop a warm, interdependent, fulfilling, loving, intimate, relationship with anyone", indicating awareness that intimacy was difficult for him. He said the same was true with his second wife, it was not an intimate relationship, and he defined a lack of intimacy as a lack of sharing himself.

Brian and Frank reported that their affairs were about sex, and not "an emotional attachment" (Brian). Brian went on to say that his wife also felt that when they had sex they weren't intimate. "I think she was right, I wasn't interested in pleasing her, I was trying to do new things with her but you know it lacked the bother for the other person". He too admits that there was a lack of reciprocity.

Colin spoke about sleeping with women as an achievement, "I could attract a woman, and get her to have sex with me. In school the big thing was to get a girl to do something, and that was an achievement." He admitted it was not a mutual relationship "She seemed content with what had I

had to offer, and I wasn't going to offer more than that". When he was attracted to his student, he was clear that it wasn't emotional, but in a sense, another acquisition "I didn't have feelings for her, but what she represented… forbidden fruit, a student, and another man's, and younger"

David described his feelings towards his wife as "I never saw her in a sexual way. … I wanted the titillation, which is not what you get from your wife." The latter half of his statement is a generalization. Somewhere, David learnt that marriage did not involve having a sexually exciting relationship. Although he said he could have married the woman he was sleeping with, he also knew that he had to pay for her. He marks the distinction between the sexual and the emotional "I had a relationship and sex with her". Whilst he admits to having feelings for her, sex and emotions - despite being with and for the same person, are fragmented.

Eli noted that relationships (which were for social status), and porn was to satisfy his sexual needs. His words imply that relationships, devoid of emotional intimacy, could not or did not fulfil his sexual needs.

It is interesting that although this sub-theme relates to sex, sexual behaviour is not the topic itself, Participants did not describe sexual behaviours, preferences, arousal or pleasure, perhaps because they did not feel comfortable doing so with a female researcher. Another possible reason is that the behaviours in and of themselves were not as important as the meaning ascribed to them, and the distinction between the meaning given to sex and that of intimacy.

Addiction

This theme provides a framework for different affective and cognitive states and experiences involved in addiction. At times the division into sub-themes is arbitrary, as there is significant overlap, for example between Rationalization and the Purpose of Addiction. The theme incorporates different facets of the addiction that were important to the participants. It is worth mentioning that the behaviours involved in the addiction per se were not raised and discussed. Indeed, their experiences and behaviours were very different, however, yet the theme has commonalities because of the impact the experiences had on the participants, namely, how they were perceived by others, feelings of powerlessness, having to rationalize and deceive, what needs the addiction fulfilled, and how they described the addiction.

Perception of the Addict

This sub-theme is relevant because it shows the multi-directional influences exerted on the addict, how he is experienced by others, and how the addiction is experienced by the addict and others as "by-standers". This in turn influences and changes relationships, and the addict's sense of self. The participants all described a point in their lives when their families found out about the addiction, and the subsequent aftermath. For some, it led to a breakdown of the marriage and losing contact with their children.

David and Eli spoke of how their children saw them after they found out. They reported that their children were hurt and angry. According to Eli they did not understand his behaviour as "part of the addiction, a symptom of the bigger picture, and I think they should have seen that. I wish my children could have been more supportive of this". He felt misunderstood and unfairly judged by them. At this point however, Eli is referring to when his children found out he was having an affair, and they did not consider the affair within the framework of sex addiction.

David added his own perception of addicts "Addicts deceive and lie". Similarly, Adam added that addicts have "every defect of character", cheating, lying, self-centred, "greedy, totally selfish, totally inconsiderate, hard, unloving, un-intimate, defensive, boring person…an unreliable bastard". The long list suggests an extreme view of the addict, and that there is little room for other, more positive aspects of the self to be present.

Frank and Eli felt that people "blame the addict". After a client filed a sexual harassment complaint against him, Eli felt that his boss "built me up to be this something". He added that specifically towards sex addicts, there is a different standard. He reasons describes his behaviour as a way of fulfilling needs, rather than as an addiction.

> "I do see it sometimes as nothing more than a man fulfilling his needs, nothing wrong with that. If I'm happy then the children and wife are happy. Some men spend the money on cars or a boat or cigarettes and I spent it on sex. I think there's a hypocrisy there."

He makes the point that society judges him too harshly, but at the same time, he is downplaying the effect his behaviour has on others.

However, Eli was able to use this to his advantage. Part of his motivation for change was "I don't want to be seen as a failure… from a bad background, untrustworthy, no self-control".

When Frank and Brian's therapists referred them to other services, both felt that this was because of how they viewed sex addiction. Frank believed that his therapist found it intimidating, and Brian felt he was being dumped, and that his problem was so pathological, he couldn't be helped.

Powerlessness

All participants reported feeling powerless to stop the behaviours, and externalized the addiction as an entity that made them behave in certain ways.

Participants frequently referred to the addiction as "it" rather than a part of them, or as behaviours they engaged in. Adam reported that he was "being dragged around London by my penis", and uses language such as "it grew so vulgar", as opposed to saying his behaviour was vulgar. It is worth noting that Adam had lived through World War II, and had experienced powerlessness from an early age.

> "The world was a frightening place. I still remember the sound of the V2 bombers. It was quite terrifying. I remember fear being the background to my life. Fear was like a permanent sort of tinnitus. The other thing was dread. Dread was in my stomach".

Whilst it may not be directly related to sex addiction, his previous experience of powerlessness may have become embedded into his identity - did he feel he had control over his life, and by extension, his behaviours?

For Brian, this started at an early age and he felt

> "completely taken over by curiosity, and it would always get the better of me. From that age of looking at the catalogues, knowing I could get caught, knowing I could get into a lot of trouble and worrying about getting the catalogues from somewhere. I was completely consumed by it".

He also spoke passively when he spoke of his wife and the affair. "I found myself in this new relationship, my wife and the underground scene". This example of language use, (I found myself), as opposed to using the active voice - (I had an affair), almost suggests he was not aware of how it happened, and that it happened outside of his own will and control.

Colin felt he was in a trance. Like Adam, he talks about being controlled by his penis or erection.

> "Nothing else existed, just my erection, and I didn't realise at the time but it was like all I could think about was getting an erection and it didn't matter that nothing else mattered.

> So that's when you start making bad decisions, without knowing what you're getting yourself into."

David admitted he felt powerless "My addiction wasn't everyday but I was powerless to stop". This highlights an important point about how addiction is defined - it is not just about frequency, but should include the inability to control or stop the behaviour. David also used a passive voice to describe what he did "I found myself in the red light district". Similarly Eli said "It felt so good and so easy to say yes, I didn't think about it. … this thing making my decisions for me. … I had stopped caring about what was right or wrong and just did whatever I felt like doing.

Frank repeated that there is a difficulty in recognizing sex addiction. "You don't really realise you're getting into something…That's what's so scary about addiction – you have no idea it's happening to you". He then added "You are a slave to this voice that tells you to do something and it's taking over your body, you have very little control over your body, and your actions, thoughts". He openly says that he has no agency over his own actions.

The similarity in narratives and descriptions could be because all participants had attended SAA, and perhaps they were influenced by the terminology of their respective groups, however this might not necessarily be the case, which could suggest that it is a central experience of addiction.

Rationalization and Deception

All the participants provided reasons that justified why they engaged in certain behaviours. Rationalization and deception are grouped together because they often occurred concurrently. Furthermore, at times it appeared that the participants were deceiving themselves in order to rationalize their behaviours. Whilst initially it seems self-serving, rationalization may have been a defensive mechanism, a way of integrating an otherwise unacceptable part of the self, to create a coherent whole.

For Adam, his behaviour was an act against God, but that could be forgiven during confession, and therefore had no consequences. Brian justified his behaviour as being beneficial

> "As a child it was to learn about women and sex, and when I was married, it was so that I could have a more exciting sex life with my wife, and with the affair… it would be good for us if I did this. I don't know how I came to that conclusion. I don't think I needed one really. I might have thought that I was satisfying myself and that meant I would be happier, which would make me a better husband for her… you don't see it as an addiction, you don't see

> it as being something bad. Well you do, but you don't think about it too much. Because if you did that would create a lot of problems. I would feel really guilty about what I was doing, for a few minutes, then I would come up with reasons in my mind to explain why I deserved to be doing what I was doing."

It can be argued that Brian was also deceptive with his wife for hiding his family history from her. She found out when Brian's mother told her. Other than that, Brian hid the affair and then downplayed the extent of his porn addiction with his wife. He does not say what stopped him from being more honest with her.

> "I made it as small as possible, that I was looking at porn, and that's where the ideas for the new stuff was coming from. I made it out to seem that I was doing it to make our sex life more interesting for her. … So my wife does know about me watching porn, but not the extent of it".

Colin justified his attitude towards his wife also. He admitted that after they slept together he ended things "quite badly" and that he had no intention of going further with her. When she was still interested in him, despite knowing that he only wanted casual sex, he took this to mean that she agreed and would tolerate his behaviour. Of his addiction later, he said "I was making up for my lost teenage years, and that I wanted to enjoy this power I had while it lasted".

David believed he wasn't harming anyone, and that he deserved to do what he was doing. When speaking about his wife, he made the distinction, "It's not the addiction that hurt her, it's when she found out". This implies that he thought that his behaviours were having no impact on her and the relationship prior to her finding out. It also feels as though he is absolving some of the responsibility for his actions.

Eli hypothesized that his son cut contact with him because his pride was hurt, rather than assume responsibility. He rationalized the impact his behaviour had on his son, in doing so, externalizing blame and responsibility.

"I was a very good dad, but then they took their mother's side when we got divorced. My son took it quite badly. He said nasty things, he was just letting his anger out teenagers are like that - though I suppose he was - I don't know. He said he was disgusted, and didn't want to see me anymore. Maybe it's a male pride thing. I think it bothered him that his father was having sex with girls his age".

This may have been a defensive position, rather than admit that he hurt his son through his actions, and that this led to the breakdown of their relationship. This seems particularly salient in lieu of Eli's relationship with his father, who Eli describes as absent. That the relationship with his son had broken down too may have been more painful for Eli in light of this.

For Eli it was because "I could get away with it", and he felt "it was difficult in those days to get porn, and when the opportunity came I thought I should take it, so I did". As explained above, he also felt his behaviour was justified and actually good for his wife because she didn't want to sleep with him.

Frank also justified cheating on his wife because she wasn't having sex with him. "I needed to have sex to keep sane, and in my mind I was doing that for both of us… When things started to change I justified it by saying that she might get worse again, and that I didn't want to rush her into having sex with me, and that it was better to fulfil my needs elsewhere"

All participants said that deception became a part of their lives, lying to others and to themselves, mostly saying that they felt that their behaviour wasn't harming anyone. Adam gave several examples of lying to his wives but also noted that it started from earlier relationships "So this poor girl was led up the gum tree by me".

David also spoke about how he was deceiving himself, in two instances, firstly by believing that his behaviours weren't harming anyone, and in the second, for telling himself he wanted to marry the woman he was having an affair with, "I would think I want to marry her. But I knew I wasn't thinking right, my brain was addled and I knew it".

For Frank, apart from hiding his behaviours, he felt he was being deceptive by hiding how he felt about himself, and wanting to appear confident.

Perhaps, justification of behaviours was not only a risk factor that precipitated sexual addiction, but also a defence mechanism that developed in response to it, in order to tolerate distressing truths about themselves.

The Purpose of Addiction

The participants identified the purpose of their addiction, what needs it fulfilled for them. Although the reasons were mostly different, the commonality to all participants was that they saw it the addiction as a way to have needs met, it did not develop randomly, or without reason.

For Adam it was about resolving conflicting needs, he wanted sexual relief but did not feel able to connect with women. “On the one hand I wasn’t allowed to have sex with anybody, on the other hand I wasn’t able to communicate with anybody, and on the other hand I was doing something sexual very often. I got into the habit of solving my sexual problem by going to prostitutes”. In this way, he could fulfil sexual needs (and possibly, the need for connection), without having to have an emotional connection, which he felt he was unable to do.

Brian considered looking at pornographic images and watching porn as an escape “I guess, I wanted to please others, because it would have been what my parents told me, and what my religion told me. But when I didn't manage, I'd escape. And the escape of doing something deliberately wrong also gave me some relief of not having to be good all the time”. In this regard, it had nothing to do with sexual needs, and nothing to do with what he told his wife - that it was to improve their sex life. Both reasons could have been true and equally valid for Brian. This suggests that porn addiction is multi-facetted, and not only about viewing porn.

Colin also saw it as an escape but adds “I thought that this is what I had been missing out on in my teenage years and early twenties, and then I felt sorry for myself that I didn't have that experience, and promised myself that I would make up for it. I felt that I wanted to do everything I could to get that buzz. I call it a power-high”. For Colin again, it was about an intrinsic need, and not about sexual stimulation.

David, similar to Adam, said “I was very shy, mostly with girls. I wanted to chat girls up but I couldn’t do that. … I had a fear of public speaking…I have a fear of confrontation and rejection. At the time I didn’t know I just wanted to be normal and chat girls up. That led me into sort of, there were no computers, so I looked at magazines of pornography. To have some sort of adolescence. I would look at these magazines and masturbate..”

Eli saw it as a reward (and suggests that his mother saw sex as a reward for success also). “I was becoming more successful at work, so I felt I deserved it… [it] kept me performing … it sustained me”.

Frank elaborated more on what the addiction gave him, including during his childhood when it wasn’t an addiction yet, but used masturbation as a form of emotion regulation. “Sex became a need. I had to prove my brother wrong and I didn’t want to be the one stuck with looking after mum anymore, so I rebelled…It was almost like I was angry, and masturbating was a way of getting rid of the anger”. As an adult, he kept using it as a form of emotion regulation. “I was just

trying to respond to depression and keep it at bay by going the opposite way…It was a great way appear confident, to mask my lack of personality".

The Nature of Addiction

This is an important sub-theme. Awareness of the nature of addiction could mean that the participants are better-equipped to identify when they are at risk of their behaviours becoming problematic, which is particularly important given that most said they were not aware of how the addiction escalated.

The participants mentioned different "qualifiers" that would imply a behaviour has become part of an addiction, and what it is like to live with addiction.

A common descriptor was the cognitive states that came with the addiction. For example, Adam mentioned rumination "What strikes me about it is the planning, and that I got into a state about it". For Brian, sexual preoccupation seemed to be a significant theme as a child and young teen. "I was constantly, if I was walking about my eyes would be looking everywhere, in the bushes to see if there were any pages thrown away, or magazines or anything with nudity. That's how conscious I was of it. I'd even go out on purpose with the intention of looking for it."

Like Adam and Brian, Frank experienced preoccupation or obsessiveness. "I had to orgasm. Had to. It became obsessive". He also reported that although he didn't masturbate more frequently than other boys as a teen, there was a qualitative difference, which he refers to as "menacing". The word "menacing" suggests that it was beyond his control, or that it was not enjoyable and caused some distress.

David spoke about how easy it is to develop porn addiction because of the availability. "Addiction was always there, but today with the push of a button, all the internet porn, it's all part of the process. It's horrific. They are on their computers for 15 hours at a time. Even I can't get my head around that". Brian also would have gotten more into it if he had had internet earlier, and Frank mentioned that it is now too easy to watch porn. He added that sex addiction will become "much more common because porn is always around, and most of the wold we live in today is all doom and gloom", referring to it is a mode of emotion regulation to counter the "doom and gloom".

Frank also discussed the Medical model. "It is a disease that needs more recognition and there needs to be a lot more understanding. Because the number of marriages breaking up because of it is incredible, and I think it will go up in the coming years, very likely it will…It just suddenly is

something you are hit with, like a disease… like diabetes, like cancer. … The longer you let it fester, the more pervasive it will be, and the more exhausting and invasive the treatment will be". This quote is suggestive of the nature of addiction – which the longer it is allowed to develop, the stronger it will become and the harder it will be to overcome. He elaborated on this "It starts off with not really effecting you, it's something you do, just because. But then it becomes about something that is bigger than you.

The theme of Addiction was central to the participants' identities, and it incorporated different facets, namely, how they believed it developed, what purpose it served, and how they juggled living with it and incorporating it into their sense of self.

Recovery

This is the final theme, however, it is not meant to depict a linear progression or the end point. It is a summary of experiences that participants went through once they decided to address and control their sex addiction. It is the only theme that seems more positive and optimistic, it represents a tentative change in tone, despite being somewhat trepid.

Turning Point

All participants reached a "low point" which served as a precipitating factor to seek help. It is unclear if this was the first time the participants reached a low point (except for Frank), or if there were previous experiences but they weren't ready for change then.

For Adam, Brian and David, this was when their wives found out about the addiction and infidelity. For Colin, it was when his ex-wife told him she was HIV-positive, and he needed to get tested. He eventually had the test and when it turned out negative, he went on a "binge".

> "It was a horrible horrible horrible experience, and I realized, I have to do something about this now… the waiting time killed me. Then I went on a binge, sort of like a celebratory binge".

He reported that he doesn't remember what happened that night but suspects that he took someone home because some valuables were missing from his place.

> "I felt that I'd gone too far, not what I was doing, the behaviour itself, but the trouble I was getting myself into had to stop. So back to SAA, and a therapist, and a psychiatrist, because I wanted all the help I could get, I was determined that this wasn't going to happen

> again and I had to go through the process of not knowing again if I'd contracted HIV and had to wait to do another test. For months I felt torn, so I went back to just watching porn, I stopped visiting brothels. It took me a very long time to be able to say I'd done that, but it took me much longer to control my urges for porn".

Eli initially said that his turning point was due to financial reasons, and his children not seeing him. Furthermore, when his mother was diagnosed with cancer, he couldn't afford to go see her. He felt ashamed of this after his brother and friend told him that he should go and he realized he couldn't "because I'd rather spend the money on a woman younger than my son to give me a blow-job. That wasn't who I thought I'd turn out to be". It shows shame and regret for his actions, as he realised that his actions had ramifications.

For Frank, his turning point was when his sister got involved and suggested he seek help after he had an overdose on cocaine.

> "It was the third time I was at a low-point, and I'd never done anything like that before, and I risked losing everything again, so it was time to call it a day."

The fact that it was his third low-point shows the nature of recovery, that it is not linear, and there is always the risk of losing any progress made. At this particular time, his sister went through his things at home and felt that he might have been a sex addict, so she pushed him to start therapy and attend SAA meetings. She even attended an SAA meeting with him. This may have been doubly reparative for Frank, not only for addressing the addiction, but also because he had previously felt abandoned by his sister. That she supported him after she found out about the addiction and didn't abandon him may have been especially reparative for Frank.

Benefits of Group Setting

The participants noted how the group setting impacted them. Participants all attended SAA, therefore it can be assumed that their experiences would be similar. Whilst they all commented on the overall positive impact of attending SAA, they highlighted different ways how it helped.

The group helped Brian because it gave him insight on his addiction, and also made him realise he needed to do something about the addiction to prevent it from getting worse.

> "It can get really gruesome, some of the stuff that goes on, which has two outcomes on you. You first realise that yours isn't so bad, which helps you feel better about yourself,

> and you also realise that you could get much much worse, so you've got to stop it in its tracks before it does".

This shows a reciprocal dynamic - how being with an Other presents an opportunity to reflect on the self.

David also found it helpful because he could connect with the group.

> "You go to meetings and you talk, you express yourself, you talk about how you feel. It's a great help… you come into a room full of people, it just feels like a safe haven, because they have been through what you have been through".

Eli similarly credited the group with helping him find understanding, which he didn't find from his family.

Frank reported that by comparison, his behaviour "wasn't as bad as that of other attendees".

> "What's tough is when you get a regular who has broken his sobriety, after he'd been clean for years. That's a reminder that you have to be vigilant at all times, because it is easy to fall off and get into things again…I used to look around the room and feel sick".

It is unclear what he means by "sick", if he meant that this was due to anxiety and dread about getting worse. It could also mean he felt disgust, however the former seems more likely.

Adam had reached a different stage within his group. He had become a sponsor (meaning other members could reach out to him for more individual support). He found this very gratifying, and said that this helped him formulate a more positive self-image.

It seems relevant to mention that the group could have been an opportunity for participants to counter the aloneness they all experienced throughout their lives. Furthermore, the experience of finding understanding and reflecting on the Other's behaviour seemed important. It could have been the experience of shifting focus from self to other (empathising and being concerned for the other), which in turn allowed them to shift back to the self, and be more accepting and empathic with themselves.

Personal Therapy

The participants discussed their experience of personal therapy. Their journeys with therapists were all different, in terms of duration, what type of therapy they attended, and whether or not they attended individual therapy before or after SAA. This could suggest that despite different

routes, therapy could offer benefits. This could be because of factors common to all modalities, or different modalities offering different benefits.

Adam described the process of therapy and why he thought it worked.

> "He disarmed self-pity as my trigger for acting out. I got rid of my self-pity and it was such a relief because it had been a burden. He tried to tackle some of my sexual fantasies, and some of my fears. And he said go off and do the 12 steps. So what he did for me he was he got rid of my mental obsession and physical compulsion. I joined SAA and I got a sponsor and I saw changes. I had fantasised about paid sex until step 10 and the compulsion or fantasy has gone. I don't look for it anymore. I used go around looking for it. Today, forget it".

Brian's therapist like Adam's also suggested joining SAA at a certain point. "My therapist felt that he couldn't really help me past a certain point, and he recommended them", however unlike Adam, Brian felt bad about this.

> "It wasn't great at first. I had confided in him, and told my wife based on what he'd said, and it felt like I was being dumped. Like I couldn't be helped. I still had a hard time accepting that it was a problem, so to be told it's such a problem that a professional couldn't help didn't make sense to me. I felt that he could have done more, though I see his point of referring me, because I did get so much help from them. I wish I carried on with both, you know, because with therapy I was getting time to talk more about myself about what was going on for me, and to have the 50 minutes to myself."

Brian does not say why his therapist didn't suggest that he attends therapy and SAA simultaneously, or if they discussed the possibility of Brian returning to therapy after he completed some of the steps, or all. Perhaps, this was because the therapist feel unqualified to help clients with sex addiction.

Colin only mentioned that therapy helped because he realized how much he hated himself. He does not elaborate much on this, such as how this helped him afterwards. David noted something his therapist said which impacted him.

> "There are three phases - being a child, an adult and an elder. I'm retired, I'm ready to be an elder. As an adult I never really succeeded properly because I never grew up emotionally, I never matured".

This shows self-awareness, understanding of his past behaviour, and a desire to change.

Frank went to two therapists, the first was for 3 sessions after which they stopped and Frank felt that it was because she might have felt intimidated. His second therapist was also a woman, “because I wanted to talk about my issues with women, why I felt I had to be confident for them, and this stuff. But it didn't work out with her, I sort of dropped out”, but doesn’t elaborate on this. He then did a residential programme in the country where his sister lived, which he said was very helpful for him because the programme was supportive and helped him transition to the less structured format of SAA. Frank might have also found it easier that he was in closer physical proximity to his sister (who he identified as the only supportive person during his recovery) during the initial stages of his recovery.

Sobriety and Change

This subtheme highlights the idiosyncratic nature of sobriety and change, making them difficult to define. For all, the definition of sobriety seemed to be in a state of flux, with all the participants aware that they could relapse easily. They also noted that sobriety would mean different things for them at different phases in their life, depending on their circumstances (such as being in a relationship).

Adam, David and Eli discussed what sobriety meant for them. For Adam “This is what recovery is all about – feeling happy and having peace”. For David, it was understanding that he will always be an addict but could learn to control his behaviour “I know I have a very addictive behaviour that will never go away, but if it is unmanageable it will destroy my life. I have to be free of that. If I have a compulsion, I’m powerless. I have to be free so that I can examine my life and see if I’m OK. What the addiction does is that is masks something else. I can’t think Oh well, I’m recovered. Recovery is progressive”. He also understood the limitations of recovery “For sex addicts healthy sex is very very difficult”

Similarly Eli pointed out

> “Sobriety is difficult to define, because people don’t want to give up sex completely, so they are very reluctant to get into therapy in the first place… It’s an individual line, of how you define that difference. For me sobriety means not spending money on sex… Others, it might mean having sex seven eight nine times a week but with their wife only. It’s very individual”.

This sensitivity shows that he understands how different sex addiction is for each person.

All participants reported change mostly in their ability to connect with themselves and others. For Adam, this was in a romantic relationship:

> “I had the most lovely intimate physical relationship with her… When you’re able to give yourself to someone. I’m free to be loving and generous and kind.”

Brian built a connection with his brother:

> “We weren't close, none of us are, because we weren't brought up to be that way… when he told me I also had this issue, and that he was concerned about it, it made me feel like there was family to go to”.

He was also trying to connect more with his sons. “I start by doing a self-scan and ask my boys to do the same, and they tell me how they’re feeling and doing. I ask about their day”. Another change is that he is trying to ensure his son receives a different message about sex than he had.

> “Recently I saw one of my sons looking at porn, and I haven't spoken to him about it. I don't know what to say to him. I don't want it to be something he doesn't do, or something he feels is wrong, but I do want to protect him and somehow tell him to be careful. I'm trying to find the right opportunity. I'm trying to be a good dad”.

It is interesting that he says “I saw” rather than “I caught on of my sons…” This suggests, along with the rest of the quote, that he has adopted a different approach towards sex than his parents did. He is also being more open with his wife. This is highly relevant given that his nature was to hide things from her.

Colin worked on insight into his own behaviour “I hated myself”, and David was better able to build an emotional attachment with his wife and connect with her

> “When I get uptight I find myself telling my wife, instead of keeping it inside for years. I feel much better now. ... You can’t deal with addiction on your own, you need the help”.

Eli was able to work on his relationship with his brother, and developed more empathy and understanding into his behaviour. “I’m reconnecting with my brother again” and “I don’t believe that porn is wrong, or that most of the things leading to my addiction are wrong, but the way I saw myself as a man, I think that could have been better if I had the insight”. He also developed more empathy for others and could see how his behaviour hurt them.

Similarly, Frank was able to connect more with himself, and with an other (his sister). Significantly, Frank noted that although he doesn't know who he is, he is free to be himself, and free from having to please others.

> "I'm working on building my personality, and my confidence and learning how to be myself, which is hard when I don't know who that person is. But at least I don't have to worry about who that person should be, to please other people and to fit in with them. So that's taken the pressure off that compelled me to become a sex addict. Without that impetus, I think a lot of the drive just went on its own accord. My meetings with SAA have also meant that I have something else to fill my time with when I feel I might break my sobriety. It's taken me years to get to where I am now, so I don't want to risk losing it all again"… "I realise now I don't have to impress a woman, and that I was using sex as a way of countering feeling depressed".

Adam, Brian and Frank mentioned other changes. For Adam, this was about becoming less selfish "Other men in recovery fight and then come to meetings and moan and how difficult life is and how it is forcing them to act out. I avoided all that. I didn't fight, I gave and didn't ask in return and this is what's making me into the human being I was meant to be before I got so screwed up as a young person".

Frank also noted "you have to give in and accept… it was good to finally not have to put on a brave or confident front". This feels like it could have been a significant point for him considering how often he mentioned in his interview that appearing confident was important to him.

Participants described different elements of what made their recoveries successful. They all experienced some sort of low point that made them decide to make a change (Turning Point), and described group features of SAA and individual therapy as being helpful in helping them achieve Sobriety. All gave different definitions of sobriety, and were in fact, living it differently.

Synopsis

In this chapter, the four themes and seventeen subsequent sub-themes were presented and illustrated through use of extracts from the interviews. The themes present a trajectory for therapists to conceptualize how sex addiction developed, and how the sex addict experienced this journey.

Throughout the analysis it became evident that the participants' experience of sex addiction is one which was influenced by a number of experiences starting from childhood, through to adulthood. Notably, all participants reported experiencing affective states prior to struggling with sex addiction, which were then further perpetuated by the addiction. It is evident that sex addiction had a significant impact on their sense of self, and their ability to make and sustain relationships with others. The experience of sex addiction was one that had a profound effect on the participants, yet they were all in a more optimistic position through therapy.

The presentation and interpretation of the findings are in no way exhaustive, however, efforts were made to ensure that the findings chosen for all the participants were bound by a common thread.

In the next chapter I will interpret the results through a theoretical perspective, and discuss clinical and research implications of the findings.

Chapter Six: Discussion

Introduction

In this chapter, the developed major themes and subthemes will be considered and evaluated vis-a-vis the existing literature. Each of the master themes will be discussed through theoretical lenses on attachment, addiction and personality development. Reflective and critical methodological considerations will be addressed, and recommendations for therapy, training and research will be suggested.

Overview of the Findings

The literature review strongly supported the view that attachment, relational trauma and broader sociological perspectives on addiction played a pivotal role in sex addiction. The current study seeks to shed light on the experience of sex addiction. As argued by Thomas et al, (2020), most information to date is quantitative in nature, and the profession needs to give attention to the person, rather than the behaviour. An important part of this inquiry is to develop an understanding of how the person makes sense of himself and others, and how these mutually influence and are influenced by their experience of sex addiction. From the data it emerged that childhood events may lead to a predisposition for sex addiction. These predispositions relate to personality traits, attachment styles and how the person views relationships and intimacy, and attitudes towards sex. I believe that the direction of the relationship amongst these factors is fluid, with each influencing the other. This in part, contributes towards porn-use becoming an addiction, because of the cyclical nature of influence amongst these predisposing factors.

In addressing the primary research question, the main themes that emerged were: Experience of Self, Relational Dynamics, Sex Addict and Sex Addiction, and Recovery. These are the themes that participants highlighted as being important to their identity and experience. Findings indicated that whilst the experiences leading towards addiction and eventual recovery were different, the underlying affective states were common amongst the participants. These affective states are what gave meaning to their experiences.

Experience of Self

This theme was divided into Aloneness, Self-Perception, Double Bind and Sense of Entitlement. A link exists between the sub-themes, in that negative affective states, such as through experiencing aloneness or being in a double bind, shaped their sense of self.

The self is an agent with specific qualities that are related to autonomy and regulation, (Fonagy, Bateman and Bateman, 2011). It is constructed through contingent distress modulation and emotional synchrony, first in the mother-infant dyad, then through other interactions to create relational patterns (Omaha, 2004 and Mitchell, 2000). Significantly, all participants reported absent parents and difficulties in relating to others later in life. From infancy we rely on the other to regulate, and fear being alone. Yalom (1980) refers to this as “Existential Isolation”. According to psychodynamic thought, the antithesis to Aloneness is a sense of being loved, and worthy of love (Cassimatis, 1984). Woods (2013) carried out research amongst participants who were attending a psychodynamic therapy group for porn addiction. Fears of abandonment stemming from childhood experiences was prevalent amongst the group.

I drew on the transcripts, together with my reaction towards the participants and thought about possible clinical conceptualization and personality traits of the participants. All experienced being humiliated, which allowed me to understand their profound sense of worthlessness and shame, and their attempts to stop these feelings (Johnson, 1994) by engaging in hypersexual behaviour. This behaviour led to further shame, which put them in a double bind.

Their sexual behaviour could therefore be understood as a coping mechanism in response to their shame. All participants lacked a secure base, which suggests there was no “mirroring” experience (Target, 1998) of how to deal with the tension of coexisting ambivalent feelings. As a result, participants might have resorted to masturbation and other sexual behaviour to regulate tension (Schore, 2003).

Furthermore, their sense of worthlessness from not feeling loved may have manifested as a grandiose “false self”. The “false self” can develop from not having a responsive care-giver (Schore, 2003), and according to Kohut’s theory of self-psychology, is the underlying foundation of narcissistic traits. Kohut saw narcissism as a normal developmental trait, which could become pathological (Kohut, 1971). This is supported by a study carried out amongst in-patient sex addicts at a rehabilitation program, which showed that sex addicts were more likely to show narcissistic traits, lacked self-compassion and efficacy, and had greater pathological senses of entitlement and concern than drug addicts and control individuals (Efrati, Gerber and Tolmacz, 2019).

Dodes (1990) explains the link between narcissistic traits and the Double Bind, or internal conflict when engaging in an addictive behaviour. It is an attempt to maintain psychic control, by engaging in a behaviour (in this case porn-use) in order to control one’s affective state. Addiction

> “provides a mechanism to re-establish such a central area of omnipotence, it may serve as a corrective when an addiction-vulnerable individual is flooded with feelings of helplessness or powerlessness. That is, by acting to take control of one's own affective state, addictive behaviour may serve to restore a sense of control when there is a perception that control or power has been lost or taken away. There is clearly a paradox here. While I am suggesting a role in addiction for an unconscious process of restoring a sense of control, addictive behaviour itself is inherently a matter of being out of control; simultaneously, then, addiction reflects both ego functioning and a loss of elements of ego functioning. The paradox is real, but also may be understood as the result of conflict: between a deeper need to ward off perceived helplessness and powerlessness, and other, healthier elements of the personality which become overwhelmed”
>
> (Dodes, 1990, pp. 402).

All the participants in the current study reported that they felt lonely and isolated, particularly during childhood. Loneliness has been found to contribute to the level of sexual compulsion (Lawal and Idemudia, 2018). Duffy, Dawson and das Nair (2016) also add that sexual addiction leads to a sense of isolation in sex addicts and their partners. It is unclear from Duffy, Dawson, and das Nair’s study if a sense of isolation was already present and further exacerbated, as was the case for Adam, Eli and Frank, who said that they lost friends because of the addiction, and/or that the addiction isolated them from others. Kotera and Rhodes (2019) found that sex addiction was associated with adverse childhood experience, and that anxious and avoidant attachment styles were a moderating factor. Other studies also show a strong link between sex addiction and early childhood experiences in the family that created conflict, turmoil, and misunderstanding, (Carnes and Lee, 2014).

A sense of entitlement was found to be of paramount importance in determining the quality of a couple’s relationships (Tolmacz, 2011). Furthermore, Hayes and Dragiewicz (2018) assert that sexual entitlement (the belief that men are entitled to sex) contributes to relational dynamics wherein the entitled person’s sexual relationships serve to fill a need for power and meet their own needs.

To summarise, there is evidence to suggest that the four sub-themes identified within the theme of Experience of the Self, namely Aloneness, Self-Perception, Double Bind and Sense of Entitlement, are linked to narcissistic traits, porn use, and addictive behaviour.

Relational Dynamics

This theme was divided into four sub-themes, Dynamics of Family of Origin, Messages about relationships and sex during childhood, Romantic Relationships, and Sex versus Intimacy. It shows a trajectory of how the addict learnt to relate to others, and learnt about sex, throughout childhood and adulthood.

Part of the process of identity formation involves perceiving the other's perception of the self (Gallese, 2005). The previous section covered how early relationships with care-givers are the baseline for developing a sense of self, and this section will cover how it is also the baseline for learning about relationships. The topics were split superficially for discussion purposes, however it should be noted that the process is one.

Responsive and attuned caregivers allow the infant to develop an awareness of feelings, and allow the child to know that these are the child's feelings, not the parent's. Minor misattunements create manageable levels of stress promoting brain growth and neural network integration (Cozolino, 2010). This is the basis for learning to interpret others' thoughts and behaviours (Gerhardt, 2004). This capacity, referred to as reflective functioning, allows the infant to understand mental states in self and others. It is influenced by the attachment process, and involves an interpersonal and self-reflective component that allows the individual to distinguish between inner and outer reality, pretend from real modes of functioning and interpersonal from intrapersonal. Exploring the meaning of others' actions is a precursor to labelling and finding meaning of the self's actions. This underlies affect regulation, impulse control, self-monitoring and self-agency (discussed later) and therefore organisation of self (Fonagy et al, 2002). Participants all had difficulties in these areas in adulthood. These interactions will serve as a template for future relationships, and influence and are influenced by sexuality (Gerber, 2008).

A consistent lack of a sensitive and infant-attuned mirroring environment impairs the establishment of secondary representations for the infant's self-states, which are necessary in making affective impulses accessible. Target (2007) explains that this starts in infancy when the primary care-giver poorly mirrors the child's state of sexual arousal:

> "the infant in a state of sexual tension is generally not offered a congruent metabolised representation of his or her psychosexual feelings, even when others are sensitively responded to … [hence] there cannot be an effective experience of containment or even a sense of ownership of these feelings."

(Target, 2007, p. 522).

However, presumably, mother-infant attunement occurs frequently enough to counteract this, and is enough for the infant to form a secure sense of self. It is when attunement consistently does not occur that psychopathologies may arise (Schore, 2003), impacting affect regulation. An infant with poor affect regulation may experience sexual tension as threatening, and therefore has to find alternative ways to self-soothe (Target, 2007).

Dewitte (2012) describes sex and attachment as being independent yet mutually supportive and functionally similar systems that have distinct evolutionary goals. Within both systems, cognitive-motivational processes are activated in response to incentive stimuli and are primarily directed toward regulating (both one's own and others) emotions. Distress further activates the attachment system, driving the infant to seek proximity with the neglectful parent. Reflective functioning is impacted because recognising the mental state of the other can be dangerous, an admission that the child is unlovable (Fonagy et al, 2002). This in fact, was a common to all participants.

In response to an emotionally absent caregiver, the child becomes attuned to the other's needs, to attempt to establish an emotional attachment, in the process creating a false self (Schore, 2003). The infant will learn that the caregiver cannot be relied on for soothing (Banai, Mikulincer and Shaver, 2005). This shows the synchronicity in the development of perception of self and perception of other. In the case of the participants, they anticipated being rejected and abandoned, and prevented this from recurring by having relationships were they did not get attached.

Research carried out by Klukas et al (2021) showed that parents who were rejecting and controlling were more likely to have negative attitudes towards masturbation. The current study supports this finding, since all the participants reported having absent parents, who had very sex-negative views. They did not facilitate an environment at home where it was safe to talk about sex. This seems significant to all the participants, as it shaped their views on sex and sexuality. This prompts the question: How can healthy sexual attitudes and behaviours develop if our sexual psychic structures are based on negative messages? Sexual working models are psychic structures that incorporate representations of self, other and the erotic and sexual (Delmonico and Griffin, 2002). Early affective autobiographical experiences involving love, challenge, fear, illicitness, intimidation and conquest are more influential (Schwartz and Southern, 2017), and these are consolidated during adolescence and adulthood.

Lichtenberg, Lachmann and Fosshage (2011, p. 28) differentiated between the sensual and the sexual:

> "The universal pursuit of many body sensations of pleasure, that is, sensuality, is often accepted, approved, and shared by parents, society and the culture. And the pursuit of other bodily sensations of pleasure is disapproved and prohibited by inducing shame. The prohibition and shaming results in a category of experience we call sexuality, a category of experience that is intrinsically associated with further arousal from the added excitement of transgressing the restrictions and subverting the pronouncements of authority".

This is relevant to the participants, firstly because it suggests that sensual and sexual are different because of the reaction of the Other. Where pleasure is shared with the Other, it is sensual, where it is shamed by the Other, it is purely sexual. This parallels the distinction that participants appeared to draw between intimacy (sharing with the Other), and sex (using the Other). This shows the link between family of origin dynamics and how this impacts sexual expression and intimacy in romantic relationships.

With regard to sexual relationships, it is interesting that for the participants sex addiction did not manifest as very frequent sex with the same partner, but it required novelty and variation (features typical of addiction). In fact, the participants all commented that they had lost interest in their spouse. Schneider's (2007) study amongst sex addicts and their partners found that among 68% of the couples one or both had lost interest in relational sex: 52% of addicts reported decreased interest in sex with their spouse, as did 34% of partners. Some couples had had no relational sex in months or years (Schneider, 2007). The participants in the current study all indicated that their addiction had started prior to them losing sexual interest in their wives. However, they did not elaborate if sex with their partners had always been lacking intimacy and mutuality, or if that developed later.

The findings of this study are in line with Eagle's (2007) and Mikulincer and Shaver's (2007) work, discussed in the literature review. The participants had negative models of self, which they attempted to improve through having sex, were very sensitive to rejection, gave a lot of meaning to sex, and were hypervigilant to signs of arousal (saying that it controlled them, as discussed under the theme of Addiction). They did not give importance to their partners' pleasure, and were emotionally distant from them, and valued sex over intimacy.

Throughout the interviews and reading the transcripts, I was very aware of the participants' style of speaking about others. In fact, in McKinney's (2014) study of therapists who work with sex addicts, therapists reported experiencing the interaction with their clients as lacking mutuality, that is, the clients related to therapists from Buber's "I-It" position. It follows that addicts also show this way of relating in other contexts. The "I-It" position was also apparent in the way they spoke about sexual relationships in particular, lacking intimacy and mutuality. This is a feature common in people with narcissistic traits.

Another feature of the participants that is suggestive of narcissistic traits, was their patterns of seduction and withdrawal (Smith Benjamin, 1998). At a physical level, this is evident in the repeated level of sleeping with someone and not fostering a relationship with them, only using the person for sex. Furthermore, this could also have occurred at another level, with their co-dependent partners, whereby after the seduction (entering a relationship with their partner), their partner becomes dependent when affection and attention are withdrawn, and they feel helpless.

Linking this mode of relating to personality traits, it can be posited that the participants in the study lost sexual interest in their partner, after their partner no longer served the purpose of fulfilling the addiction (as a sexual novelty). According to Johnson (1994), within the narcissistic spectrum, an Other's significance is based exclusively on their attachment to the person, valuable only as they relate to oneself, existing only to serve one's needs unconditionally. When those needs are no longer met, they lose interest.

More research needs to be carried out on co-dependent partners in sex addiction. However, Smith Benjamin (1998) suggests a co-created dynamic, whereby "submissive nurturance" invites exploitation and entitlement by the partner, in this case, the sex addict. Individuals with severe attachment disorganization are likely to rely on dissociative sexual responses as a self-soothing mechanism (Holmes, 2014). These strategies include high-risk, shame-inducing sexual behaviours. In doing so, sex is not based on mutuality, but on dominance and submission.

Efrati, Gerber and Tolmacz (2019) postulate that one reason why porn addiction is correlated to narcissistic personality is because porn commonly depicts women in humiliating and degrading ways. This fulfils the narcissistic need to belittle and project vulnerability onto the other (Kohut, 1971). Porn promotes heteronormative views, with male sexuality being seen as more powerful than women's, and hence men's sexual needs being given more priority (Dajches and Teran, 2020). Men are expected to be obsessed with sex, and women are expected to conform (MacNair, 2013). This fosters a lack of empathy and consideration towards the other. Throughout the

interviews it was clear that participants held somewhat traditional views of their partners, seeing them as objects who were there to serve them. They were not interested in mutually satisfying sexual relationships with them. They did not have much consideration for their feelings, lied to them and did not express remorse (during the interview) for infidelity. The participants did not make clear that their views were shaped by porn, and it is possible that they held these beliefs prior to being addicted to porn, or perhaps that these views put them at greater risk of being addicted to porn. All this evidence gives more weight to the anti-porn feminist argument.

The research presented in this section shows continuity between the experience of self, and relating to others in sex addiction.

The Sex Addict and the Addiction

This theme pertained very much to the meaning the participants attributed to the addiction, and how they experienced it. The sub-themes identified were Perception of the Addict Powerlessness, Rationalization and Deception, the Purpose of Addiction and the Nature of Addiction.

Phillips, Hajela and Hilton (2015) state that sex addiction is regarded by others as a "moral failing" and those suffering with addiction were treated harshly and with great prejudice and fear. Significantly, though participants showed little insight into the thinking of Others' in other contexts, they were all aware of the negative attributions given to sex addiction. Perhaps this is because they too shared these prejudices. Could this shared negative view of the self be a hindrance that prevents the sex addict from seeking to connect with an Other? If this is the case, then there is a cyclical pattern of interaction between Perception of Self, Relating to Others and Addiction. The addiction would serve to perpetuate the negative sense of self, and further block the addict from reaching out for help.

Only David and Eli spoke about their children knowing about their addiction, and they wished that their children were more supportive. Schneider (2007) noted that adverse effects on addicts' children included (a) exposure to cyberporn and to objectification of women, (b) involvement in parental conflicts, (c) lack of attention because of one parent's involvement with the computer and the other parent's preoccupation with the cybersex addict, (d) breakup of the marriage. However, Schneider's study ignored the possibility of how sex addiction might affect the addict's child, when the child isn't aware of it. This was the case for Brian's son, who knew of his parents' relationship difficulties but not about the addiction. Brian was the only participant to suggest he wanted that his sons have a healthier attitude towards porn but he wasn't sure how to go about it. This

suggests that at an implicit level, Brian's addiction, and subsequent recovery, could have had an impact on the attitudes and values he tried to pass on to his sons.

Another predominant feature was powerlessness, which according to Dodes (1990), is a contributing factor to the development of an addiction.

> "In many cases addictive behaviour serves to ward off a sense of helplessness and powerlessness via controlling and regulating one's affective state. Addicts have a vulnerability to feelings of powerlessness, which reflects a specific narcissistic impairment.
>
> (Dodes, 1990, 398)

The participants' perceived powerlessness led them to shame and secrecy, and perpetuated their sense of aloneness. It is not clear if the participants had identified their sense of loss of control prior to joining SAA, or if they were influenced by SAA discourse, however other sex addiction research shows that it is an oft-reported phenomenon (Andreassen, Pallesen and Griffiths, Torsheim and Simha 2018, and Briggs, Gough and das Nair, 2017). The discourse of loss of control positions the addict as passive, and adopting the "sick role", and therefore not accountable for the behaviour (Briggs, 2014). This has implications within the therapeutic space. If loss of control is taken to imply lack of accountability, then part of the therapeutic process would be to establish accountability and self-agency (Medina, 2012).

I understand the participants' motivation to engage in the addictive behaviour through the lens of Lichtenberg's theory of motivation (Lichtenberg et al., 2011) which states that we are motivated to satisfy needs - regulation of physiological needs, attachment and affiliation, exploration and assertion, averseness, sensual enjoyment and sexual excitement. Collectively, these needs may be seen as a drive towards maturation, which Rogers (1961) considered to be our primary motive, i.e. to maintain and enhance the self. Humans are motivated to seek experiences that confirm their expectations, and information that contradicts these expectations is ignored (Rogers, 1961 and Bowlby, 1969). This is because at times, the motive to mature and the motive to repeat what we already know may be conflicting. This conflict leads to incongruity within the self-structure or a double bind (Fonagy et al., 2002), and is managed by seeking further attachments or experiences that would confirm our beliefs so that our sense of reality becomes coherent (Migone and Liotti, 1998).

For the participants, the motivation to satisfy sexual excitement outweighed the need for attachment and affiliation. This may be partly due to the fact that the participants had histories of

insecure attachments, and this led them to engage in behaviours that would not challenge their expectations. Their attachments were devoid of emotional intimacy, however, their need for closeness still prevailed. To address this need, they engaged in sexual behaviour. Masturbating to porn provided a safe medium to fulfil their need for intimacy, without risking being rejected. In fact, masturbating to porn is often a replacement for intimate relationships (Carvalheira, Træen and Stulhofer, 2015 and Taylor and Gavey, 2019).

Metacognitive theory further explains motivation for engaging in addictive behaviour (Thomas et al, 2020). According to this theory, a trigger activates negative metacognitive beliefs about control (i.e. I have no control over my sexual desire), and positive beliefs about extended thinking (i.e. thinking about sex will make me feel better), therefore negative affect and cravings are simultaneously occurring. This leads to a reduced ability to regulate the behaviour. After engaging in the behaviour, the person ruminates about why the behaviour occurred. Thomas et al (2020) found that mental self-talk and thoughts of the need for sexual activity increased as perception of dysregulated sexual desire increased. The findings of the current study support this research, showing that the participants all believed they could not control their behaviour, and that masturbating to porn (and other sexual activity) would make them feel better. The participants also engaged in ruminating about why the behaviour occurred, through rationalizing it to themselves, and to me as the researcher.

A common thread for the purpose of addiction is that it arose from experiences that induce negative affective states, although the context was different for each participant. Hypersexual disorder and sex addiction refer to the reliance on sex in response to dysphoric moods (Kingston, 2018), however the literature does not specify that the behaviour is an immediate response to dysphoria. The participants' sense of dysphoria appears to be chronic and pervasive, a state, rather than a temporary mood, and that the addiction's purpose was to bring relief to their otherwise constant affective state. This concurs with Berry and Berry's (2014) finding that out-of-control sexual behaviour may often be a maladaptive psychological strategy to defend the individual against difficult or problematic thoughts and feelings.

A feature of addiction common to all the participants was an evasion of guilt and responsibility prior to recovery, as evidenced by statements of justification (or rationalization) for their behaviour or minimizing the consequences. Colin was the only participant who did not hide porn use from his wife, as they watched it together. However, he did hide other behaviours from her. The other participants also deceived and hid their behaviours from their partners and others, and this appears to have had a significant effect on the relationship. In other studies, sex addicts' partners

reported that being lied to repeatedly was a major cause of distress (Schneider, 2007). The presence of sexual addiction in a romantic relationship can result in lack of trust, feelings of shame, anger or betrayal, and ultimately the deterioration of the relationship (Love, Moore and Stanish, 2016). This happened with both of Adam's marriages, Colin, Eli and Frank. David's wife had left him for about a month until his children intervened, and Brian's wife was not fully aware of the extent of the addiction. Furthermore, they were already in therapy when he told her.

Burris and Schrage (2014) concluded that social perception of addiction increased anxiety and perceived stigma. This in turn led to dissociation and concealment strategies (deception) in sexual situations. Rationalizing the behaviour was a form of dissociating from potential negative consequences. By lying and dissociating from the problematic behaviours, the sense of self can be preserved (Tsang, 2002).

When describing the nature of the addiction, participants did not quantify it, or discuss behaviours they engaged in. Instead, they discussed features of addiction such as planning, feeling better or relieved afterwards, engaging in the behaviour to alleviate a distressing feeling, a lack of control, and negative effects on their relational, occupational and social functioning (Carreno and Pervez-Escobar, 2019). The wide variety of descriptors shows how personal the experience is, and perhaps how sensitive researchers and clinicians need to be when trying to define sex addiction. It would be impossible to have a definition that covers each individual's experience; it would be more beneficial to think of sexual addiction as a clinical concept, which can combine any number of behaviours, frequencies and meanings attributed to it.

Process of Recovery

The final theme was divided into four sub-themes, Turning Point, Benefits of the Group Setting, Personal Therapy, and Sobriety and Change. It should be noted that although the division into sub-themes implies that there is a linear trajectory, this is not necessarily the case. The process of recovery, as was the addiction, was idiosyncratic for each participant, however, they managed to construct common meanings through different pathways.

The primary motivators for controlling the behaviour for the participants appeared to be getting caught by family, and having to facing severe consequences for the addiction. At both these junctures, it means that addiction can no longer be rationalised or denied (Heaton Matheny, 2002). According to Canning Fulton (2002), this process involves making the unconscious, conscious. Several studies show that sex addiction therapy is often precipitated by the spouse

finding out about it (Fearing, 2001). The implications for this are that the therapist is therefore potentially having to deal with the addiction, as well as possible termination of the relationship (Schneider, 2007). More recent research however shows that the increased amount of information online is allowing more people to “self-diagnose” and this is their first step in their recovery (Dhuffar and Griffin, 2015). Another possible reason as a motivator to change that was not covered in the present study, is engaging in ego-dystonic behaviours (behaviours which they believe defy their identity) (Saunders, 2006).

At different stages in their recovery, participants attended SAA. For some it was the first form of support they sought, others reached it after having had individual therapy. According to Parker and Guest (2002G) and Woods (2013) psychotherapy (of different modalities), and 12-Step programmes can successfully be integrated in sex addiction therapy.

The analysis revealed that all participants found the SAA meetings to be a vital and challenging part of their recovery. This in itself is to be expected, since they were recruited through SAA, however, it is a finding consistent with other research (Nerenberg, 2002).

According to the 12 Steps of SAA, attendees must first “surrender to a higher power”, and admit that they are powerless (SAA, 2021). Initially it seems counter-productive, given that the addiction may have escalated due to a sense of powerlessness to control it. However, the meaning attributed to this powerlessness is phenomenologically different. In the first instance, the participants’ powerlessness was accompanied by fear, disgust and shame. In the second, their powerlessness was accompanied by acceptance. Participants found this initial step of acceptance to be particularly salient to their recovery.

Participants highlighted how being in a group helped them in ways which they couldn’t have had in individual therapy, for example, by hearing others’ stories. According to Woods (2013) the group setting provides intimacy without sexualisation, primarily through a sibling transference. Research on other addiction groups, also shows that the benefits of the group setting include developing empathy and emotion regulation (Stone, 2017). Despite the challenges (being overwhelmed by others’ experiences, not agreeing with all SAA philosophy and guidelines), through attending regularly, participants began to see the benefit in attending by feeling connected with other attendees, and could see the therapeutic value in trusting and sharing with others. They found it beneficial to learn that they were not alone, and that others had similar experiences, a concept Yalom (1980) referred to as “Universality”.

There is no evidence to suggest that a group setting of SAA is more advantageous to individual therapy, or that one should attend both, as was the case for the participants.

An oft-cited difficulty in sex addiction therapy is that therapists feel they did not have enough training (Coleman, 2015). The findings of this study would confer with this, as participants reported having reached an impasse with their therapists and needing to be referred elsewhere. Watson and Vidal (2011) found that therapists do not receive training in this area, and experience anxiety about the legitimacy and efficacy of their work. In a study with a group of master level addiction counsellors, 92.5% reported never having received training in the area, yet they all worked with clients who faced sex addiction (Hagedorn, 2009).

I am reminded of the participants' experiences of being referred on to SAA or another professional or service for further therapy. This parallels the narcissist's process of splitting – of having things they do not share with others because there is something so bad about them that it must be hidden (Johnson, 1994), and of fragmenting different elements of their self (Watson and Vidal, 2011).

All participants touched on the nature of addiction and sobriety, each giving their own definition, which shows how difficult it is to define what sex addiction is and what recovery would be. The "definition" (if any) should be one that considers the nuances, how each individual defines it and experiences it. David mentioned that sobriety would be different to everyone, however what is interesting is that there was a commonality to all participants' recovery, in that it involved connection with others, and with the self. Participants indicated that recovery from addiction is an ongoing process, and that relapses were a possibility. Further research could be done on relapse in sex addiction, exploring what brings it on, and how the person makes sense of it.

Interestingly, participants did not mention impediments or challenges to their recovery, apart from Frank who mentioned financial reasons. This information would have been useful in identifying how the process of recovery could be better facilitated.

Implications for Counselling Psychology

Therapy

Therapy requires that therapists are able to their regulate body-based emotions and shame, while staying connected to the client, especially as the client may be in a dysregulated state (Schore, 2003). Bollas (1982) suggests that therapy should be a reconstruction of the infant's holding environment. This is because the mother-child relationship is the foundation for the capacity to

symbolise, empathise and the ability to develop a perception of self through another person's thinking and feeling (Fonagy et al, 2002). If during childhood, clients experienced shame in the holding environment, it would be reparative for them to experience therapy as an intrasubjective space where their sexuality can be held contained, and eventually integrated into their sense of self, without shame. If therapy can arouse this state and the therapist responds to it differently to the client's previous experiences, the client can learn to relate differently (Gerhardt, 2015). For sex addicts, this would mean that a goal of therapy would be to integrate their sexual behaviour, including what meanings they ascribed to it, into their identity. This is different to "accepting" the addiction in the way that is done when they are rationalizing it. The therapist can work towards this goal by working on insight as to why the addiction arose, and what relational injuries preceded it.

According to Johnson (1994, p. 306), one of the aims of therapy to address narcissistic traits is to

> "access self-statements of reliance on achievement, grandiosity, pride, entitlement, manipulation and rationalization"

The transcripts were laden with such statements from the participants, they all had a sense of entitlement and rationalized with regards to the behaviours. For example David spoke with grandiosity when he said his girlfriend would have married him, a year after he stopped paying to see her, and showed manipulative tactics when she refused to see by paying for her services through the website so that she couldn't refuse. Therapists need to be aware of these nuances in the addict's speech. From here, they can work with the client to increase awareness, and to reflect on what their speech implies. This will be the foundation for identifying deeper, meaningful change that the client can work towards (instead of solely focussing on reducing acting out behaviours).

In light of this, enactments, erotic transference, and counter-transference could be therapeutic, if processed. In fact, Woehler, Giordano and Hagedorn (2018) reported that working with relational depth helped clinicians conceptualize sex addiction treatment and address client shame and attachment insecurities. Adam said that his therapy was helpful because it addressed trauma and self-pity, David said he was able to connect to his loss. This indicates that they were working with relational depth, and not just focusing on symptom-management.

Insecure attachment prevents the formation of secure relationships and disrupts affect regulation. These can be key factors in the maintenance of sexual addiction (Benfield, 2018). Sex addiction treatment strategies may therefore benefit from incorporating a focus upon developing the

capacity for secure attachment, alongside treating sexual compulsivity. This would serve as the basis for developing the client's reflective functioning capacity.

Being thought about (by the therapist) in a contingent way facilitates the capacity of the client to feel safe and think about the social world. This in turn encourages the development of intersubjectivity. In order to do this, the therapist would have to accurately represent the affective state of the patient and its accompanying internal representations (Fonagy et al. 2002). For example, with the participants of this study, therapy could involve recreating a new representation of intimacy with others, from being something which is to be avoided, to something which can be mutually beneficial. Similarly, the affective state of being aroused, and its representation, where sexual arousal and sex are seen as disgusting, shameful, or an area to exert power, and fragmented from the self (as evidenced by the externalization of the addiction "it made me …") to a part of the self which is robust, does not invoke shame and have to be kept secret, and is an integrated part of the self.

In light of narcissistic traits, trauma, significant isolation and attachment styles, sex addicts are at risk of co-morbid issues. These could also be pre-existing prior to the addiction. The Personality Assessment Inventory (PAI) was administered amongst 222 sex addicts in residential treatment and found that 22.8% had No Comorbid Psychopathology, 14.9% had Dysfunctional Negative Emotions, 38.1% had Mild Depression and Substance-Related Problems, Clinical Depression and Anxiety (18.8%), 5.6% had Severe Psychopathology (De Guzmán et al 2016). It was beyond the scope of the current study to assess for comorbid conditions, and none of the participants made direct reference to having been diagnosed, however, this could have been because they were not assessed during the course of therapy.

Ultimately, the aim of therapy would be to facilitate an understanding and identification of emotional states which precipitated and maintained the addiction (such as Shame, Isolation, feeling humiliated, avoidant and traumatic attachments, narcissistic injuries). This is highly relevant following from Kor et al.'s (2014) study on neuroimaging of sexual motivation in sex addicts (mentioned in the literature review), which found that sexual motivation had less to do with pleasure than with extrinsic rewards such as recognition. It could explain why the participants did not discuss pleasure and arousal, or sexual preferences. This study showed examples of what those extrinsic rewards were for the participants (highlighted in the sub-theme, Purpose of the Addiction).

Therapy should also focus on addressing internal conflict and a fragmented sense of self that arises from engaging in sexual behaviour which is perceived as incompatible with personal values (Walton, Cantor, Bhullar and Lykins, 2017).

Prall (2004) suggests an approach to psychotherapy that involves asking questions (usually the ones clients don't want asked), rather than a reductionist approach that leads towards succinct theories. Based on this, I have compiled a list of questions, informed by this study, which therapists could reflect on and address during supervision. Clinical supervision is considered to a standard ethical practice across all modalities (BPS, 2014), however, I believe it is particularly necessary when working with sex addiction. Leading up to therapy and recovery, the participants all showed poor reflective capacity, as evidenced by their lack of empathy towards partners, their faulty cognitions regarding addiction, their fragmented sense of self, and their inability to sustain secure relationships. When facing such clients, the therapist is at risk of diminished reflective capacity, particularly if they have an insecure attachment style (Bucci et al, 2016), or if they have a history of sexual ruptures (Benfield, 2018). Supervision would be especially salient, an opportunity for therapists to be in a containing environment to reflect on their difficulties and blind spots. I have based these questions on my experience of having carried out this research, having identified what some of the challenges were for me, and based on what previous literature suggests about therapists working with sex addiction:

1. What is your theoretical framework for understanding psychopathology?

2. How would you define sex addiction? Do you use other terms instead? What behaviours would you include under sex addiction?

3. What are the dominant sexual values and attitudes in your culture? In your client's/participant's? Do these align?

4. What are your views on porn use?

5. When does porn use become harmful?

6. Thinking back to relational and sexual ruptures in your history, is this work likely to be emotionally challenging for you?

7. Would this work be challenging to discuss in supervision? What might the underlying cause of those difficulties be?

8. What supports you professionally when you experience shame?

9. How would you respond to erotic transference/counter-transference dynamics within the researcher-participant dyad, or therapist-client dyad?

10. In your work with this client, who is defining the issue as sex addiction? (You, your client, their spouse, another professional they have seen?)

This list is not intended to be comprehensive, but a starting point for therapists and researchers to begin to reflect on working with sex addiction. As highlighted in previous chapters, defining sex addiction has been influenced by a number of conflicting political streams of thought, as well as theories of psychopathology. To varying degrees, these will influence the therapist, and the client. They will therefore define the scope of therapy. These questions invite therapists to think about the broader societal, influences on their clinical thinking, as well as to reflect on more personal material about how they might be influenced by and influence the work.

Research

Emotional support for the researcher is not given as much importance as emotional support for therapists (Coles et al 2014). However, I believe it is crucial when working with sensitive data, especially research that requires the researcher to immerse herself in the data.

On the topic of prostitution, Hammond and Kingston (2014, p.54) asked “What kind of woman does such research?” This is because researchers investigating stigmatized behaviours tend to be stigmatised themselves (Hammond and Kingston, 2014). They face backlash by the academic community, as well as within their personal circles. Research on sexuality makes the private, public. The boundaries on what is legal and illegal, and what is healthy and pathological are pushed (Hammond and Kingston, 2014), therefore making it especially difficult on researchers, in a way which other topics would not.

Connolly and Reilly (2007) investigated the impact that investigating sexual violence had on researchers. They found that researchers were very likely to develop secondary traumatic stress

and identified several ways in which the researcher may be affected. For example, through resonance between the story of the participant and the life experiences of the researcher, complex researcher roles and identities, power imbalances in the researcher-participant relationship, the need for compassion for the participants, and insufficient self-care for the researcher. At various stages, I encountered these difficulties.

This study has taught me to seek support, not just in terms of understanding the data and the technical aspects of the research process, but also to allow the personal to integrate with the professional self. This deepened my understanding of the data, and helped me be fairer towards the participants. However, it was only possible by being transparent with my supervisors (and the readers) and processing what I was experiencing through personal support and supervision. It could be argued that my personal trauma may have reduced the quality of the study, by impacting my ability to be objective. Instead, by having support, I argue that it enriched the research inquiry, as it allowed me to empathise more with the participants.

Based on my experience as a researcher in this study, I recommend that researchers reflect on potential traumatic triggers prior to engaging in the material, through using a journal, personal therapy or research supervision. It would be helpful to reflect on personal and professional values regarding the topic, and ensure that they have a good support system.

Contribution of the Study

This study contributes to the field of Counselling Psychology by providing a trans-theoretical framework for understanding the experience of sex addiction. According to Barker (2014, p.124) there needs to be a move away from experimental behaviourist research and adds

> "critical and applied psychologies, in particular, have much to contribute, with their ability to analyse the ways in which pornographies, sex and gender are constructed, and to hold on to the lived experiences of those engaging with pornographies".

Using IPA as a methodology has given an alternative to the prevalence of quantitative studies in the area, mostly dominated by the Medical Model. This study has allowed for a more in-depth understanding of living with sexual addiction, beyond what is presented in statistical studies and in the media. The findings demonstrate the complexity of factors that contribute throughout the person's life towards exacerbating sexual addiction. By not focusing on symptomatology and objective truths, the study contributes to the field because it emphasized subjectivity of the participant.

According to social constructionism,

> “client problems exist in and are mediated through the language used to frame their experiences. Human sufferings can be influenced by the descriptions applied to them”
>
> (Chen, Noosbond and Bruce, 1998, p. 77)

Subsequently, change in language can lead to a change in the client’s experience (Chen, Noosbond and Bruce, 1998). This study contributes to the field of knowledge by providing in-depth descriptions of the language used by sex addicts themselves to describe their experience and how this has shaped them. Smith (2017) calls precisely for this: “the phenomenological clarification of their experience” so as to facilitate agency. He sees sex addiction not as pathology, but as a manifestation of how the person relates to their lived experience. By understanding the phenomenology and meaning attributed to the experience of sex addiction, therapists will be able to formulate a therapeutic understanding of the person’s experience.

This study has also provided a developmental perspective of sex addiction, as links were drawn between early childhood experiences, teenage experiences and how these had some bearing on sex addiction. It showed how sex addicts see themselves, others, and what meaning they give to their experience of sex addiction. It also highlighted preceding thought processes that led to the behaviours, which, as previously discussed in the literature review, was deemed a necessary component of successful therapy (Shepherd, 2010). Previous studies mostly focussed on behaviours and factors in adulthood (de Alarcon et al, 2019). Longitudinal studies would be needed to give a more detailed understanding of developmental factors.

One area where this study provided insight was on how the participants experienced disclosing to partners and family members, or being discovered. This is relevant to therapeutic practice, because involving the addict's current family unit in therapy contributes to changing the behaviour (Carnes and Lee, 2014), yet little is known about how clients experience it. Furthermore, little is known about the therapy of sex addiction within a romantic relationship (Love, Moore and Stanish, 2016). The study therefore begins to address this gap in the research.

It is important to note that clients may attend therapy but might not mention problems with sex addiction initially. They may present with other issues, such as co-morbid substance abuse, mood and anxiety disorders (Hagedorn, 2009). Sex addiction may be hidden behind other issues and disorders such as depression, suicidal ideation, or relational difficulties. This study is contributes to the field because it provides insight into how clients may present in therapy vis-à-vis early childhood experiences, reflective functioning and attachment styles.

Arguments for pathologising porn have long been based on evidence that it does harm (Klein, 2016). Indeed, the current study does show that the participants and their loved ones experienced significant distress because of their porn (and sex) addiction. I believe the role of Counselling Psychologists is to educate further on this matter. Psychologists have a role in reducing the harm, highlighting potential experiences that could put people at risk of developing sex addiction, as well deconstructing societal beliefs by "depathologizing" sex addiction and understanding it in terms of early ruptures and developmental history.

Lastly, by creating more understanding, this study aims to contribute towards the destigmatization of sex addiction by understanding its phenomenology. This can lead to a more empathic and therapeutic stance, which will benefit both client and therapist.

Limitations

In this section, I will evaluate the current study in terms of the methodology and method chosen. Firstly, this research is based on a self-selected sample. This raises questions about pre-existing attitudes towards sex addiction and the possibility that the participants were all a certain 'type' of individual who are prepared to share their personal experiences (Catania, Gibson, Chitwood and Coates, 1990). However, such bias is difficult to avoid in such a study. Further investigation might reveal the extent to which the men in this study might be representative of men who are sex addicts.

Some criticisms of the study relate to the selection process. Although the sample was open to all SAA attendees across the UK, participants in the sample were Caucasian and therefore, the sample was not culturally diverse. Other cultures may have different perspectives on sex addiction, and how it is lived, and perhaps how it impacts family members. Moreover, the participants were self-selected on the basis that they self-identified as sex addicts. Objective assessment might have indicated otherwise. However, this decision was taken so as to respect participants/clients autonomy. Another limitation was that participants were only recruited through SAA. Therefore the study might not reflect the experiences of people who had different paths towards recovery. Also, all the participants would have been influenced by the philosophy of SAA, which might have had a bearing on the overall results. A sex addict who attended therapy but not SAA might have a different understanding and experience.

A possible criticism of the study is that it perpetuates the use of a socially constructed label. Briggs, Gough and das Nair (2017) argue that sex addiction is used as a stigmatizing label for

those who deviate from a socially constructed sexual standard, and using the label only serves to pathologize and alienate those who do not conform to the norm. As a sex therapist, I found that a related limitation of this study is that it only focuses on porn use as a negative thing. Participants were not asked about this, in part out of concern that it would be an opportunity to justify the addiction. Consequently, the study does not mention any positives of porn use, and might be perpetuating stereotypes of who is using porn, and why. This would contribute towards stigmatization of porn use, as well as stigmatization of research in the field. Reay, Attwood and Gooder (2013) argue that porn use has become pathologised because of social panic and for financial reasons within the field of psychiatry and psychotherapy, arguing that these fields tend to make financial gains by promoting the notion that porn-use should be treated. My stance is that porn use is not inherently problematic in itself, but that it can lead to difficulties, and that part of the role of counselling psychology is to identify when there is greater risk of developing these difficulties.

Another language-based criticism of the study, is that this was the only medium used to capture the experience of sex addicts. From a Heideggerian perspective, subjective experience is only partially known through language. Therefore, the findings of the study are not a complete representation of the participants' experience.

Having only one interview was another limitation of the study. Participants were required to delve into a very personal topic, without having built trust and rapport. The brevity of the relationship also meant that there was less opportunity to allow counter-transferential dynamics to unfold. As discussed in the previous chapter, these were very influential in my interpretation of the results. Longitudinal studies, or a study where I met with the participant more than once would have allowed for a stronger rapport. However, this is uncommon in qualitative research (Creswell and Creswell, 2018) and was not feasible within the restrictions of this study.

Another limitation of the study was potential researcher bias, which I discussed in the Reflexivity chapter and minimized by discussing the project at various stages with my supervisor and attending therapy.

Lastly, as noted previously, not all findings were reported, in part due to the word limitation. Furthermore, findings were interpreted as they seemed relevant to the researcher in relation to clinical experience and theory.

Future Research

Yontef (1991, p.xx) states that "All reality is relating" and therefore to embark on research (to capture an essence of reality) requires a relational approach.

> "Fully present people share meaning with each other. For the therapist it means sharing meaning with the patient. Full meaning includes despair, love, spirituality, anger, joy, humor and sensuality."
>
> (Yontef, 1991, p. 17).

Based on my experience of relating to the participants, and to the transcripts after that, I think it would be important to understand how therapists share meaning of their inter and intrasubjective experience with clients dealing with sex addiction, and how the client would receive these feelings. Another question would be on the use (or lack of) erotic transference and counter-transference. Therefore, an area of further study would be on the experience of the therapist when working with sex addicts.

The current study also suggests that relational trauma may be part of the sex addict's history, as is noted with other types of addiction (Ford and Russo, 2006). Relational trauma is known to promote a defensive withdrawal from the mental world (Fonagy and Target, 1997). All participants appeared to have been withdrawn in their significant romantic relationships. What role, if any, does trauma have on the initiation and trajectory of sexual addiction?

As discussed above, future research should also be more diverse with regards to age, race, gender and sexual orientation in particular, because different groups may experience sexual addiction differently to the homogenous sample presented here. More research is also needed in the role of addict's partner, the reason being two-fold, firstly so that support can be given to them, as disclosure has been shown to be a traumatic experience, and also, because, as in the case of David and Brian, having a supportive partner was important for the addict.

More research is needed on the phenomenology of sex addiction, including on change and therapeutic goals. What would participants define as meaningful change? How could this be defined and reached in therapy?

Disseminating Findings

The preliminary results of the study have been disseminated at two events, the first being a conference attended by therapists, doctors and other professionals and at a lecture given to

Masters in Psychology and Masters in Family Therapy students at the University of Malta. In December 2021 I will be giving a lecture titled “Sex Addiction – theoretical frameworks, classification, prevalence, interventions and policy implications” to the students of the Masters in Psychology at the University of Malta, as part of the study unit Behavioural Addictions.

I am currently working on integrating the findings of this research together with those of my undergraduate research, which examined Perceived Parental Role in Sex Education. The study dealt with how parents spoke to their children about sex and sexuality, and this covered porn use. Sex addiction was not discussed by the participants, however it would be interesting to use what I learnt from both studies to create guidelines that parents could refer to regarding speaking to their children about porn use. Although results of this study cannot be generalised, based on the findings here, anti-porn rhetoric, be it in literature, media or passed on through social interactions, did not prevent porn-use from becoming an addiction. In fact, all participants looked upon the sex-negative messages they received as harmful.

Initially, my focus was to be on the associated risks of porn-use, and how this can lead to sexual addiction. However, having to re-submit the dissertation has given me the opportunity to reassess my own stance towards porn use. This change is partly due to immersing myself in anti-porn literature, and finding that as a therapist, I disagreed with the tone of the rhetoric, finding some of it to be unempathetic, and feeling that it would serve to isolate further porn-users. Furthermore, more recent research has consistently shown that self-perceived porn addiction is a greater predictor of sexual dysfunction, psychological distress, and other negative consequences, rather than objective measures of porn addiction (Whelan and Brown, 2021). I believe that therapists have a duty to address this discrepancy. By engaging in rhetoric that it is fear or shame-inducing, therapists would be perpetuating the problem. Based on my clinical practice and the findings of this research, my stance towards porn-use is that it should be about “entertainment”, not “education”, and can be a facilitator for sexual health, but not a replacement for intimacy.

Conclusion

This chapter discussed the research findings in relation to the existing literature, addressing each major theme in turn. Theoretical concepts linked the themes of Experience of Self, Relational Dynamics, Sex Addict and Addiction, and Process of Recovery. By presenting them thus, it was hoped that the reader would have an understanding of the “lifespan” of the addiction, from its roots in childhood, to its ongoing management in recovery.

Chapter Seven: Conclusion

Summary

The focus of this Interpretative Phenomenological Analysis of the experience of men who identified as sex addicts was to understand the individuals' experiences, to bring more of the personal to the current existing body of research in the field. Five superordinate themes were identified, "Experience of Self", "Relational Dynamics", "The Sex Addict and Addiction", and "Recovery". These themes illustrated that there are

Using this theoretical perspective provided more depth in understanding of the phenomenology of sex addiction, than the diagnostic criteria clinicians and researchers rely on, because it gave voice to the individual's perspectives, and to the nuances of their experiences.

Sex addiction can present as a number of sexual behaviours, in any combination. However, as pointed out by the participants themselves, it is not the behaviours per se that constitute the addiction. Rather, it is the context in which they occur and the subsequent impact they have on the person's social, relational and occupational functioning, and wellbeing. This study therefore recommends an integrative problem formulation and therapeutic approach in order to address the complexity and uniqueness of each person living with sex addiction. Such an approach should take into account:

- Developmental factors - attachment history and relational trauma
- Contextual factors - familial and cultural values towards sex, porn use, and infidelity, mental health issues of significant others (partners and family of origin)
- Potential diagnostic features – personality traits and relational styles
- Existential issues – social and support network, relationship status and attachment within romantic relationship, subsequent trauma.

An assessment and formulation should also consider the individual' perception of the "purpose" of the addiction, and how the behaviours are affecting the person.

It is recommended that researchers and therapists working in this field should consider undergoing training in working with sex addiction beforehand, and subsequently engaging in supervision and reflexive practice as an ongoing part of the work. The reason is twofold, firstly because the work can be emotionally demanding, and because the practitioner's reactions can be informative the sex addict's experience and the experience he or she elicits from others.

Practitioners should also critically reflect on their own attitudes and values towards how they would define sex addiction.

On a final note, this exploratory qualitative study of the phenomenology of sex addiction has contributed to the development of a more integrated understanding of the person and their understanding of their beliefs and behaviour. At a personal level, conducting the research has depathologised the concept, and allowed me to empathise more with men who identify as sex addicts.

References

Abel, G., Coffey, L., & Osborn, C., (2008). Sexually Arousal Patterns: Normal & Deviant. *Sexually Compulsive Behavior: Hypersexuality*, *31*(4), 643-656.

Andreassen C., Pallesen S., Griffiths M., Torsheim T. and Sinha R (2018). The Development and Validation of the Bergen–Yale Sex Addiction Scale With a Large National Sample. *Frontiers in Psychology. 9* (144) doi: 10.3389/fpsyg.2018.00144

Adams, K., & Robinson, D. (2002). Shame Reduction, Affect Regulation & Sexual Boundary Development: Essential Building Blocks in Sexual Addiction Treatment. In: P.J. Carnes & K.M. Adams, (Eds.). *Clinical Management of Sex Addiction*. (pp. 67-88). New York, NY: Brunner-Routledge.

Adams, M. (2008). The abandonment: enactments from the patient's sadism & the therapist's collusion. In: D. Mann & V. Cunningham (Eds.). *The Past in the Present*. (pp. 62-75). London: Routledge.

Adams, M. (2014). *The myth of the untroubled therapist: private life, professional practice*. London: Routledge, Taylor & Francis Group.

Adams, T.E., Jones, S.H. & Ellis, C. (2015). *Autoethnography*. Oxford: University Press.

Aksan, N., Kisac, B., Aydin, M., & Demirbuken, S. (2009). Symbolic interaction theory. *Procedia - Social and Behavioral Sciences, 1*(1), 902-904

American Psychiatric Association. (2000). *Diagnostic & statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Ayala, G. & Elder, P. (2011). Qualitative methods to ensure acceptability of behavioral & social interventions to the target population. *Journal of Public Health Dentistry, 71*(S1), 69-79.

Ayers, M., & Haddock, S. (2009). Therapists' Approaches in Working with Heterosexual Couples Struggling with Male Partners' Online Sexual Behaviour. *Sexual Addiction & Compulsivity, 16*, 55-78.

Ballinger, C. (2006). Demonstrating Rigour & Quality. In: L. Finlay & C. Ballinger (Eds.). *Qualitative Research for Allied Health Professionals* (pp. , 235-246). West Sussex: Wiley.

Banai, E., Mikulincer, M., & Shaver, P. R. (2005). "Selfobject" Needs in Kohut's Self Psychology: Links With Attachment, Self-Cohesion, Affect Regulation, and Adjustment. *Psychoanalytic Psychology, 22*(2), 224–260. https://doi.org/10.1037/0736-9735.22.2.224

Bancroft, J. & Vukadinovic, Z. (2004). Sexual Addiction, Sexual Compulsivity, Sexual Impulsivity, or What? Toward a Theoretical Model. *The Journal of Sex Research, 41*(3), 225-234.

Barker, M., (2014). Psychology & pornography: some reflections. *Porn Studies, 1*(1-2), pp. 120-126.

Basescu, C. (2009). Shifting Ground. *Contemporary Psychoanalysis, 45*(1), 44-64.

Becerra, M.D., Robinson, C. & Balkin, R. (2011). Exploring Relationships of Masculinity & Ethnicity as At-Risk Markers for Online Sexual Addiction in Men. *Sexual Addiction & Compulsivity, 18*(4), pp. 243-260.

Benfield, J. (2018). Secure Attachment: An Antidote to Sex Addiction? A Thematic Analysis of Therapists' Experiences of Utilizing Attachment-Informed Treatment Strategies to Address Sexual Compulsivity. *Sexual Addiction & Compulsivity, 25*(1), 12-27.

Berlin, F.S. (2008). Basic Science & Neurobiological Research: Potential Relevance to Sexual Compulsivity. *Sexually Compulsive Behavior: Hypersexuality, 31*(4), 623-642.

Berry, M.D. & Berry, P.D. (2014). Mentalization-based therapy for sexual addiction: foundations for a clinical model. *Sexual & Relationship Therapy, 29*(2), 245-260.

Black, D. (2000). The Epidemiology and Phenomenology of Compulsive Sexual Behavior. *CNS Spectrums, 5*(1), 26-35. doi:10.1017/S1092852900012645

Bőthe B., Tóth-Király I., Zsila Á., Griffiths M.D., Demetrovics Z., Orosz G. (2018). The Development of the Problematic Pornography Consumption Scale (PPCS) *Journal of Sex Research* 55, 395–406.

Bollas, C. (1982). On the relation to the self as an object. *The International journal of psychoanalysis, 63*(Pt 3), 347-359.

Bond, T. (2004). Ethical Guidelines for researching counselling & psychotherapy. *Counselling & Psychotherapy Research, 4*(2), 10-19.

Bowlby, J. (1969). *Attachment and Loss. Vol. 1*. Attachment. New York: Basic Books

Boyle, K. (2010). Porn consumers' public faces: mainstream media, address and representation. In K. Boyle, (Ed.). *Everyday Pornography* (pp. 134-146). Oxford: Routledge

Braun V., & Clarke, V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology, 3*(2), 77-101, DOI: 10.1191/1478088706qp063oa

Braun-Harvey, D. and Vigorito, M. (2016). *Treating Out of Control Sexual Behaviour. Rethinking Sex Addiction.* New York, NY: Springer Publishing Company.

Brewer, G., and Tidy, P. (2019). Sex Addiction: Therapists' Perspectives. *Sexual and Relationship Therapy, 34*(1), 40-53.

Briggs, J. (2014). *A discursive analysis exploring constructions of sex addiction in clinical text and 'addict' accounts.* (DClinPsy thesis, University of Lincoln).

Briggs, J., Gough, B. & Das Nair, R. (2017). Losing control in sex addiction: "Addict" & "Non-addict" accounts. *Sexual & Relationship Therapy, 32*(2), 195-209.

British Psychological Society (2014). Ethical Code of Human Research Ethics. Retrieved from http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

Brocki, J.M., & Wearden, A.J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. Psychology & Health, 21(1), 87-108. doi: 10.1080/14768320500230185

Buber, M. (1996). I and Thou (W. Kaufmann, Trans.). New York: Simon and Schuster-Touchstone. (Original work published 1921)

Burr, V. (2003). *Social Constructionism.* London: Routledge.

Burris, C.T. & Schrage, K.M. (2014). Incognito Libido: Introducing the Sexual False Self Scale. *Sexual Addiction & Compulsivity, 21*(1), 42-56.

Butler, M.H., Meloy, K.C. & Call, M.L. (2015). Dismantling Powerlessness in Addiction: Empowering Recovery through Rehabilitating Behavioral Learning. *Sexual Addiction & Compulsivity, 22*(1), 26-58.

Canning Fulton, M. (2002). Breaking Through Defenses. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 31-44). New York, NY: Brunner-Routledge.

Carnes, P.J. (2001). *Out of the Shadows. Understanding Sexual Addiction*. 3rd ed. MN: Hazelden.

Carnes, P. (2016). Pattern Seeking In Science: An Evolutionary Process, *Sexual Addiction & Compulsivity, 23*(1), 1-3, DOI: 10.1080/10720162.2015.1103342

Carnes, P., Green, B., & Carnes, S. (2010) The Same Yet Different: Refocusing the Sexual Addiction Screening Test (SAST) to Reflect Orientation and Gender, Sexual Addiction & Compulsivity, 17:1, 7-30, DOI: 10.1080/10720161003604087

Carnes, S. & Lee, M.A. (2014). Picking Up the Pieces: Helping Partners & Family Members Survive the Impact of Sex Addiction. *Behavioral Addictions*, 267-284.

Carnes, P.J., & Wilson, M. (2002). The Sexual Addiction Assessment Process. In: P.J. Carnes, & K.M., Adams (Eds.), *Clinical Management of Sex Addiction* (pp.3-20). NY: Brunner-Routledge.

Carreno, D. & Perez-Escobar, J.A. (2019). Addiction in existential positive psychology: from a critique of the brain disease model towards a meaning-centered approach. *Counselling Psychology Quarterly, 32*(3-4), 415-435.

Carvalheira, A., Træen, B., Stulhofer, A. (2015). Masturbation and pornography use among coupled heterosexual men with decreased sexual desire: How many roles of masturbation? Journal of Sex & Marital Therapy, 41, 626–635. doi:10.1080/0092623X.2014.958790

Cassimatis, E. (1984). The 'False Self': Existential and Therapeutic Issues. *International Review of Psychoanalysis 11,* 69-76.

Catania, J.A., Gibson, D.R., Chitwood, D.D. & Coates, T.J. (1990). Methodological Problems in AIDS Behavioral Research: Influences on Measurement Error & Participation Bias in Studies of Sexual Behavior. *Psychological Bulletin, 108*(3), 339.

Chen, M., Noosbond, J. P., & Bruce, M. A. (1998). Therapeutic document in group counseling: An active change agent. *Journal of Counseling & Development, 76*(4), 404–411. https://doi.org/10.1002/j.1556-6676.1998.tb02699.x

Chisholm, M., & Gall, T. (2015). Shame and the X-Rated Addiction. The Role of Spirituality in Treating Male Pornography Addiction. *Sexual Addiction and Compulsivity, 22,* 259-272.

Codispoti, M., Bradley, M. & Lang, P.J. (2001). Affective reactions to briefly presented pictures. *Psychophysiology, 38*(3), 474-478.

Cohn, H.W. (1997). *Existential Thought & Therapeutic Practice*. London: Sage.

Cohn, R. (2014). Calming the tempest, bridging the gorge: healing in couples ruptured by "sex addiction". *Sexual & Relationship Therapy, 29*(1), pp. 76-86.

Coleman, E. (2015). Impulsive/Compulsive Sexual Behaviour. In: K. Wylie (Ed.), *ABC of Sexual Health* (pp.93-95). West Sussex: Wiley Blackwell.

Coles J, Astbury J, Dartnall E, & Limjerwala S. (2014), A Qualitative Exploration of Researcher Trauma and Researchers' Responses to Investigating Sexual Violence. *Violence Against Women, 20*(1), 95-117. doi:10.1177/1077801213520578

Connolly K, Reilly RC. (2007) Emergent Issues When Researching Trauma: A Confessional Tale. *Qualitative Inquiry 13*(4), 522-540. doi:10.1177/1077800406297678

Cooper, A., Scherer, C. & Mathy, R.M. (2001). Overcoming Methodological Concerns in the Investigation of Online Sexual Activities. *CyberPsychology & Behavior, 4*(4), 437-447.

Coveney, L., Jackson, M., Jeffreys, Kay, L. & Mahony, P. (1984). Theory into practice: sexual liberation or social control? In L. Coveney, M. Jackson, S. Jeffreys, L. Kay & P. Mahony (Eds.), *The Sexuality Papers. Male Sexuality & the Social Control of Women, Routledge Library Editions: History of Sexuality.* (pp.85-103). London: Routledge.

Cox, R., & Howard, M. (2007) Utilization of EMDR in the Treatment of Sexual Addiction: A Case Study, *Sexual Addiction & Compulsivity, 14(*1), 1-20, DOI: 10.1080/10720160601011299

Cozolino, L. (2010). *The neurosicence of psychotherapy: Healing the social brain*. New York: Norton & Company.

Craparo, G. (2014). The role of Dissociation, Affect Dysregulation, and Developmental Trauma in Sexual Addiction. *Clinical Neuropsychiatry, 11*(2), 86-90.

Creswell, J & Creswell, D. (2018). *Research Design: Qualitative, Quantitative and Mixed Method Approaches.* 5th ed. Los Angeles: Sage.

Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process. London: SAGE Publications.

Dajches, L., & Terán, L. (2020). Hetero-(sex)pectations: Exploring the link between compulsive pornography consumption, heterosexual script endorsement, and hookups among emerging adults. *Psychology of Popular Media, 10*(3), 406–410.

Davies, D. (2017). *In or out of control?: viewing sexual compulsion otherwise Dominic Davies FBACP, FNCS, CEO Pink Therapy.* As accessed from https://www.researchgate.net/publication/319901671_In_or_out_of_control_viewing_sexual_compulsion_otherwise_Dominic_Davies_FBACP_FNCS_CEO_Pink_Therapy

de Alarcon, R., de la Iglesia, J.I., Casado, N.M. & Montejo, A.L. (2019). Online Porn Addiction: What We Know & What We Don't-A Systematic Review. *Journal of clinical medicine, 8*(1), 63-79.

de Guzman, I.N., Arnau, R.C., Green, B.A., Carnes, S., Carnes, P. & Jore, J. (2016). Empirical Identification of Psychological Symptom Subgroups of Sex Addicts: An Application of Latent Profile Analysis. *Sexual Addiction & Compulsivity, 23*(1), 34-55.

de Tubino Scanavino, M., Ventuneac, A., Abdo, C. H. N., Tavares, H., do Amaral, M. L. S.A., Messina, B., … Parsons, J. T. (2013). Compulsive sexual behaviour and psychopathology among treatment-seeking men in Sao Paulo, Brazil. Psychiatry Research, 209, 518–524. doi:10.1016/j. psychres.2013.01.021

Delmonico D., Miller J. (2003). The Internet Sex Screening Test: A comparison of sexual compulsives versus non-sexual compulsives. *Sexual and Relationship Therapy,* 18, 261–276. doi: 10.1080/1468199031000153900.

Delmonico, D., & Griffin, E. (2002). Classifying Problematic Sexual Behaviour: A Working Model Revisited. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 361-378). New York, NY: Brunner-Routledge.

Denzin, N.K. (2007). Symbolic Interactionism. In U. Flick, E. von Kardorff & I. Steinke (Eds.), A companion to qualitative research (pp. 81-87). London: SAGE Publications.

Derbyshire K.L., Grant J.E. (2015). Compulsive sexual behavior: A review of the literature. *Journal of Behavioural. Addictions.* 4, 37–43. doi: 10.1556/2006.4.2015.00

Deurzen, E. van (2002). *Existential Counselling and Psychotherapy in Practise* (2nd ed.). London, UK: Sage Publications.

Dewitte, M. (2012). Different Perspectives on the Sex-Attachment Link: Towards & Emotion Motivational Account. *Journal of Sex Research, 49*(2-3), 105-124.

Diamond, L.M., & Huebner, D.M., 2012. Is Sex Good for You? Rethinking Sexuality & Health. *Social & Personality Psychology Compass, 6*(1), 54-69.

Dodes, L. (1990) Addiction, Helplessness, and Narcissistic Rage, *The Psychoanalytic Quarterly, 59*(3), 398-419, DOI: 10.1080/21674086.1990.11927278

Duffy, A., Dawson, D. & das Nair, R. (2016). Pornography Addiction in Adults: A Systematic Review of Definitions and Reported Impact. *The Journal of Sexual Medicine, 3* (5), 760-777

Eagle, M. (2007). Attachment and Sexuality. In D. Diamond, S. Blatt & J. Lichtenberg (Eds.). *Attachment and Sexuality* (pp. 27-50). London: Routeledge.

Eatough, V., & Smith, J. (2006a). I feel like a scrambled egg in my head: An idiographic case study of meaning making & anger using interpretative phenomenological analysis. *Psychology & Psychotherapy: Theory, Research & Practice, 79*, 115-135.

Eatough, V., & Smith, J. (2006b). 'I was like a wild wild person': Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, *97*, 483-498.

Easton, S. (1994). *The Problem of Pornography. Regulation & the right to free speech.* London: Routledge.

Edwards, T. (1994). *Erotics and Politics. Gay Male Sexuality, Masculinity and Feminism.* London: Routledge.

Edwards, W., 2012. Applying a Sexual Health Model to the Assessment & Treatment of Internet Sexual Compulsivity. *Sexual Addiction & Compulsivity, 19*(1-2), 3-15.

Efrati, Y., & Gola, M. (2019). The Effect of Early Life Trauma on Compulsive Sexual Behavior among Members of a 12-Step Group. *The Journal of Sexual Medicine 16*(6), 803-811

Efrati, Y., Gerber, Z. & Tolmacz, R. (2019). The Relation of Intra-Psychic & Relational Aspects of the Self to Compulsive Sexual Behavior. *Journal of sex & marital therapy,45*(7), 618-631

Etherington, K. (2004). Research methods: reflexivities – roots, meanings, dilemmas. *Counselling and Psychotherapy Research 4*(2), 46-47

Faisandier, K., Taylor, J., & Salisbury, R. (2012). What does attachment have to do with out-of-control sexual behaviour? *New Zealand Journal of Psychology, 41*(1), 19 – 29.

Faulconer, J. (2005) Knowledge of the Other, European Journal of Psychotherapy & Counselling, 7:1-2, 49-63, DOI: 10.1080/13642530500087062

Fausto-Sterling, A. (2019). Gender/Sex, Sexual Orientation, & Identity Are in the Body: How Did They Get There? *The Journal of Sex Research*, *56*(4-5), 529-555, doi: 10.1080/00224499.2019.1581883

Fearing, J. (2002). Intervention and the Sexually Addicted Patient. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 21-30). New York, NY: Brunner-Routledge.

Ferree, M. C. (2002a). Females. The Forgotten Sexual Addicts. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 45-66). New York, NY: Brunner-Routledge.

Ferree, M. C. (2002b) Sexual Addiction and Co-Addiction: Experiences Among Women of Faith, Sexual Addiction & Compulsivity, 9:4, 285-292, DOI: 10.1080/10720160216048

Ferree M. C. (2003). Women and the web: Cybersex activity and implications. *Sexual and Relationship Therapy, 18,* 385–393. doi:10.1080/1468199031000153973

Finlay, L. (2006). The body's disclosure in phenomenological research. *Qualitative Research in Psychology, 3*, 19-30.

Finlay, L. (2008). A Dance Between the Reduction and Reflexivity: Explicating the "Phenomenological Psychological Attitude". *Journal of Phenomenological Psychology, 39*(1), 1-32. doi: 10.1163/156916208X311601

Finlay, L. (2011). *Phenomenology for Therapists: Researching the Lived World*. London: Wiley-Blackwell.

Fonagy, P. & Target, M., (1997). Attachment & reflective function: their role in selforganization. *Developmental Psychopathology, 9*(4), 679-690.

Fonagy, P., Bateman, A., & Bateman, A. (2011). The widening scope of mentalizing: A discussion. *Psychology & Psychotherapy: Theory, Research & Practice, 84*, 98-110.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect Regulation, Mentalization, & the Development of the Self*. NY: Other Press.

Ford, J. & Russo, E. (2006). Trauma-Focused, Present-Centered, Emotional Self-Regulation Approach to Integrated Treatment for Posttraumatic Stress and Addiction: Trauma Adaptive Recovery Group Education and Therapy (TARGET). *The American Journal of Psychotherapy, 60*(4), 335-355.

Forrester, M. (2010). This Book and How to use it. In: M. Forrester (Ed.). *Doing Qualitative Research in Psychology: A Practical Guide* (pp.1-12). Los Angeles: Sage.

Frances, A., & Widiger, T. (2012). Psychiatric Diagnosis: Lessons from the DSM-IV Past & Cautions for the DSM-5 Future. *Annual Review of Clinical Psychology, 8*(7), 1-22.

Freedman, E., & D'Emilio, F. (1990) Problems encountered in writing the history of sexuality: Sources, theory and interpretation, *The Journal of Sex Research, 27*(4), 481-495, DOI: 10.1080/00224499009551577

Frie, R. (2010). A hermeneutics of exploration: The interpretive turn from Binswanger to Gadamer. Journal of Theoretical and Philosophical Psychology, 30(2), 79-93. doi: 10.1037/a002157

Fraumeni, J. (2019) Addiction and Mindfulness; Pornography Addiction and Mindfulness-Based Therapy ACT, Sexual Addiction & Compulsivity, 26:1-2, 42-53, DOI: 10.1080/10720162.2019.1576560

Fuchs, T. (2013). Temporality and psychopathology. Phenomenology and the cognitive sciences, 12(1), 75-104. Retrieved from http://link.springer.com/article/10.1007%2Fs11097-010-9189-

Gadamer, H.G. (1996). *Truth and method* (2nd rev. ed., J. Weinsheimer and D. Marshall, Trans). New York: Continuum. (Original work published 1960)

Gerber, J. (2008). Treatment of Sexually Compulsive Adolescents. *Sexually Compulsive Behavior: Hypersexuality, 31*(4), 657-670.

Gerhardt, S. (2015). *Why love matters: how affection shapes a baby's brain*. (2nd ed). New York, NY: Routledge.

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. Journal of Phenomenological Psychology, 28, 235-260. doi: 10.1163/156916297X00103

Giovazolias, T. (2005). Counselling psychology & the integration of theory, research & practice: A personal account. *Counselling Psychology Quarterly, 18*(2), 161-168.

Gilliland, R., South, M., Carpenter, B., & Hardy, S. (2011) The Roles of Shame and Guilt in Hypersexual Behavior, *Sexual Addiction & Compulsivity, 18*(1), 12-29, DOI: 10.1080/10720162.2011.551182

Given, L. (2008). *The Sage Encyclopedia of Qualitative Research Methods*. Thousand Oaks, CA: Sage Publications

Gold, S.N., & Heffner, C.L. (1998). Sexual Addiction: Many Conceptions, Minimal Data. *Clinical Psychology Review 18*(3), 367-8.

Goodman, A. (2001). What's in a Name? Terminology for Designating a Syndrome of Driven Sexual Behavior, Sexual Addiction & Compulsivity, 8:3-4, 191-213, DOI: 10.1080/107201601753459919

Griffin-Shelley, E., 2009. Ethical Issues in Sex & Love Addiction Treatment. Sexual Addiction & Compulsivity, 16, 32-54.

Griffiths, M.D. & Dhuffar, M. (2014). Treatment of sexual addiction within the British National Health Service. *International Journal of Mental Health and Addiction, 12*, 561-571.

Guba, E.G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (pp. 191-215). UK: SAGE Publications.

Hagedorn, W.B. (2009). Sexual Addiction Counselling Competencies: Empirically-Based Tools for Preparing Clinicians to Recognize, Assess, & Treat Sexual Addiction. *Sexual Addiction & Compulsivity, 16*(3), 190-209.

Hall, P. (2014) Sex addiction – an extraordinarily contentious problem, *Sexual and Relationship Therapy, 29*(1), 68-75, DOI: 10.1080/14681994.2013.861898

Hammond, N. & Kingston, S. (2014). Experiencing stigma as sex work researchers in professional & personal lives. *Sexualities, 17*(3), 329-347.

Hayes, R. & Dragiewicz, M. (2018). Unsolicited dick pics: Erotica, exhibitionism or entitlement? *Women's Studies International Forum, 71*, 114-120.

Heaton Matheny, J. (2002). Strategies for Assessment and Early Treatment with Sexually Addicted Families. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 45-66). New York, NY: Brunner-Routledge.

Heidegger, M. (1968). What is called thinking? (J. G. Gray, Trans.). New York: Harper & Row. (Original work published 1953)

Heron, J., & Reason, P. (1997). A Participatory Inquiry Paradigm. *Qualitative Inquiry*, *3*(3), 274–294. https://doi.org/10.1177/107780049700300302

Hertlein, K. (2004). *Internet Infidelity: An Examination of Family Therapist Treatment Decisions and Gender Biases.* (Doctor of Philosphy thesis, Virginia Polytechnic and State University).

Hollway, W. & Jefferson, T. (2013). Doing Qualitative Research Differently: A Psychosocial Approach. Second Edition. SAGE. London.

Holmes, J. (2014). *John Bowlby & attachment theory*. (2nd ed). New York: Routledge, *Taylor* & Francis Group.

Hornbacher, M. (2011). *Waiting. A non-believer's higher power.* Center City, MN: Hazelden.

Humphreys, K. (2018). Of moral judgements and sexual addictions. *Addictions, 113*(3), 387-388.

Husserl, E. (1970). The crisis of European Sciences and Transcendental Phenomenology (D. C. Evanston, Trans.). Illinois: Northwestern University Press. (Original work published 1936)

Jackson, M. (1984). Sexology and the universalization of male sexuality. In L. Coveney, M. Jackson, S. Jeffreys, L. Kay & P. Mahony (Eds.), *The Sexuality Papers. Male Sexuality & the Social Control of Women, Routledge Library Editions: History of Sexuality.* (pp.69-84). London: Routledge.

Johnson, S.M. (1994). *Character styles*. New York: Norton.

Jensen. R. (2010). Pornography is what the end of the world looks like. In K. Boyle, (Ed.). *Everyday Pornography* (pp. 105-113). Oxford: Routledge.

Kafka, M. (2010). Hypersexual Disorder: A Proposed Diagnosis for DSM-V. *Archives of Sexual Behaviour, 39*, 377-400. https://doi.org/10.1007/s10508-009-9574-7

Kaptein, A. (2011) Pick up the pieces and go home – on the demise of health psychology, *Health Psychology Review, 5*(1), 39-47, DOI: 10.1080/17437199.2010.520114

Karila L., Wéry A., Weinstein A., Cottencin O., Reynaud M., Billieux J. (2014). Sexual addiction or hypersexual disorder: Different terms for the same problem? A review of the literature. *Current Pharmaceutical Design, 20*(25), 4012–4020. doi:10.2174/13816128113199990619

Kasl, C. (2002) Special Issues in Counseling Lesbian Women for Sexual Addiction, Compulsivity, and Sexual Codependency. *Sexual Addiction & Compulsivity, 9*(4), 191-208, DOI: 10.1080/10720160216044

Katehakis, A. (2009). Affective neuroscience and the treatment of sexual addiction. *Sexual Addiction & Compulsivity, 16* (1), 1-31.

King, N., Horrocks, C., & Brooks, B. (2018). *Interviews in Qualitative Research.* Los Angeles, Sage.

Kingston, D. (2018). Hypersexuality: Fact or Fiction? *The Journal of Sexual Medicine, 15* (5), 613-615.

Kingston, D., & Firestone, P. (2008). Problematic Hypersexuality: A Review of Conceptualization & Diagnosis. *Sexual Addiction & Compulsivity, 15*, 284-310.

Klein, M. (2016). *His porn, her pain: confronting America's pornpanic with honest talk about sex*. Santa Barbara, California: Praeger.

Klukas, E., Draper, K., Kaseweter, N., Gregoire S., & Cioe, J. (2021) The Impact of Parenting Style on Attitudes toward Masturbation: A Latent Profile Analysis, *The Journal of Genetic Psychology*, DOI: 10.1080/00221325.2021.1948386

Kohut, H. (1971). The analysis of self: Systematic approach to treatment of Narcissistic Personality Disorder. NewYork: International University Press.

Kotera, Y. & Rhodes, C. (2019). Pathways to Sex Addiction: Relationships with Adverse Childhood Experience, Attachment, Narcissism, Self-Compassion & Motivation in a Gender Balanced Sample. *Sexual Addiction & Compulsivity, 26*(1-2), 54-76.

Kor A., Zilcha-Mano S., Fogel Y.A., Mikulincer M., Reid R.C., Potenza M.N. (2014). Psychometric development of the Problematic Pornography Use Scale. *Addictive Behavior 39,* 861–868.

Kraus, S., Sturgeon, J., & Potenza, M. (2018). Specific Forms of Passionate Attachment Differentially Mediate Relationships between Pornography Use and Sexual Compulsivity in Young Adult Men. *Sexual Addiction and Compulsivity, 25* (4) 380-395.

Kvale, S. (2007). Doing interviews. In U. Flick (Ed.), The sage qualitative research kit (pp. 21-38). London: Sage publications.

Kuzma, J.M. & Black, D.W., 2008. Epidemiology, prevalence, & natural history of compulsive sexual behavior. *The Psychiatric clinics of North America, 31*(4), 603-611.

Lago, C. (2006). *Race, culture, & counselling: the ongoing challenge*. New York: Open University Press.

Langdridge, D. (2007). Phenomenological Psychology: Theory, research and method. Harlow, UK: Pearson Education Limited.

Larkin, M. & Thompson, A. (2011). Interpretative phenomenological analysis. In: A. Thompson, (Ed.). *Qualitative Research Methods in Mental Health and Psychotherapy: A guide for students and practitioners* (pp43-59). Oxford: Wiley.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. Qualitative Research in Psychology, 3(2), 102-120. doi: 10.1191/1478088706qp062oa

Lawal, A. & Idemudia, E. (2018) Gender difference, class level and the role of internet addiction and loneliness on sexual compulsivity among secondary school students, *International Journal of Adolescence and Youth, 23(*4), 422-430, DOI: 10.1080/02673843.2017.1406380

Lazard, L. & McAvoy, J. (2017). Doing reflexivity in psychological research: What's the point? What's the practice? *Qualitative Research in Psychology,17*(2), 159-177.

Lehman G. (2011). Interpretivism, postmodernism and nature: Ecological conversations. *Philosophy & Social Criticism 37*(7), 795-821. doi:10.1177/0191453711410031

Levering, B. (2006). Epistemological Issues in Phenomenological Research: How Authoritative Are People's Accounts of their own Perceptions? *Journal of Philosophy of Education 40*(4), 451-462.

Ley, D. (2012). *The Myth of Sex Addiciton.* London: Rowman & Littlefield.

Lichtenberg, J.D., Lachmann, F.M. & Fosshage, J.L. (2011). *Psychoanalysis & motivational systems: a new look.* New York: Routledge.

Love, H.A., Moore, R.M. & Stanish, N.A. (2016). Emotionally focused therapy for couples recovering from sexual addiction. *Sexual & Relationship Therapy, 31*(2), 176-189.

Lyons, E. & Coyle, A. (2015). *Analysing Qualitative Data in Psychology*. Second Edition. Sage Publications. London

MacMahon, P. (2019). *Integrative Therapists' clinical experiences of personal blind spots: An Interpretative phenomenological analysis*. (Doctoral thesis, Metanoia Institute, University of Middlesex)

Manning J.C. (2006). The Impact of Internet Pornography on Marriage & the Family: A Review of the Research. *Sexual Addiction & Compulsivity, 13*(2-3), 131-165.

McCarthy, B., & Ross, L. (2018). Healthy Male and Couple Sexuality: Integral Components of the Sexual Compulsivity/Addiction Recovery Process, *Sexual Addiction & Compulsivity, 25*(2-3), 216-225, DOI: 10.1080/10720162.2018.1532363

McKeague, E. (2014). Differentiating the Female Sex Addict: A Literature Review Focused on Themes of Gender Difference Used to Inform Recommendations for Treating Women With Sex Addiction, *Sexual Addiction & Compulsivity, 21*(3), 203-224, DOI: 10.1080/10720162.2014.931266

McKinney, F. (2014). *A relational model of therapists' experience of affect regulation in psychological therapy with female sex addiction*. (Doctoral thesis, Metanoia Insitute and University of Middlesex, England).

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London, UK: Sage.

McNair, B. (2013). *Porno? Chic! How pornography changed the world and made it a better place.* London: Routledge.

Meades, P. (2019). *An Exploration of Six Lesbian and Gay People's Experiences of Organised Religion (Christianity, Islam, and Judaism), and their Implications for Psychotherapy: An Interpretative Phenomenological Analysis (IPA).* (Doctoral thesis, Metanoia Insitute and University of Middlesex, England).

Medina, M. (2012). *The Paradox of Self Surrender and Self Empowerment: An Interpretative Phenomenological Investigation of the Individual's Understanding of the Higher Power in Alcoholics Anonymous*. (Doctoral thesis, University of Middlesex).

Merleau-Ponty, M. (2007). *Phenomenology of Perception*. London: Routledge. (Original work published 1945).

Migone, P., & Liotti, G. (1998). Psychoanalysis and Cognitive-Evolutionary Psychology: an Attempt at Integration. *International* Journal of Psychoanalysis ,79, 1071-1095

Mikulincer, M. & Shaver, P. (2007). A Behavioural Systems Perspective on the Psychodynamics of Attachment and Sexuality. In D. Diamond, S. Blatt & J. Lichtenberg (Eds.). *Attachment and Sexuality* (pp. 51-78). London: Routeledge.

Mitchell, S. (2000) *Relationality From Attachment to Intersubjectivity.* New York, Routledge.

Mollen, D., Burnes, T., Lee, S., & Abbott, M. (2020). Sexuality training in counseling psychology, *Counselling Psychology Quarterly, 33*(3), 375-392, DOI: 10.1080/09515070.2018.1553146

Moran, D. (2000). *Introduction to phenomenology*. London: Routledge.

Morrow, S. (2005). Quality & Trustworthiness in Qualitative Research in Counselling Psychology. *Journal of Counselling Psychology, 52* (2), 250-260.

Moser, C. (2011). Hypersexual Disorder: Just More Muddled Thinking. *Archives of Sexual Behavior, 40*(2), 227-229.

Moustakas, C. E. (1990). Heuristic research: Design, methodology, and applications. Newbury Park: SAGE Publications.

Muise, A., Milhausen, R.R., Cole, S.L. & Graham, C. (2013). Sexual Compulsivity in Heterosexual Married Adults: The Role of Sexual Excitation & Sexual Inhibition in Individuals not Considered "High-Risk". *Sexual Addiction & Compulsivity, 20*(3), 192-209.

Murrey, M. (2008). Narrative psychology. In J.A., Smith (ed.), Qualitative psychology: A practical guide to research (2nd ed.). (pp. 111-132). London, UK: Sage.

Murray, F. (2017). 'There are two clocks in here & they are not in sync': Counsellors' & clients' struggles with online pornography. *Counselling & Psychotherapy Research, 17(*1), 34-41.

Nietzsche, F. (1962). Philosophy in the tragic age of the Greeks (M. Cowan, Trans.).Washington, DC: Regnery Publishing. (Original world published 1873)

Nerenberg, A. (2002). The Value of Group Psychotherapy for Sexual Addicts. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 183-198). New York, NY: Brunner-Routledge.

Oberg, K., Hallberg, J., Kaldo, V., Dhejne, C., & Arver, S. (2017). Hypersexual Disorder According to the Hypersexual Disorder Screening Inventory in Help-Seeking Swedish Men and Women With Self-Identified Hypersexual Behavior. *Sexual Medicine* DOI:https://doi.org/10.1016/j.esxm.2017.08.001

O'Brien, M., Marshall, L. E., & Marshall, W. L. (2008). Sexual addiction. In D. L. Rowland & L. Incrocci (Eds.), *Handbook of sexual and gender identity disorders* (pp. 587–602). London: John Wiley & Sons Inc.

Omaha, J. (2004) *Psychotherapeutic Interventions for Emotion Regulation.* New York, W.W Norton & Company.

Opitz, D., Tsytsarev, S.V., & Froh, J. (2009). Women's Sexual Addiction & Family Dynamics, Depression, & Substance Abuse. *Sexual Addiction & Compulsivity, 16,* 324-340.

Parker, J., & Guest, D. (2002). The Integration of Psychotherapy and 12-Steps Programs in Sexual Addiction Treatment. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 116-124). New York, NY: Brunner-Routledge.

Peloquin, K., Brassard, A., Lafontaine, M. and Shaver, P. (2014). Sexuality Examined Through the Lens of Attachment Theory: Attachment, Caregiving and Sexual Satisfaction. *Journal of Sex Research, 51(*5), 561-576.

Perel, E. (2006). *Mating in Captivity.* New York, NY: Harper Collins.

Pfaus, J.G., Kippin, T.E., Coria-Avila, G.A. (2012) Who, What, Where, When (and Maybe Even Why)? How the Experience of Sexual Reward Connects Sexual Desire, Preference, and Performance. *Archives of Sexual Behaviour 41***,** 31–62 url: https://doi.org/10.1007/s10508-012-9935-5

Philaretou A. G., Mahfouz A. Y., Allen K. R. (2005). Use of Internet pornography and men's well-being. *International Journal of Men's Health,* 4, 149–169. doi:10.3149/jmh.0402.149

Phillips, B., Hajela, R. & Hilton, D.L. (2015). Sex Addiction as a Disease: Evidence for Assessment, Diagnosis, & Response to Critics. *Sexual Addiction & Compulsivity, 22*(2), 167-192.

Pietkiewicz, I., & Smith, J.A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*. 7-14.

Ponterotto, J.G. (2005). Qualitative Research in Counseling Psychology: A Primer on Research Paradigms & Philosophy of Science. *Journal of Counseling Psychology, 52* (2), 126-136.

Prall, W. (2004). Failing better: Integrative theory as a work in progress. The British Journal of Psychotherapy Integration, 1, 1, 24-31

Purnell, C. (2007). Masculinity and Sexuality in Therapeutic Work with Male Survivors of Childhood Sexual Abuse. In K. White & J. Schwartz (Eds.). *Sexuality and Attachment in Clinical Practice* (pp. 65-78). London: Routeledge.

Reay, B., Attwood, N. & Gooder, C. (2013). Inventing Sex: The Short History of Sex Addiction. *Sexuality & Culture, 17*(1), 1-19.

Reid, R.C., Cyders, M.A., Moghaddam, J.F. & Fong, T.W. (2014). Psychometric properties of the Barratt Impulsiveness Scale in patients with gambling disorders, hypersexuality, & methamphetamine dependence. *Addictive Behaviors, 39*(11), 1640-1645.

Reid, K., Flowers, P., & Larkin, M. (2005). Interpretative phenomenological analysis: An overview and methodological review. *The Psychologist, 18,* 20–23.

Rogers, C. R. (1961). Client-centered therapy: Its current practice, implications, and theory. London: Constable.

Ross, A. (2013). *Walking on Eggshells: Having a Parent Who Has Obsessive Compulsive Disorder.* (Masters' thesis. Monash University, Australia).

Sartre, J.P. (2009). Being and nothingness: an essay on phenomenological ontology. London: Continuum International Publishing Group. (Original work published 1943).

Saunders, J. (2006). *Addiction, Special Issue: Diagnostic Issues in Substance Use Disorders: Refining the Research Agenda 1*(1), 48-58.

Schneider, J.P. (2007). Effects of cybersex addiction on the family: Results of a survey. *Sexual Addiction & Compulsivity, 7*(1-2), 31-58.

Schore, A. (2003*). Affect Dysregulation. Disorders of the Self*. London: WW Norton & Company.

Schwandt, T. A. (2014). *Dictionary of qualitative inquiry* (5th ed.). Thousand Oaks, CA: Sage

Schwartz, J. (2007). Attachment and Sexuality. What does our clinical experience tell us? In K. White & J. Schwartz (Eds.). *Sexuality and Attachment in Clinical Practice* (pp. 49-56). London: Routeledge.

Schwartz, M.F. (2008). Developmental Psychopathology perspectives on Sexually Compulsive Behaviour. *Sexually Compulsive Behavior: Hypersexuality, 31*(4), 567-586.

Schwartz, M.F. & Southern, S. (2017). Recovery from Sexual Compulsivity. *Sexual Addiction & Compulsivity, 24*(3), 224-240.

Sex Addicts Anonymous. (2021). Retrieved from https://saa-recovery.org/

Ševčíková, A., Blinka, A., & Soukalová, V. (2018) Excessive Internet use for Sexual Purposes Among Members of Sexaholics Anonymous and Sex Addicts Anonymous, *Sexual Addiction & Compulsivity, 25*(1), 65-79, DOI: 10.1080/10720162.2018.1431166

Shepherd, L. (2010). Cognitive Behavior Therapy for Sexually Addictive Behavior. *Clinical Case Studies, 9*(1), 18–27. https://doi.org/10.1177/1534650109348582

Slattery, J.M. & Park, C.L. (2007). Developing as a Therapist. *Professional Psychology: Research & Practice, 38*(6), 554-560.

Smith Benjamin L. (1998). *Interpersonal Diagnosis and Treatment of Personality Disorders*. Oxford: Guilford Publication.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology 1,* 39-54. doi: 10.1191/1478088704qp004oa

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method & Research.* London: Sage.

Smith, J., Jarman, M., & Osborn, M. (1999). Doing Interpretative Phenomenological Analysis. In: M. Murray & K. Chamberlain (Eds.). *Qualitative Health Psychology Theories & Methods* (pp.218-239). London: Sage.

Smith, J.A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical guide to methods* (pp. 53-80). London: SAGE Publications.

Smith, A. (2017). Existential Perspectives on working with Sex Addiction. In: T. Brichard, & J. Benfield. The Routledge International Handbook of Sexual Addiction. **London: Routledge.**

Smith, J.G. & Luyk, A. (2017). Race play in BDSM porn: the eroticization of oppression. *Porn Studies, 4*(4), 433-446.

Sniewski, L. & Farvid, P. (2019) Abstinence or Acceptance? A Case Series of Men's Experiences With an Intervention Addressing Self-Perceived Problematic Pornography Use, *Sexual Addiction & Compulsivity, 26*(3-4), 191-210, DOI: 10.1080/10720162.2019.1645058

Snyder, H. (2008). What is Third Wave Feminism? A New Directions Essay. *Signs Journal of Women in Culture and Society 34(*1), 175-196

Sokolowski, R. (2000). Introduction to Phenomenology. Cambridge University Press. Cambridge.

Southern, S. (2007). Countertransference & Intersubjectivity: Golden Opportunities in Clinical Supervision. *Sexual Addiction & Compulsivity, 14*(4), 279-302.

Southern, S., & Cade, R. (2011). Sexuality counseling: A professional specialization comes of age. *The Family Journal.* https://doi.org/10.1177/1066480711408028.

Stavro, K., Rizkallah, E., Dinh-Williams, L., Chiasson, J. & Potvin, S. (2013). Hypersexuality among a Substance Use Disorder Population. *Sexual Addiction & Compulsivity, 20*(3), 210-216.

Stein, D. (2008). Classifying Hypersexual Disorders: Compulsive, Impulsive, & Addictive Models. *Sexually Compulsive Behavior: Hypersexuality, 31*(4), 587-592.

Stein, D. J., Black, D. W., Shapira, N. A., Spitzer, R. L. (2001). Hypersexual disorder and preoccupation with Internet pornography. American Journal of Psychiatry, 158, 1590–1594. doi:10.1176/appi.ajp.158.10.1590

Stern, S.E. & Handel, A.D. (2001). Sexuality & mass media: The historical context of psychology's reaction to sexuality on the internet. *The Journal of Sex Research, 38*(4), 283-291.

Stone, W. (2017) Self-Psychology: Empathy and Process*, International Journal of Group Psychotherapy, 67*(1), 164-170, DOI: 10.1080/00207284.2016.1218283

Target, M. (2007). Is our sexuality our own? A developmental model of sexuality based on early affect mirroring. *British Journal of Psychotherapy, 23*(4), 517-530.

Taylor K, Gavey N. (2020). Pornography addiction and the perimeters of acceptable pornography viewing. *Sexualities 23*(5-6), 876-897. doi:10.1177/1363460719861826

Thomas, J., Katsikitis, M., Allen, A., & Kannis-Dymand L. (2020) Desire Thinking and Metacognition Associated with Dysregulated *Sexuality, Sexual Addiction & Compulsivity, 27(*1-2), 119-134, DOI: 10.1080/10720162.2020.1772155

Toates, F. (2009). An Integrative Theoretical Framework for Understanding Sexual Motivation, Arousal, & Behavior. *The Journal of Sex Research, 46*(2-3), 168-193.

Tolmacz, R. (2011). Sense of Entitlement in Couple Relationships: An Attachment Theory Perspective. *Am J Psychoanal 71,* 37–57 https://doi.org/10.1057/ajp.2010.40

Tolman, D., & Diamond, L. (2014). Sexuality Theory: A Review, a Revision and a Recommendation. In D. Tolman and L. Diamond (Eds.). *American Psychological Association Handbook of Sexuality and Psychology* (pp.3-32). New York, NY: American Psychological Association.

Tonigan, J., Miller, W., & Schermer, C. (2002). Atheists, agnostics and AA. *Journal of Studies on Alcohol, 63*(5), 534–541.

Tracy, L. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry 16*(10), 837–851.

Traen, B., Nilsen, T.S. & Stigum, H. (2006). Use of pornography in traditional media & on the internet in Norway. *The Journal of Sex Research, 43*(3), 245-254.

Tsang J. (2002). Moral Rationalization and the Integration of Situational Factors and Psychological Processes in Immoral Behavior. *Review of General Psychology 6*(1), 25-50. doi:10.1037/1089-2680.6.1.25

Turner, M. (2009). Uncovering & Treating Sex Addiction in Couples Therapy, *Journal of Family Psychotherapy*, *20*(2-3), 283-302.

Turner, M. (2008). Female Sexual Compulsivity. A New Syndrome. *Sexually Compulsive Behavior: Hypersexuality, 31*(4), 713-728.

Tyler, M. (2010). Now that's pornography: Violence and domination in Adult Video News. In K. Boyle, (Ed.). *Everyday Pornography* (pp. 50-62). Oxford: Routledge.

Van der Merwe, A., & Hunt, X. (2019). Secondary trauma among trauma researchers: Lessons from the field. *Psychological trauma: theory, research, practice & policy, 11*(1), 1018.

Vassiliou, A. (2016). *The Intersubjective Arena of the Psychotherapy for Psychosis: A Phenomenological Account of Therapists' Experiences*. (Doctorate thesis, University of Middlesex, England).

Voss, G. (2012). 'Treating it as a normal business': Researching the pornography industry. *Sexualities*, 15(3-4), 391-410.

Voss, G. (2015). *Stigma & the Shaping of the Pornography Industry.* London: Routledge.

Vossler, A., & Moller, N. (2014) "The relationship past can't be the future": couple counsellors' experiences of working with infidelity, *Sexual and Relationship Therapy, 29*(4), 424-435, DOI: 10.1080/14681994.2014.924619

Waldman, J. (2003). New mother/old therapist: transference & countertransference challenges in the return to work. American Journal of Psychotherapy, 57(1), 52-63.

Walton, M., Cantor, J., Bhullar, N. & Lykins, A. (2017). Hypersexuality: A Critical Review & Introduction to the "Sexhavior Cycle". *Archives of Sexual Behavior, 46*(8), 2231-2251.

Watson, R. & Vidal, M. (2011). "Do you see other men who do this?" Reflections upon working with men who visit commercial sex workers in a National Health Service sexual health clinic. *Sexual & Relationship Therapy, 26*(1), pp. 61-71.

Webber, V. & Sullivan, R. (2018). Constructing a crisis: porn panics & public health. *Porn Studies, 5*(2), 192-196.

Weeks, J. (2011). *The Languages of Sexuality*. London: Taylor & Francis Ltd.

Weiss, R. (2002). Treatment Concerns for Gay Male Sexual Addicts. In: P.J. Carnes, & K.M. Adams (Eds.). *Clinical Management of Sex Addiction* (pp. 331-342). New York, NY: Brunner-Routledge.

Weitzer, M. (2013). *Researching Sex Work in the Twenty-First Century*. Los Angeles, CA: SAGE Publications.

Wertz, F. (2005). Phenomenological Research Methods for Counselling Psychology. *Journal of Counseling Psychology, 52* (2), 167-177.

Wery, A., Vogelaere, K., Challet-Bouju, G., Poudat, F., Caillon, J., Lever, D., Billieux, J. & Grall-Bronnec (2016). Characteristics of self-identified sexual addicts in a behavioural addiction outpatient clinic. *Journal of Behavioural Addictions, 5*(4), 623-630.

Willig, C. (2009). *Introducing qualitative research in psychology*. UK: Open University Press.

Willig, C. (2012). *Qualitative Interpretation and Analysis in Psychology*. Maidenhead: Open University Press.

Wingfield, R. (2007). Reflections on the role of frustration or aggression in sexual pleasure from an Attachment point of view. In K. White & J. Schwartz (Eds.). *Sexuality and Attachment in Clinical Practice* (pp. 57-64). London: Routeledge.

Woehler, E.S., Giordano, A.L. & Hagedorn, W.B. (2018). Moments of Relational Depth in Sex Addiction Treatment. *Sexual Addiction & Compulsivity, 25*(2-3), 153-169.

Woods, P. (2013) Group analytic therapy for compulsive users of internet pornography, *Psychoanalytic Psychotherapy, 27*(4), 306-318, DOI: 10.1080/02668734.2013.853907

Working Party on the Code of Research Ethics, British Psychological Society (2014). *Code of Human Research Ethics*. Leicester: British Psychological Society.

Wylie, K. (2015). *ABC of sexual health*. (3rd ed). Hoboken, NJ: John Wiley & Sons, Inc.

Yalom, I.D. (1980). *Existential psychotherapy*. New York, NY: Basic Books.

Yardley, L. (2000). Dilemmas in Qualitative Research. *Psychology & Health, 15*(2), 215-228, DOI: 10.1080/08870440008400302

Yontef, G. (1991). Dialogic Engagement. *British Gestalt Journal, 1*(5), 16-20.

Ziegler, P. (2000) Treating Gay, Lesbian, Bisexual and Transgender Professionals with Addictive Disease, *Journal of Gay & Lesbian Psychotherapy, 3*(3-4), 59-68, DOI: 10.1300/J236v03n03_05

Zitzman, S. & Butler, M. (2005) Attachment, Addiction, and Recovery: Conjoint Marital Therapy for Recovery from a Sexual Addiction, *Sexual Addiction & Compulsivity, 12*(4), 311-337, DOI: 10.1080/10720160500362652

Appendix 1 - Proposed Criteria for Hypersexuality Disorder (APA, 2012)

A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urgers and sexual behaviour in association with four or more of the following five criteria:
    a. Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behaviour.
    b. Repetitively engaging in these sexual fantasies, urges and behaviour in response to dysphoric mood states.
    c. Repetitively engaging in sexual fantasies, urges and behaviour in response to stressful life events.
    d. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges and behaviour.
    e. Repetitively engaging in sexual behaviour 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 behaviour.
C. These sexual fantasies, urges and behaviour arenot due to direct physiological effects of exogenous substances (e.g. durges 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 Behaviour with consenting adults, Cybersex, Telephone Sex, Adult Entertainment Venues/Clubs.

Specify if: In a controlled environment, in remission (no distress, impairment, or recurring behaviour for five years and in an uncontrolled environment).

Appendix 2 – Invitation to Participate

Self in Sexual Addiction

Invitation to participate in a study on the Self in Sexual Addiction

If you identify as a porn addict, and would be willing to be interviewed confidentially about your experience, please read the information below.

Most of the information available on sexual addiction is of a statistical nature, rather than on the experience of the individual. The aim of this study is to inquire into the lived experience of sexual addiction. It will focus on the participant's views on living with sexual addiction, and how this impacts self-perception and relationships.

All information will be kept confidential. Participants are free to drop out of the study at any point, prior to publication of results.

This study has been reviewed and approved by the Metanoia Research Ethics Committee and is being undertaken bas part of the course requirements for a Doctorate in Counselling Psychology and Psychotherapy.

For more information please read the attached document, or contact me on marieali@gmail.com
Thank you

Maria Ali

Appendix 3 – Participation Information Sheet (PIS)

Self in Sexual Addiction

Participant Information Sheet

Metanoia Institute and Middlesex University

Invitation to participate in a study on the Self in Sexual Addiction

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.
Thank you for reading this.

Purpose of the Study

The aim of this study is to inquire into the lived experience of sexual addiction. It will focus on the participant's views on living with sexual addiction, and how this impacts self-perception and relationships.

Why have I been chosen?

Organisations, practitioners and groups who work with sex addicts were contacted and informed of the study. Their permission was sought to distribute this information. Participants are chosen based on the criteria that they identify as porn addicts. If you are a porn addict and also engage in other forms of sexual addiction, you are still eligible to participate.
A total of six participants will be invited for interviews.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason at any point prior to the publication of results.

What will happen to me if I take part?
If you choose to the participate in the study, you will be asked to attend an interview which will be audio-recorded, and lasting no longer than 90 minutes.

What are the risks involved?

Whilst no risks are directly involved by participating, during the interviews you may become distressed. Should this happen, you may choose to terminate the interview. There will be an opportunity to debrief. Should you require support after the interview, further information and contacts can be given.

You may also find the following contacts useful:

NHS: http://www.nhs.uk/Livewell/addiction/Pages/sexandloveaddiction.aspx

Sexaholics Anonymous: http://sauk.org

Sex and Love Addicts Anonymous: www.slaauk.org

Sex Addicts Anonymous: www.saa-recovery.org.uk

What are the possible benefits of taking part?

We hope that participating in the study will help you. However, this cannot be guaranteed. The information we get from this study may be informative in helping us understand the experience of sexual addiction, and this may help us treat future participants with sexual addiction better.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name removed so that you are not recognised.

The interview will be recorded, but all personally-identifying information will be changed to protect your identity and the identity of any other people you name. When the recording of the interview has been transcribed, the recording will be erased. Data will be stored in password protected computer files only accessible by the researcher. All of the information you provide will be treated confidentially.

I am ethically bound by the British Psychological Society to report any risk of harm. Only in these circumstances can confidentiality be breached, as per the British Psychological Society's Code of Ethics and Conduct, Section 1.2. The circumstances in which confidentiality can be breached involve the safety of the participant, the safety of others and the health, welfare and safety of children and vulnerable adults. For this reason, you are being asked not to disclose instances of illegal activity for which you have not been convicted.

What will happen to the results of the research study?

Results of this study will be published as part of a postgraduate dissertation. Results may also be presented at conferences or in articles. You will not be recognisable from results published.

Ethical Review

This study was reviewed and approved by the Metanoia Research Ethics Committee.

Contact for Further Information

Any queries you have may be discussed prior to the interview. You may contact me at marieali@gmail.com
Alternatively, you may contact my supervisor, Dr Richard de Visser, at 01273 876585, or r.de-visser@sussex.ac.uk
Metanoia Research Ethics Committee: 020 8579 2505

You will be given a copy of this information sheet to keep, as well as a signed consent form to keep.

Version Number:

Date:

Thank you

Maria Ali

Researcher

Appendix 4 – Interview Schedule

Family Background

Could you tell me about your family background?

How would you describe your relationship with your family members, as a child? And now?

What were your family's view on sex?

Information on Sex Addiction

When and how did it start?

Could you tell me what your addiction involved? (Behaviour, Frequency)

Has it changed over time?

Were there any times in your life when you weren't using pornography (engaging in

[behaviour])?

Significant Relationships/Relationship History

Ask about relationship/dating history. (Prompts: When did you start dating? Was it important to be in a relationship? Were there any "patterns"?)

What was your family's attitudes towards women/dating/relationships?

Attitudes towards Sex Addicition

How do you manage other people's responses to sex addiction in general?

What in your opinion, drives sexual addiction? What was your experience?

Self-Perception

Can you tell me about experiences or people in your life that influenced the way you saw/see yourself.

How do you think others see you?

Do people in your life know about the addiction? Has it changed your relationship with them? (Did you tell them, why? Did they find out?) What was that process like for you?

Experiences

Can you tell me about efforts to control your addiction?

When did you decide to seek help? Why?

What has helped you control it?

What has hindered you?

Has your addiction impacted your relationships?

Relapse

Has it interfered with how you lead your life?

Can you tell me about a time when you were close to relapsing, but didn't?

Do you engage in other sexual behaviours that would fall under sex addiction? (GIve examples)

Could you tell me about a time when you relapsed? (Prompts: more than once? any triggers?)

Do you do take measures to prevent relapse?

Appendix 5 – Tracey (2010) Check-list for Qualitative Research

Tracey (2010, p. 842) Eight "Big-Tent" Criteria for Excellent Qualitative Research

Criteria for quality (end goal)	Various means, practices, and methods through which to achieve
Worthy topic	The topic of the research is • Relevant • Timely • Significant • Interesting
Rich rigor	The study uses sufficient, abundant, appropriate, and complex • Theoretical constructs • Data and time in the field • Sample(s) • Context(s) • Data collection and analysis processes
Sincerity	The study is characterized by • Self-reflexivity about subjective values, biases, and inclinations of the researcher(s) • Transparency about the methods and challenges
Credibility	The research is marked by • Thick description, concrete detail, explication of tacit (nontextual) knowledge, and showing rather than telling • Triangulation or crystallization • Multivocality • Member reflections
Resonance	The research influences, affects, or moves particular readers or a variety of audiences through • Aesthetic, evocative representation • Naturalistic generalizations • Transferable findings
Significant contribution	The research provides a significant contribution • Conceptually/theoretically • Practically • Morally • Methodologically • Heuristically
Ethical	The research considers • Procedural ethics (such as human subjects) • Situational and culturally specific ethics • Relational ethics • Exiting ethics (leaving the scene and sharing the research)
Meaningful coherence	The study • Achieves what it purports to be about • Uses methods and procedures that fit its stated goals • Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other

Appendix 6 – Creswell and Creswell (2018) Check-list for Qualitative Research

Creswell and Creswell (2018, p. 241) Checklist of Questions for Designing a Qualitative Procedure

- Are the basic characteristics of qualitative studies mentioned?
- Is the specific type of qualitative design to be used in the study mentioned? Is the history of, a definition of, and application for the design mentioned?
- Does the reader gain an understanding of the researcher's role or reflexivitiy in the study (past historical, social, cultural experiences, personal connections, to sites and people, steps in gaining entry, and sensitive ethical issues), and how they may shape interpretations made in the study?
- Is the purposeful sampling strategy for sites and individuals identified?
- Is a clear recruitment strategy for enrolling participants mentioned?
- Are the specific forms of data collection mentioned and rationale given for their use?
- Are the procedures for recofrding information during the data collection detailed?
- Are the data analysis steps identified?
- Is there evidence that the researcher has organised the data for analysis?
- Has the researcher reviewed the data generally to obtain a sense of the information?
- Are the ways that the data will be represented mentioned - such as in tables, graphs and figures?
- Has the researcher coded the data?
- Have the codes been developed to form a description and/or to identify themes?
- Are the themes interrelated to show a higher level of analysis been specified (personal experiences, the literature, questions, action agenda)?
- Has the researcher mentioned the outcome of the study (developed a theory), provided a complex picture of themes)?
- Have multiple strategies been cited for validating the findings?

Appendix 7 – Adam's Transcript: Keywords

Abandonment

- Mother going to parties when he was ill
- Never got calls at school
- Mother's suicide (she didn't say good-bye), wondered if she really loved him

Displacement

- Parents - moved countries
- Early childhood - moving countries
- Moved to countryside with mother and step-father
- Changed schools often
- Sent to boarding school
- As an adult - moving countries several times

Violence

- Between parents
- Chasing Mother with knife
- Fighting at school
- Physical fights with first wife
- Father ferocious temper
- War refugee
- Father in the army
- Working in war zones

Others

- Abandonment by and Rejection from others
- Violence
- Not able to speak to others (romantic relationships and friendships). Repeated several times – to young boy, at parties, to cover model girlfriend.
- Wanting to avoid others
- No friends
- Not liked
- Church failed me
- I wasn't interested in people.
- I got the impression my wife had nothing against massages and happy endings
- I was isolating. I didn't want to see friends.

- Considering the other’s perspective to change behaviour
- I’m now able to sponsor other people and it’s wonderfully rewarding.

Father

- No mention of father after mother re-married
- Father was in the army
- "Not a fighter like my father"
- Similarities with Father
- He couldn't remember afterwards what he'd done and "He said it was an accident" [of breaking mother's nose] - shows a lack of ownership, similarly lack of ownership when he talks of addiction - "it made me do things".
- I was a Ferocious little fellow and father had a Ferocious temper
- Sexual adventurer
- Affairs

Mother

- Suicide
- Never cuddled him
- Would leave him alone when ill to go to parties
- People saw her as wonderful
- Never called when he was at school
- Mother had affairs

Affect

- Humiliation after fight, sheets, school fete
- "I swallowed that" (fight,
- Disgust (sheets,
- Guilt about masturbation
- Fear
- Self-pity
- Dread
- Felt dreadful about masturbating in front of boy
- Relief (look for relief), and when he “got rid of my self-pity”
- I was ashamed.
- Sinking feeling
- Fear like tinnitus

Relationships

- “I was completely incapable of having a relationship with anybody”.
- I couldn’t have relationships at all
- “I would go and sit on the toilet in order to avoid any sort, people looking at me, and not really knowing people
- “I just wasn’t able to develop a warm interdependent fulfilling loving intimate loving relationship with anyone”.
- This poor girl was led up the gum tree by me.
- I was completely afraid.
- She was betrayed and horrified.
- After we split up she said those two years were hell. She hated it.
- Two relationships since second wife
- “I had the most lovely physical intimate relationship with her. The sort of thing you dream, when you really give yourself to someone”.

Friendships

- No desire to be in a relationship with anybody
- "I really hate him"
- Lost friendships

Sex

- Prostitution (first time totally unsatisfactory and perfunctory), and as a means of solving sexual problem.
- Unhealthy sex with myself
- Had an affair with a friend of a friend
- “I was totally indiscriminate”.
- “I never sought to express or fulifil love through sex. It was just about the orgasm. There was no intimacy, it was just mechanical”.
- I wasn’t participating in family life.
- “Didn’t want a relationship with her I just wanted sex”.
- Sex as a need
- As separate from relationships – with long-term girlfriend, with wife.

Sex Addiction

- Masturbation, massage parlours, prostitutes, watching porn when having sex with wife, tried to have an affair with a colleague, sex with men, tried to fondle a stranger who came to the flat to sell DVDs, not wearing underwear when he went out so that people could see his penis.
- Planning to myself
- “I got myself into a state”

- “Shivering, sweating obsession”
- As external entity "this thing" "it" "it ruins lives" "it made me do..."
- Prevented from getting darker through confession
- Relief after acting out
- “I don’t have this terrible thing hanging on to me”
- “This was my answer”.
- I felt that my brain was in my groin. I was being dragged around the streets of London by my penis.
- It was something I didn’t want to do. (Shows lack of control, desire to stop for discussion).
- I was like a drunk in a liquor store
- “Being loved by a sex addict would not have been very productive”.
- “So although I kept on going to brothels and masturbating next to her when I thought she was asleep, we stayed together.
- I was isolating. I didn’t want to see friends.
- Planning to go to massage parlour when wife was at work. Got caught.
- This thing made me do things that were outside my cultural upbringing.
- An offence to God, but not to wife and children.
- Addiction is probably good for you. It forced me to do what I had to – get a new life and become a good person.
- Controlled my life
- “Made me do bad things for myself and others around me”
- All other considerations were thrown out. It made me into a greedy totally selfish totally inconsiderate, hard, unloving, un-intimate, defensive boring person. ... It made me a cheat, a liar, a thief, an unreliable bastard. Self-seeker.”
- Masturbation
- Only consolation and pleasure in life
- Guilt
- Disgusting
- Daily
- In the toilets on the train alone on the way home after term
- In front of pretty boy

Religion

- Confession after acting out, continued even at the age of 69
- Sin against God
- I don't believe in divorce
- Church failed me
- Didn’t want an abortion on grounds of being Catholic.

Rejection

- I was the unwanted child of an unwanted marriage
- “I thought my god I’ve been rejected and rejection was the big thing all my life. To me I wait someone and I’m just waiting to be rejected and so poor little me that’s the story of my life”.

Recovery

- Meditation
- Decided to seek therapy after his wife left him, and two months later had gone to visit his children for Christmas. During the visit he “acted out” and decided that he needed to change.
- EMDR
- Stopped going to prostitutes since he had EMDR
- Barry was a “good guy”.
- Self-pity identified as trigger
- 12 steps
- Worked on mental obsession and physical compulsion
- Addressed fantasies and fears
- Felt lighter
- 12 steps
- Feeling happy and having peace
- “I didn’t fight I gave in and didn’t ask in return and this is what’s making me into the human being I was meant to be before I got screwed up as a young person.

Trauma

- War
- Being abandoned by mother?
- Traumatic experience of wife overhearing him make an appointment with a massage parlour.

Lack of ownership?

- Church failed me
- I went to a brothel because that’s what we did, I always went off to brothels whenever I could.
- I didn’t know that [sex addiction] was responsible for my behaviour.
- This thing made me do things Made me do bad things for myself and others around me

Self-Perception

- Selfish - “I was interested in what was going on inside me only”.
- Ferocious
- "The whole world is against you nobody really like you and they are probably right.
- I couldn’t be normal
- Shy
- Desolate existence
- I was impossible to talk to
- Contradiction between my behaviour and what I thought I was. I always wanted to be good but always behaved badly.
- I was totally closed in myself. I wasn’t a nice person to be with, I was horrible.
- “This was not the man I was or wanted to be”.
- Totally selfish, totally insane.
- Poor Andrew
- I’m free to be loving and generous and kind.
- Considering the other’s perspective to change behaviour, when he was leaving his wife.
- Compassionate, loyal, spiritual, intelligent, charming, a mediator, a nice person, “I think I’m ok”.

Appendix 8 - Table of Main Themes and Sub-Themes for Adam

Self-Perception	View of Self Affect Abandonment and Rejection Lack of Ownership
Others	Perception of Others Friendships Others' Perception of self Mother Father Relationships
Formative Circumstances and Experiences	Violence Displacement Religion Trauma
Addiction	Sexual Behaviour Addiction Recovery