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Sex addiction: therapist perspectives

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ABSTRACT

Sexual addiction may be defined as sexual behaviour that is "compulsive and yet continues despite adverse consequences". Knowledge and understanding of sexual addiction has been impaired by the use of multiple labels, definitions, and assessment procedures, hence the present study investigated therapist perspectives and experiences of assessing and treating the condition. Interviews were conducted with nine psychosexual therapists and subjected to interpretive phenomenological analysis. Three superordinate themes emerged from the analysis. These were distress, risk, and treatment. The distress theme included three sub-themes: stress and coping; suicidal ideation; and partner experience. Three sub-themes formed the risk theme: physical safety; disease, dysfunctions, and pregnancy; and co-addiction. The treatment theme contained three sub-themes: awareness; assessment and diagnosis; and successful therapy. Findings have important implications for the diagnosis and treatment of sexual addiction. Future research should investigate these themes further and introduce interventions to support the safety and well-being of sexual addiction clients.

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Interpretative phenomenological analysis; sexual addiction; sexual compulsion; therapy; treatment

Introduction

Sexual addiction may be defined as sexual behaviour that is "compulsive and yet continues despite adverse consequences" (Carnes & Adams, 2013, p. 5). It is characterised by the failure to resist impulses, pleasure or release following sexual behaviour, increased tension prior to sexual activity, and a lack of control (Goodman, 1990). Understanding of this condition is however hindered by the use of multiple labels, definitions, and assessment procedures. For example, though the label sexual addiction was originally proposed and perhaps as a consequence is most widely accepted, literature refers to addiction, compulsion, dependence, impulsivity, and excessive sexual behaviour (see Gold & Heffner, 1998 for a review). Furthermore, some professional bodies deny the existence of such a condition and consider sexual addiction to be a myth or social construct. They argue that within a dominant monogamous heterosexual culture, non-relational sex and excessive sex have been pathologised and reject attempts to diagnose sexual addiction. Furthermore, for those accepting that a condition exists which should be termed sexual addiction,

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substantial variation occurs with regards to the conceptualisation of addiction and the degree to which treatment providers view addiction as a disease or a coping mechanism (Russell, Davies, & Hunter, 2011).

Estimates of sexual addiction prevalence range between 3% and 10% (Carnes, 1991; Cooper, Morahan-Martin, Mathy, & Maheu, 2002), though the prevalence of sexual addiction within the UK remains unclear (Griffiths & Dhuffar, 2014). Men, and particularly men who have sex with men, homosexual men, and bisexual men, are more likely to self-diagnose or be diagnosed with sexual addiction (Kuzma & Black, 2008; Missildine, Feldstein, Punzalan, & Parsons, 2005). Furthermore, men and women may differ in their experience of sexual addiction. For example, Skegg, Nada-Raja, Dickson, and Paul (2010) report that women engage in concurrent sexual relationships, large numbers of opposite sex partners, or sex with partners from the Internet whereas men described same-sex attraction and paying for heterosexual sex. These sex differences may be exacerbated by societal perceptions of male and female sexual behaviour, shame, and stigma which may disproportionately impact on female clients. Of course, attempts to accurately determine the prevalence of sex addiction are hindered by the lack of agreement which surrounds definition and diagnosis. Furthermore, though standardised approaches have been developed such as the Sexual Addictions Screening Test (Carnes, 1989) these are not typically intended for minority groups (e.g. women and non-heterosexual clients).

Those experiencing sexual addiction may engage in frequent sexual encounters, sexual risk taking, compulsive masturbation, frequent use of pornography, and obsessive thoughts (e.g. Briken, Habermann, Berner, & Hill, 2007; Grov, Parsons, & Bimbi, 2010). Shame and secrecy, a lack of control, and a separation of intimacy and sexual behaviour may also occur. The intensity, occurrence, and scope of sexual addiction increase across time and may extend to exploitation or illegal behaviour (Irons & Schneider, 1994). Hence, addiction can result in distress, reduced quality of life, and poor physical and psychological health which impact on personal, relational, and occupational pursuits (e.g. Kuzma & Black, 2008; Odlaug et al., 2013). Indeed though the compulsive behaviours and obsessive thoughts appear to temporarily reduce stress and anxiety, they produce an unhealthy self-perpetuating cycle.

Therapist-led treatment approaches are available to support those with sexual addiction including a 12-step programme, group therapy, and pharmacological interventions (see Gold & Heffner, 1998 for a review). Relatively few treatment evaluations are available however and "current evidence on efficacy, efficiency and security of psychotherapeutic treatment of sexual addiction is insufficient to guide clinicians in terms of the best techniques and the most appropriate duration of treatment" (Garcia et al., 2016, p. 59). It is therefore important to consider therapist accounts which may reveal important information about client experiences, the therapeutic relationship, and the condition itself which can inform the treatment process and improve current practice (e.g. Mackereth, Parekh, & Donald, 2012; Rybovic, Halkett, Banati, & Cox, 2008). Furthermore, it is important to obtain therapist perspectives as previous research has documented the manner in which therapist characteristics, beliefs, and behaviours influence client outcomes (Degnan, Seymour-Hyde, Harris, & Berry, 2016; Moyers & Miller, 2013).

The current study employed interpretative phenomenological analysis to investigate therapist perspectives of assessing and treating sexual addiction. The approach has been

Table 1. Participant characteristics.

No	Age	Sex	Location	Work history	Primary modality	Sex addiction cases in current practice
(1)	50	F	Private	11 years as a psychotherapist and 5 years as a psychosexual therapist	Person-centred	80%
(2)	32	F	Private	4 years as a couple therapist and 1 year as a sexual addiction therapist	Eclectic-integrated	20%
(3)	61	F	Private	28 years as a couple therapist and 21 years as a psychosexual therapist	Psychodynamic	40%
(4)	48	M	Private and NHS	18 years as a psychotherapist and 5 years as a psychosexual therapist	Person Centred	80%
(5)	55	M	Private	20 years as a couple therapist	Integrated	70%
(6)	45	M	Private	5 years as a couple therapist and 1 year as a sexual addiction therapist	Psychodynamic, systemic, and CBT	25%
(7)	52	F	Private	15 years as an addiction therapist, and 10 years as a psychosexual therapist and sexual addiction therapist	Integrated	100%
(8)	55	M	Private	10 years as a couple therapist and 3 years as a sexual addiction therapist	Psychodynamic	25%
(9)	50	M	Private	12 years as an addiction therapist and 2 years as a sexual addiction therapist	Integrated	40%

successfully employed to understand patient and therapist perspectives of a range of conditions. For example, interpretative phenomenological analysis has highlighted those factors influencing the incidence of premature ejaculation, the impact of the condition on partners, and barriers to effective assessment and diagnosis (Brewer & Tidy, 2017).

Method

Participants

Participants ($N = 9$) were qualified psychosexual therapists identified via the Association for the Treatment of Sexual Addiction and Compulsivity (ATSAC) website. Each participant had provided therapy for sexual addiction for at least one year and was a registered member of a relevant organisation or professional body such as the College of Sexual and Relationship Therapists, British Association of Counselling and Psychotherapy, or the ATSAC. Participant age ranged from 32 to 61 years ($M = 49.78$, SD = 8.12) and post qualified experience ranged from 4 to 28 years ($M = 13.67$, SD = 7.57). Eight therapists worked in private practice only and one therapist worked in both private practice and National Health Service (NHS) settings. Primary counselling modalities were integrated ($n = 4$), psychodynamic ($n = 3$), and person-centred ($n = 2$). See Table 1 for full participant details.

Materials and procedure

Prior to interview, participants completed a questionnaire identifying demographic status, professional training history, and client profile. Individual semi-structured interviews were then conducted at the participant's place of work, with only the interviewer and interviewee present. Each interview lasted between 39 and 69 minutes ($M = 47.11$, SD = 9.43) resulting in 424 minutes of interview material. Open-ended questions prompted participants to report and reflect on their experiences. The interview schedule was

Table 2. Superordinate and sub-themes.

Superordinate theme	Sub-theme
Distress	Stress and coping
	Suicidal ideation
	Partner experience
Risk	Physical safety
	Disease, dysfunctions, and pregnancy
	Co-addiction
Treatment	Awareness
	Assessment and diagnosis
	Successful therapy

prepared following established guidelines (Smith, 1995) and questions were framed to obtain information about the aetiology and experience of sexual addiction and the recovery process. Interviews were recorded on a portable hand-held device and transcribed verbatim. Interviews were anonymised at the point of transcription and subjected to interpretive phenomenological analysis (Smith, 1996).

Interpretative phenomenological analysis adopts a phenomenological, hermeneutic, and idiographic perspective (Smith, Flowers, & Larkin, 2009) which allows researchers to describe, interpret, and understand the lived experience of a population and the manner in which individuals make sense of this lived experience. The researcher listened to the recordings, repeatedly read the interview transcripts to aid familiarisation, and made notes of significant areas of the text. Following further readings of the transcripts, notes were formed into emergent themes. Relationships between emerging themes were then identified and these were grouped into superordinate themes and sub-themes. The analytic process was validated by discussions between the first and second author, during which the appropriateness of each theme and sub-theme was established. Principles proposed by Smith et al. (2009) were adhered to throughout the data collection and analytic process to provide rigour and cohesion.

Results

Interpretative phenomenological analysis of interview transcripts generated three superordinate themes: (1) distress; (2) risk; and (3) treatment. Each superordinate theme contained a number of sub-themes, as detailed in Table 2.

Distress

Stress and coping

Therapists reported that stressful situations may act as triggers for sexual behaviour and described sexual addiction as a coping strategy for stress and past trauma. Specifically, sexual addiction serves to regulate emotions, e.g. to replace negative emotions. These maladapted coping strategies first appear to work for the clients but as the behaviours escalate and the clients engage in therapy they begin to realise that they are not coping. In addition, the consequences or potential consequences of discovery (e.g. dissolution of a relationship) exacerbated the stress experienced by clients. The clients are encouraged to

express their emotional needs to their family and friends and increase contact with them by replacing the time spent engaging in sexual behaviour with healthy social activity:

> Sex addiction is a form of emotion regulation, absolutely, 100%, 100%, it is a self-soothe mechanism, there is no doubt. They think they cope with it in their working day but actually when they look back they realised that they didn't cope with it at all, it is treadmill, they just keep going. (Therapist 1)

> Behavioural addictions are related to emotional regulation and coping. Again it seems that many people haven't been able to develop a way to regulate their emotions, to cope with stressful or upsetting events and therefore these behaviours are being used. One particular client uses massage parlours at stressful times or having a difficult time, he was using the massage parlours to relax, to calm and to cope with stress. They aren't really connecting with people, so a lot of the consequences of that is that they actually don't have anywhere to turn, they don't have friendships, the relationships aren't emotionally intimate. (Therapist 2)

> So for some people it is a way of forgetting, numbing out, and zoning out. For some people it is a way of lifting them out a numb place. For some people it is a way of giving them some energy, for some people it is bringing them down from hyperarousal. (Therapist 5)

Suicidal ideation

Five therapists spoke of sexual addiction clients presenting with suicidal thoughts. The suicidal thoughts were closely associated with discovery and relapse. Furthermore, whilst the remaining therapists reported no experience of clients presenting suicidal thoughts two mentioned that partners may have presented with suicidal thoughts, though this was believed to be of low risk:

> I have not had anybody with suicidal tendencies. I have had people that have told me their partners have been suicidal. (Therapist 1)

> I have had one client in particular recently who made a very serious suicide attempt when he thought that he was going to be exposed, which would have meant him losing his family. I would say about half of them will have had suicidal thoughts. (Therapist 3)

> About 20% of my clients have been suicidal… .just this week a client who I would have thought on the surface was not at risk at all because he is very wealthy, he seems to be fairly happy, he said that he felt suicidal. I asked him how often you feel like killing yourself, he replied about once a month, I asked if he had thought how he would do it. He said oh yes absolutely. (Therapist 7)

Partner experience

Each therapist commented on the manner in which sexual addiction impacts on the partner. Two therapists reported that partners can become obsessed with checking up on their partner and therefore exhibit compulsive behaviour themselves. Therapists also spoke about partners experiencing anxiety and depression which can lead to poor health and require medication. One therapist highlighted the importance of ongoing partner support and the extent to which dismissive, hostile, or angry behaviour can negatively impact on the recovery process. Therapists described partner trauma following a disclosure of sexual

addiction and indicated that this commonly results in longer recovery times than the person with the addiction. Hence, both the addict and partner require therapy:

> The partner is often very, very anxious or they may get depressed. Very often they will go on to medication, antidepressants at some stage, then they have time off work as they feel that their whole life has spiralled out of control. (Therapist 3)

> When dealing with sex addiction, partner support is very important, because it doesn't matter how well the addict is doing during the session, if when they go home and their partner is dismissive, hostile and keeps reminding them that they have done something bad, "how can you do that to me." This can knock them back. So the partner will need support in terms of understanding why, and that question can be ongoing for months. (Therapist 4)

> Partners of people with sex addiction have a dreadful time. For the partner who has discovered or just had a disclosure, that's when their trauma starts, and the recovery for partners in some respect can be a much lengthier, harder process than it is for people presenting the sex addiction. (Therapist 5)

Risk

Physical safety

Therapists described a range of sexual behaviours which placed clients at risk of physical harm (e.g. assault). These behaviours often included anonymous meetings and cruising and the practice of Bondage and Dominance, Sadism and Masochism. The risk to physical safety caused distress to both clients and therapists:

> The majority, if they meet people, are just oral sex, being tied up or humiliated, hit or whatever, but actual penetration, unless it is paid ladies or paid men, then there is penetration, but if they are just meeting or cruising, it's not penetration at all…The most severe risky sex my clients talk about is bondage and being hit but not auto-asphyxiation. (Therapist 1)

> I think the risky behaviours is a biggie because in terms of opportunistic people going onto the internet, trying to find someone to have sex with and then meeting them in public. One of the women was actually trying to recreate a rape scene. She was trying to have sex somewhere public with someone she didn't know, with a man she didn't know, and she was quite excited by the idea of rape. So the amount of risks involved with the behaviours she was undertaking was phenomenal. She could actually be killed because she was going in dark places, down the back of bars, down side streets, really dangerous situations. (Therapist 2)

> They are often quite risky; they want to have sex in a fairly public place. It is not that they want a relationship, because they will often have sex with somebody minutes after meeting them but they will often be quite risky…A client who came for therapy, so frightened, he had chatted to somebody online, didn't really know her and met up with her in a flat and she tied him up and asphyxiated him till he passed out, and he thought oh my God, next time I could be dead, so he was really afraid of that. (Therapist 3)

Disease, dysfunctions, and pregnancy

Five therapists described their clients' experience of sexually transmitted infections and sexual dysfunctions. It emerged that clients often practice unsafe sex and that the impact of these diseases and disorders can extend to partners. One therapist commented that

clients may repeatedly present at sexual health clinics with concerns about sexually transmitted infections and sexual disorders (such as erectile dysfunction or premature ejaculation) though their sexual addiction is not identified or addressed by the service. Three therapists spoke about pregnancy, births, or termination. These included termination following anonymous sex and childbirths resulting from extramarital relationships:

> There is a risk of pregnancy. I have had a couple of clients who have had a termination of pregnancy because they have had sex with a stranger and got pregnant. (Therapist 3)

> They will be meeting people they don't know, maybe sex with strangers and that can increase the risk of STI's or HIV. With females it could be pregnancy. When you talk about safe sex with them rationally they will say yes that is what I should be doing but when they were going through that addiction circle, everything just goes out of the window, so it is very unlikely that they will practice safe sex. If they become infected with any STI's potentially they can pass this onto their partners. (Therapist 4)

> In my experience the clients with sex addiction have had difficulties with usually either premature ejaculation or erectile dysfunction for the men. (Therapist 6)

Co-addiction

Each therapist identified other compulsive behaviours such as co-addictions or cross-addictions which may increase the risks posed to clients. These included issues associated with alcohol, gambling, shopping, exercise, and recreational drugs. One therapist highlighted genetic factors associated with sexual addiction (which may therefore influence other addictive behaviours) reflecting research in the field of epigenetics which has identified links between addiction and biological genetic gene expression.

> They tend to do other things, such as binge drink, binge eating, and other addictive behaviour. Sometimes it may be gambling as well, but it is not uncommon to have cross addiction. (Therapist 4)

> Clients report a history or present with other compulsive behaviours such as gambling, shopping, smoking, alcohol consumption. (Therapist 6)

> About 30% of my clients probably have some kind of cross-addiction as well. (Therapist 7)

Treatment

Awareness

Each therapist reported that the provision for sexual addiction is limited and provided primarily by private practice or by religious organisations. Three therapists commented on the limited awareness of sexual addiction amongst health care professionals and the general counselling community and provided examples of sexual addiction not being identified or assessed. This may reflect a reluctance to discuss sexual behaviour among health care professionals:

> Within the counselling community, I don't think there is a particularly high level of awareness. They don't recognise that there is a therapy for it, there is still quite a low awareness of

> sex addiction and sex addiction therapy. A client referral I had said they worked together for eighteen months previously and this hadn't been assessed or detected. (Therapist 2)

> I think the general awareness and genuine understanding of the problem is pretty shocking amongst other health professionals and that can have a significant impact on clients in terms of reinforcing shame, not being signposted to the right places for appropriate services. People who are trying to work with it who do not understand anything about sexuality or addiction. (Therapist 7)

> Some people are being seen by doctors but nobody is actually asking the right questions. (Therapist 8)

Assessment and diagnosis

All therapists commented on client assessment and diagnosis. Interviewees received mostly self-referral clients with the few remaining referrals provided by other counsellors or therapists. Self-referrals commonly presented with a self-diagnosis of sexual addiction though therapists reported being tentative with their use of sexual addiction as a label or diagnosis. In particular, those interviewed stated that the client's perception and experience was more important than the label. One therapist commented on the lack of diagnostic criteria in DSM V which may contribute to the tentative nature of providing a diagnosis due to uncertainty about diagnostic criteria. Overall, clients expected to receive a diagnosis and felt relief when this was provided; there could however be resistance to a diagnosis of addiction:

> They invariably turn up on the first day and say "I am a sex addict" I say let's look at this broader thing and do the assessment first. So what I say to them is you have turned out positive for addiction issues around sexual behaviour or we can call that out of control sexual behaviour, whichever fits better. (Therapist 1)

> Some people may self-diagnose, some people have been diagnosed by their partners. We sit lightly to the label, we might actually say well that is the sort of thing that we would describe as someone who has a sex addiction problem but it is not the label that counts but their actual experience. (Therapist 5)

> Sometimes people believe drug and alcohol addictions may be their primary addiction, in fact, it may not be, it may be that sex addiction is the primary addiction, so there is the question of assessing which comes first. I have not had a client that didn't see it as a positive thing. Again I don't do it as a label, I talk about more behaviours or showing signs than actually "oh yes you are a sex addict." (Therapist 6)

Successful therapy

Each therapist spoke about the importance of an integrated approach involving psychoeducation, cognitive behavioural therapy, and behaviour change-based interventions incorporating motivational interviewing techniques. Empathy towards the client and partner was believed to be particularly important. Four therapists also commented on the lies told within and outside of the treatment sessions and the subsequent difficulties those with sexual addiction experience developing trust with the therapist. Successful treatment often focused on a couple developing an appreciation of each other's difficulties,

understanding of their processes and feelings, and the re-establishment of trust and intimacy, allowing clients to recognise that their behaviour is inconsistent with their need for an emotionally close relationship:

> I think you have got to have a therapist who is willing to challenge, because the addicts are accomplished liars. I am not saying they lie all the time, because I think as they begin to trust you they will open up and be very honest, but I think as a therapist you have got to be very, very empathic towards that, but on the other hand you have got to be willing to challenge when they are lying. As you get to know the person you also get to know when they are telling the truth, not always, but often you will know. (Therapist 3)

> We require the cooperation and alliance with the client about how much motivation they have, whether they are coming of their own accord or whether they are coming because they have been discovered using porn or sex outside their marriage, their partners are expecting them to come and fix it. (Therapist 4)

Discussion

Interpretative phenomenological analysis revealed three superordinate themes (1) distress; (2) risk; and (3) treatment. Nine sub-themes emerged; these were stress and coping, suicidal ideation, partner experience, physical safety, disease, dysfunctions, and pregnancy, co-addiction, awareness, assessment and diagnosis, and successful treatment.

Distress

Sexual activity was viewed as a coping mechanism which at first appeared to regulate emotion though the maladaptive nature of this approach later became clear to clients. Findings are consistent with previous research indicating that sexual behaviour may be used to lower pain, anger, and fear (Hughes, 2010). It is therefore essential for successful treatment to include interventions which support the development of adaptive coping mechanisms. In particular, as clients often lack social support (Torres & Gore-Felton, 2007) they may be encouraged to strengthen their social networks.

Therapists commented on the incidence of suicidal ideation both amongst clients and their partners. Findings are consistent with previous online research demonstrating increased suicide risk among those with sexual addiction (de Tubino Scanavino et al., 2013). Risk of discovery in particular influenced suicidal ideation. Findings are also consistent with greater suicide risk amongst those attracting police attention for sexual offences (King et al., 2015) and demonstrate the importance of effective sexual addiction treatment.

Partners were believed to experience considerable distress, extending in some circumstances to anxiety, depression, and compulsive behaviour. Findings are consistent with research suggesting that sexual addiction influences the psychological well-being of the partner and the quality of the romantic relationship (Schneider, 2000). However, previous research indicates that sexual addiction is associated with an insecure attachment style (Weinstein, Katz, Eberhardt, Cohen, & Lejoyeux, 2015; Zapf, Greiner, & Carroll, 2008) and additional research is required to determine the extent to which specific factors (e.g. the addiction itself or other relationship dynamics) influence partner distress.

Risk

The increased prevalence of dating sites and mobile apps has provided greater opportunities for anonymous encounters and clients frequently placed themselves at risk. These situations included meeting in high crime areas and with strangers. Clients were therefore at substantial risk of physical harm. There is a paucity of research investigating sex addiction victimisation and future studies should investigate these experiences and consider interventions to safeguard vulnerable clients.

Clients often practiced unsafe sex leading to sexually transmitted infections and unplanned pregnancy. Findings are consistent with previous research indicating that sexual addiction increases the risk of sexually transmitted infections and is a barrier to disease prevention efforts (Kalichman & Cain, 2004; Reece, Plate, & Daughtry, 2001). Sexually transmitted infections may result in shame, stigma, or guilt (Malta et al., 2007) whilst unplanned pregnancy and termination are associated with a range of adverse consequences including emotional distress, anxiety, depression, and substance use (e.g. Lauzon, Roger-Achim, Achim, & Boyer, 2000; Thorp, Hartmann, & Shadigian, 2003). Future studies should further consider the consequences of sexual addiction and the promotion of protective behaviours such as condom use.

All therapists reported that clients presented with co-addictions; these included addiction to alcohol, gambling, and illegal substances. This is consistent with previous reports of co-addiction amongst those with sexual addiction (Carnes, Murray, & Charpentier, 2005; Odlaug et al., 2013; Swisher, 1995). Research suggests that comorbid sexual and substance addictions may be successfully treated concurrently (Hartman, Ho, Arbour, Hambley, & Lawson, 2012). It may however be difficult to identify the primary addiction and recommendations for the effective treatment of sexual addiction remain inconsistent. Further, for some clients, a successful detoxification programme may be required prior to commencement of the sexual addiction therapy and referral to a rehabilitation facility may be appropriate. Additional research is required to establish the relationship between sexual addiction and other addictions and the manner in which available treatments improve client well-being.

Treatment

Therapists commented on the low level of awareness amongst health professionals and counsellors and the inadequate provision available to support sexual addiction. This is consistent with previous reports of misdiagnosis and under diagnosis (Sussman, Lisha, & Griffiths, 2011; Swisher, 1995) and reports from mental health professionals themselves that they do not feel competent to treat problematic sexual behaviour (Short, Wetterneck, Bistricky, Shutter, & Chase, 2016). This situation may reflect a general reluctance to discuss sexual behaviour (Gott, Galena, Hinchcliff, & Elford, 2004). It is therefore difficult for health care professionals and therapists, without specific training, to work with or identify sexual addiction. Indeed therapists reported that those with sexual addiction repeatedly received medical attention (e.g. attended sexual health clinics) but sexual addiction was not discussed and therefore further support was not provided. Hence, there is a need for further training amongst health care professionals, particularly those providing sexual health treatment.

Clients often presented via self-referral and provided a self-diagnosis of sexual addiction, suggesting some understanding or awareness of the condition amongst the general population. Future research should investigate perceptions of the various terms employed by researchers and practitioners (e.g. compulsion, impulsivity, dependence) and the manner in which these are perceived by the general population. In particular, whether the term addiction is more or less stigmatising than other terms and more or less likely to encourage help seeking and disclosure. Additional studies may investigate the manner in which the lack of agreement with regards to terminology and definitions has impacted on the assessment and diagnosis process.

Treatment typically included a range of techniques such as cognitive behavioural therapy, trauma work, psychodynamic therapy, and psychoeducation. Counselling skills and empathy in particular were important. In part, this may serve to address the stigma and shame associated with sexual conditions. It is consistent with the importance of empathy reported by Swisher (1995). Of course, recommended treatments vary between therapists and future research should consider the manner in which provider characteristics (e.g. level or type of training) influence perceptions of sexual addiction and related practice. Further research is also required to establish levels of client honesty and the extent to which this impacts on treatment success. Whilst therapists in the present study appeared to be aware of client deception, less experienced therapists may not be and additional training or support may be required.

Limitations and future research

The current study employed a small sample which whilst limiting the number of therapists contributing allows an inherently rich analysis that may be constrained by larger sample sizes (Smith et al., 2009). The present study recruited therapists predominantly working in private practice and therefore treat clients who (1) can afford to pay for treatment and (2) are seeking support. Furthermore, clients were typically young to middle aged men with female partners. Subsequent research should explore the themes identified in the current study with a larger, more diverse sample. In particular, as therapist perspectives and experiences may vary, contributions should be obtained from therapists who do not associate with the ATSAC. These studies may consider the importance of both client and therapist characteristics. For example, few studies have considered sexual addiction amongst women which may reflect misunderstanding or the belief that few women experience sexual addiction and should be addressed (Ferree, 2001). Furthermore, the values held by therapists appear to influence the assessment of sexual addiction (Hecker, Trepper, Wetchler, & Fontaine, 1995), suggesting considerable variation in client experience.

To conclude, interviews were conducted with nine psychosexual therapists and subjected to interpretative phenomenological analysis. Three superordinate themes were identified; these were distress, risk, and treatment. The distress theme contained three sub-themes: stress and coping; suicidal ideation; and partner experience. The risk theme consisted of the physical safety, disease, dysfunctions, and pregnancy, and co-addiction sub-themes. Finally, the treatment theme contained three sub-themes: awareness; assessment and diagnosis; and successful therapy. Findings have important implications for the treatment of sexual addiction. Future research should further investigate these themes in

a wider, more diverse sample, and introduce interventions to support the safety and well-being of sexual addiction clients.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Dr Gayle Brewer is a Lecturer at the University of Liverpool. Her work specialises in romantic and sexual relationships. Paul Tidy is a therapist specialising in sexual addiction.

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