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OVERCOMING SEXUAL DEPENDENCY: USING ACCELERATED EXPERIENTIAL DYNAMIC PSYCHOTHERAPY (AEDP) TO HEAL ATTACHMENT WOUNDS

by

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ABSTRACT

This concept paper explores the influences of trauma and attachment with brain development and sexual dependency. Attachment failures in childhood and the development of attachment styles will be acknowledged as potentially predisposing individuals towards adapting sexually dependent coping strategies. Treatment modalities involving psychosomatic processing as discussed, provide substantial promise for addressing clients with sexual dependence. Accelerated Experiential Dynamic Therapy (AEDP) is an emerging approach which provides emotional and experiential healing while optimizing brain plasticity. This therapeutic approach to trauma acknowledges the deeper emotional wounds which commonly underlie addictive behaviours. By addressing emotional dysregulation within the safety of the therapeutic alliance, therapists can facilitate emotionally-corrective and reparative experiences. Sexual dependency treatment methods will be further discussed, while incorporating practical examples of these up-and-coming techniques.

Keywords: sexual dependency, trauma therapy, addictive behaviour, attachment theory, sexuality, accelerated experiential dynamic psychotherapy.

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RATIONALE AND INTRODUCTION

This concept paper has originated from a culmination of personal and professional experiences over several years. The desire to explore themes regarding sexuality started 20 years ago, in the context of profound conversations with friends and acquaintances. Many of them, like myself, grew up in conservative, Christian upbringings, where the topic of sex was mostly ignored or if it was addressed, it related to themes of sin and shame. I recall one of my friends, in particular, who courageously and vulnerably shared about his sexual angst. This single conversation opened the floodgates for ongoing discussions as we discovered how similar themes of shame, isolation, and hurt started to emerge with little resolution. I found myself wrestling with the difficult and confusing navigation of sexuality and its expression, along with the subsequent existential crisis that emerged from being innately sexual yet lacking the safety of a community to facilitate a deeper exploration.

Further into my adulthood and within the beginning stages of my professional counselling career, themes of sexuality once again began to emerge. While working as an intern at a social service agency focusing on substance dependencies, I became increasingly aware of the presence of sexual dependency alongside chemical dependence. Through conversations with my clinical director~~,~~ I began to consider the possibility of writing a thesis on sexual dependence. While working with these clients, the consistent presence of trauma-filled histories was undeniable. I noticed that the theme of sexual dependency presented itself in tandem with traumas pertaining to relationships.

Concurrently, I developed an interested in Accelerated Experiential Dynamic Psychotherapy (AEDP) as a therapeutic approach, which resonated with my personal interest in phenomenological experiences and the potential of using emotions for healing. I was drawn to AEDP's emphasis on stories of resilience, courage, and hope, which hold such a powerful potential for transformation. Upon personal reflection, including a return to significant moments in my own story of resilience and transformation, it became clear that an important aspect to explore would be effective therapeutic interventions for those facing sexual dependencies and attachment trauma. I truly believe that in order to successfully address one's sexual dependency, substantial emotional healing must be integrated into the therapeutic process. With further AEDP training, it became clear that this modality would successfully provide an avenue to achieve this goal.

Through my ongoing reflections on sexual dependence and the potential for AEDP with this population, it seemed that my explorations would be best formulated into a concept thesis. This idea weighed on my heart as I considered the opportunity to encapsulate the depth of pain, rejection, and shame experienced by those struggling with sexual dependency. The notion that I could incorporate my personal dialogues alongside my professional research and training to effectively present new methodologies towards treatment excited me immensely. As I considered this opportunity, I could not help but acknowledge the universality of suffering experienced with those facing dependency, and knew that my ongoing exploration of sexuality in both this thesis and my clinical practice would serve a profound purpose.

Once it was determined that I would be exploring the treatment of sexual dependency through an experiential therapeutic framework, in this case AEDP, the research for this project commenced. From onset of this process, I knew it would be important to seek out the experienced guidance of a qualified supervisor. This led to my selection of Dr. Alex Kwee, who specializes in addiction-related matters in both his private clinical practice as well as his research and publications. His knowledge, familiarity, and insight pertaining to sexuality, dependency, and spirituality has served as a guiding beacon throughout the formulation of this project. Additional clinical direction was received from interactions with Dr. Verseveldt, Dr. Pando-Mars, and Mr. Sabrouin, which only further strengthened my interest in this particular area.

Additionally, throughout this formulation period, I had the honour of working alongside several clients that considered themselves to be dealing with sexual dependence. These therapeutic journeys informed my personal and professional learning as well as clinical integration, and provided me with numerous first-hand accounts of the complexities involved when facing sexual dependence. As a result, I gained greater comprehension of both the dynamics involved in treating this issue and the drawbacks connected to previously developed treatment approaches.

In my endeavours to learn more about a possible interface between AEDP and sexual dependence as this might relate to diverse expressions of sexuality, I informally interviewed people with varying sexual preferences including: same sex relationships, bisexuality, fetishes, swinging, and polyamoury. From these interviews, I formed

tentative suppositions about the diversity of sexual expression and the phenomenological underpinnings of what may be considered adaptive and maladaptive sexual behaviour.

Over time my continued education in and clinical practice of AEDP provided me with a greater understanding of this therapeutic modality and reinforced my belief in its capacity to provide substantial healing for individuals facing sexual dependency.

Lastly, it was crucial for me to engage in a thorough literature search of publications pertaining to addiction, AEDP, attachment theory, eye movement desensitization and reprocessing (EMDR), sexual dependence, sexual addiction, sexuality, trauma, pornography, the effects of pornography, trauma and neurodevelopment, brain plasticity, existentialism, and spirituality. Often these search terms were used in conjunction with each other, in order to receive applicable search results. This research information has been accumulated over one year, reflected on carefully in light of my personal as well as professional development, and is now being synthesized into this thesis. It is written as a research concept paper.

Sexuality seems to dominate North American culture. In 1998, “sex” was the most frequently searched term on the Internet (Freeman-Longo & Blanchard, 1998). Recent statistics show that 12 out of the top 50 most frequently searched terms on the Google search engine are adult content related sites (Seattle Organics SEO, 2012). In America, a pornographic website is created every 39 minutes (Ropelato, 2012). Such websites would not continually be developed unless there is both demand for them and profitability in them. In 2011 alone, the pornography industry generated $97.06 billion, an amount greater than Microsoft, Google,

Amazon, eBay, Yahoo, Apple and Netflix combined (Ropelato, 2012). These shocking figures convey the dominance of the sex-industry within today's culture. The vast consumption of pornographic materials indicates a far-reaching, insatiable influence. This demand can be interpreted as a societal prioritization of pornographic and sex-related materials.

In today's society, sexual dependency is a relevant and seemingly unavoidable issue. Carnes, Delmonico, and Griffin (2007) stated that 20% of the American population browses pornographic sites. Furthermore, research suggests that internet pornography is often times one's first exposure to sexual material. The average exposure is 11 years old, while 70% of teenagers report regularly seeing sex-infused images online (Carnes, Delmonico, & Griffin, 2007; Eberstadt, 2010). These statistics convey that pornography consumption exists as a regular expression of sexuality and may play a role in developing sexual dependencies. The term "sexual dependency" refers to a phenomenological experience in which individuals use sexuality as a coping strategy, numbing moments of unwanted emotions instead of processing them.

Over the last few decades, sexuality has infiltrated the entertainment industry, advertisement, and most recently, social media. Children and teenagers are introduced to sexual content much earlier than ever before. While the average age for pornographic exposure is 11, significantly younger children are also being instilled with sexually suggestive messages. In his 2012 study, Jerry Ropelato noted that childrens' brand-names such as "Pokemon" and "Action Man" are targeted by pornographic websites to market their products, using similar terms to appear in online search engines. Children associate

these names with innocent entertainment, yet may encounter sexually explicit material by mistake. Early exposure of sexual experiences for young children may normalize the perpetuating pursuit of sexualized materials and sexual objectification into adulthood.

Intertwined with the prominence of pornographic websites and suggestive advertising, social media contributes to the normalization of increased sexualization. Facebook, MySpace, Twitter, Google+, Skype, online dating sites, and chat rooms provide numerous avenues for individuals to engage with explicit content or plan physical sexual encounters. The natural desire for sexual expression increase**s** involvement with sexually-related modalities. Forms of participation may include: posting provocative pictures, streaming suggestive web-cam footage, or conversing through racy posts, comments, or “tweets”. These varying outlets for sexual exploration and expression tempt individuals of all ages. As a result, these sexual experiences are readily available for those with access to the internet.

The prominence of the internet is redefining sexual expression in society. The popularity and accessibility of internet pornography allows for sexual exploration to occur behind closed doors (Daneback, Ross, & Månsson, 2006; Mustanski, 2001). Browsing suggestive websites is relatively inexpensive and private, offering the misconceptions of minimal consequences, intimacy, and sexual fulfilment. Over time, these activities, including viewing online pornography sites, have the potential to consume lives. These sexually-driven activities often become more elaborate, requiring increased amounts of time, energy, and money, which result in personal, social, relational, and occupational consequences (Carnes, 2001). The internet has decreased social,

financial, and personal barriers while increasing the exposure towards adult content related material. This may lead to new forms or solidify old forms of sexual dependence.

It is estimated that 13%-20% of the American population regularly browse pornographic sites and of those, 17% report problematic sexual behaviours (Carnes, 2001; Cooper, Delmonico, & Burg, 2000). Many individuals willingly engage in viewing sexual content but fail to acknowledge the potential for developing sexual dependency. According to Caroll et al. (2008), 67% of young men reported no problem with viewing internet pornography. While seemingly accepted by the majority of young males, this act has the potential to develop into a devastating dependency, which negatively affects individuals, their partners, and their families. Sussmann (2007) further supported indications of internet pornography's impact on the family system, postulating that nearly all male sex addicts utilize pornography within their addiction. Internet pornography has the potential of becoming a dependency itself or assists in supplementing other forms of sexual acting out, such as: prostitution, orgies, or fetishes**.** Time spent seeking out pornographic material bypasses potential interactions with spouses, partners, or child(ren). These individuals commonly choose their preferred sexual activities instead of fulfilling personal responsibilities, resulting in systemic, relational, and personal deterioration.

The detrimental effects of viewing online pornographic material are undeniable, yet this issue remains controversial. This dilemma is laden with varying viewpoints: can value be found in the heightened availability of online pornography, or are these avenues contributing to perpetuating sexual dependence? For instance, the level of healthy

masturbation is difficulty to objectively assess and needs to be considered on a more phenomenological and individual basis (Kwee & Hoover, 2008). Research has shown masturbation to provide benefits such as boosting the immune system, fighting prostate cancer, and alleviating depression (Denison, Grant, Calder, & Riley, 1999; Kelly, & Critchley, 1997; Leitzmann, Platz, Stampfer, Willet, & Giovannucci, 2004). In other cases, people may find educational value in viewing pornography, claiming sexual enhancement with their partners (Coleman, 1986; Goodman, 1990 & 1993). However, at what point do these and other common sexual practices threaten one's personal well-being and hinder functioning? While viewing pornography has the potential of enhancing one's sexual satisfaction or promoting prostate health in men through masturbation, this same behaviour may develop into an addiction for others. This dilemma is compounded by the fact that sexual addiction, or dependency, is exceptionally difficult to define.

A multitude of descriptors have been used for describing maladaptive sexual behaviour, including: compulsion, obsession, impulsion, dependence, sexual addiction, hypersexuality, intimacy disorder, and sexual dependence. While addictive behaviours are present, finding an accurate or appropriate description for the observed symptoms remains challenging. Sexuality is innate to human beings, making it incredibly difficult to differentiate between normal and maladaptive behaviour. Therefore, challenges arise when it comes to therapeutic interventions or treatment. Sexuality is an important part of one's identity, making it important not to deny or completely abstain from one's sexual expression, but rather develop ways to achieve fulfilment appropriately. In therapy, individuals with sexual dependence must be supported and encouraged to strive for

healthy functioning at a realistic and individualized pace. Treatment must be non-judgemental and offer likelihood for success.

In therapy, challenging individuals to adopt new behaviours and lifestyle changes without the necessary support and safety can be counterproductive to the healing process. Both from personal experience and reviewed literature, individuals who are sexually dependent often carry significant attachment wounds, which have occurred in childhood (Schwartz & Masters, 1994; Carnes & Delmoncio, 1996; Carnes, 2001; Schwartz & Galperin, 2000; Schachner & Shaver 2004). To effectively acknowledge these wounds, therapeutic goals may extend beyond the cessation of present-day symptoms and include the healing of deeper emotional and relational trauma. Through careful development and maintenance of the therapeutic relationship, the client's resiliency and resources can be encouraged, providing hope and potential for life transformation. A process that speaks to the existential and spiritual nature of human universality and its ability to adapt and evolve in most difficult circumstances. Emotional and relational deficits can be safely acknowledged and addressed within a caring and empathic setting. Without the invested time and safety of a developed therapeutic alliance, relapse will likely occur after treatment completion.

Group therapy, 12-Step programs and cognitive behavioural therapy have proven successful in the treatment of sexual dependency, yet relapse rates remain at 70%. (Brown, et al., 2006; Hook, Hook, & Hines, 2008; Muller & Rosenkranz, 2009; Schneider & Irons, 2001; Wan, Finlayson, & Rowles, 2000). Decreasing the likelihood for relapse requires comprehensive therapeutic interventions to appropriately address all

contributing factors. Treatment for sexual dependency must respectfully extend beyond currently utilized implementations. In order to effectively understand and treat sexual dependency, it is necessary to consider recent research pertaining to neurobiology and its relationship to trauma and addiction.

Damasio (1999), Odgen, Minton, & Pain, (2006), Schore (2001, 2002 & 2009a), and Siegel (1999) have explored the correlation between childhood trauma and brain development. This is valuable information when addressing sex addiction. Substantial connections have been found between individuals who “act out” sexually and who have experienced previous traumas; sexual, physical abuse, neglect, abandonment, and observed relational conflict or domestic violence.

Individuals who have experienced childhood trauma often develop relational and emotional deficits; wounds which carry negative impacts into adulthood. In the face of overwhelming emotions, necessary self-functioning qualities are absent, causing individuals to revert to and depend upon their psychological defences and coping mechanisms (Damasio, 1999; Fosha, 2008; Fosha & Slowiaczek, 1997).

Addressing clients' attachment issues and coping mechanisms provides a deeper understanding of their desires for intimacy and rationale towards their behaviour. According to Schwartz and Southern (2000), emotionally or physically maltreated or neglected children are caught in a double bind where their desires for love and connection persist, yet these desires remain unfulfilled. Eventually, children become dismissive or confused about their needs, developing “expectations of being hurt, disappointed, and abandoned” (Schwartz, 2008, p. 574).

Working through clients' attachment wounds through psychosomatic processing has the transformational capacity to re-shift relational patterns and curtail sexually dependent behaviours. In order to successfully overcome the addictive coping cycle, individuals must successfully develop alternative ways to manage emotional intensity. This process involves a two-part approach. First, individuals struggling with sexually maladaptive behaviours must lessen instances of acting out in an achievable manner. Eventually, individuals will ideally achieve abstinence from their sexually driven rituals. Secondly, by working through deeper attachment wounds, individuals will increase their relational capacity, developing the skills to safely connect with others when distressed, rather than pursuing sexually isolating behaviours when distressed. In order to achieve these two goals, effective trauma modalities must be incorporated to facilitate the necessary depth required for an individual's full recovery.

When treating sexual dependency, trauma informed approaches must be carefully considered within treatment. Identifying and overcoming clients’ traumas involves actively processing the attachment wounds resulting from their pain-filled pasts. To do so, an experiential, psychosomatic approach may prove beneficial in therapy. In working through trauma and by promoting self-functioning qualities, clients learn new aspects of existence that do not require them to compulsively engage in sexual activities.

This concept paper provides a clinical foundation to understand how to process emotions while fully addressing the effects of sexual dependency. It explores the issue itself and draws on recent advances in psychosomatic processing modalities for promising, effective treatment outcomes. Attachment psychology will provide the

theoretical framework by which to understand sexual dependency. From the foundational attachment approach, issues pertaining to intimacy and dysfunction will be discussed as they relate to sexual dependency. A discussion of primary emotions and how to facilitate integration within the therapeutic process will be the next vital step. This also touches on the importance in psychological processing in regards to physiological affects both in the body and the brain. This modality will be further described, outlining how it can integrate traumatic relational experiences while providing efficiency of treatment for sexual dependence (Fosha, 2000).

This treatment option does not focus on the reduction of maladaptive behaviour as a primary purpose. Instead, therapists work with clients' expressed psychosomatic and emotional experiences within sessions. By processing emotions in the "here-and-now", clients actually access the plasticity potential of their brain, allowing for new neural connections to be created through experience (Bradshaw, Cook, & McDonald, 2011; Siegel, 1999). ADEP allows individuals to work through psychological defences and inter-personal triggers, developing resilience and transformational growth. Successfully achieving this growth causes the emergence of hope for clients, furthering the positive changes in their lives. This approach increase the possibility to process trauma on a psychosomatic level with increased effectiveness. An integral part of successfully processing clients' painful traumatic memories is a strong therapeutic relationship. AEDP believes in the human potential of transformation rather than fixating on psychopathology. In this, the aim extends beyond symptom cessation, including existential and experiential shifts which allow individuals to expand their identity beyond

just being a “sex addict”. The value placed on safety within the therapeutic relationship provides an opportunity for therapists to accompany individuals as they work towards developing appropriate, beneficial relational behaviours.

The author explores and highlights the relationship of attachment, trauma, and the brain as contributing to the cycle of sexual dependence in males. Within this discussion, the author aspires to identify how incorporating psychosomatic processing in the recovery process may prove huge benefits for individuals dealing with sex dependence. This process will be explained through the integration of clinical interventions developed by AEDP. The author's hope is to highlight the need for trauma processing within the treatment of sex dependence, with the ultimate goal of accessing and unlocking an individual's innate transformative potential. This transformative potential has spiritual components that works with inner concept of a person’s identity and existence. The therapeutic process itself is innately spiritual because AEDP highlights the value of human beings and their existential experience of life, while seeing sexual dependence as a maladaptive behavioural coping strategy.

CHAPTER ONE: TERMINOLOGY FOR ABNORMAL SEXUAL BEHAVIOUR

While masturbation or viewing pornography can be seen as socially acceptable, these same acts may also be considered as disgusting, dysfunctional, or perpetuating sexual dependency (Hook, Hook, & Hines, 2008). When looking at adaptive and maladaptive sexual behaviour, its effects cannot only be measured according to type, frequency, and acceptability. For instance, at what point does masturbation or viewing pornography become pathological? Sexuality and sexual expression differ immensely between individuals, therefore making it difficult to determine when sexual expressions become problematic (Giles, 2006). Coleman (1986, 1990, 1992) and Guigliano (2009) have cautioned against using the term “addiction”, which can exaggerate cultural bias, potentially oppress sexual minorities, pathologize normalcy, and oversimplify a complex biopsychosocial phenomenon. While the term “addiction” is seen as potentially discriminating, a common frame of reference is still necessary to define unhealthy sexual expressions.

The difficulty in finding a clear, consistent definition for sexually maladaptive behaviour is due to the enormous range of frequency and diversity of sexual expression (Marshall, Marshall, Moulden, & Serran, 2008). A study by Twhoig, Crosby, and Cox (2009) suggests that similar usage of sexual materials has differing effects on individuals. Certain individuals had the propensity to develop sexually maladaptive behaviour, yet others engaged in these sexual acts without developing a dependency.

In an ideal situation, therapists would easily be able to differentiate between healthy sexual functioning and sexual addiction. In order to accurately diagnose a client's sexual behaviour, specific guidelines and symptomatology must be present. Clearly established definitions and guidelines pertaining to sexual dependency would assist clinicians in developing effective treatment plans and resources. According to Katehakis (2012), a formal diagnostic criteria would more effectively determine the presence of problematic sexual behaviour and prevent misdiagnosis. Having an appropriate conceptualization of sexual dependency would alleviate any confusion potentially arising in therapeutic settings.

Establishing clear definitions around sexual dependence may ease anxiety for individuals who are concerned about their sexual behaviour. Specified guidelines allows for clear diagnoses that assures individuals that their concerns and symptoms are not uncommon but are encountered by clinicians and shared by other individuals. Having established terminology around sexual dependence provides perspective for individuals who may be overwhelmed by their situation. By normalizing these behaviours with an universal frame of reference, clients may re-frame their experience into a larger social context.

Multiple terms describing sexually maladaptive behaviours are currently being used. In order to understand the slight differences between terminologies, it is important to discuss each concept. These commonly-used terms include: sexual disorders, sexual dysfunctions, compulsion, obsession, impulsion, dependence, hypersexuality, and intimacy disorder (APA, 2000; Hall, 2008; Kaplan, 1995, 2008; Schwartz, 2008;

Schwartz & Masters, 1994). These terms all describe varying characteristics appearing with clients who struggle with sexually maladaptive behaviours. These terminologies have been developed by the American Psychiatric Association (APA), prominent researchers in the field of sex addiction, and the author's own framework.

American Psychiatric Association Terminology

The American Psychiatric Association (2000) references several forms of abnormal sexual functioning. The Diagnostic and Statistical Manual of Mental Disorders Text Revision(DSM-IV-TR) outlined key factors which must be present in the diagnosis of a sexual disorder (APA, 2000). Initially, sexual disorders can be distinguished as either paraphilic or non-paraphilic activities (APA, 2000; Carnes, 2001; Hook et al., 2008; Kafka & Prentky, 1994). Paraphilic activities are those which include objects, role-play, sadism, masochism, voyeurism and fetishes, whereas non-paraphilic acts are "… characterized by a lack of control of the individual's sexual drive towards culturally sanctioned activities such as masturbation, pornography, or protracted promiscuity" (Hook, et al., 2008, p. 219). While the DSM-IV provides diagnoses for numerous sexual dysfunctions and disorders, it fails to capture the complete nature of sexual dependence, which is commonly referred to as "sexual disorder unspecified" within therapeutic communities (APA, 2000; Giugliano, 2009). The newly released DSM-V places greater priority on the sexual response cycle, while also requiring a minimum six month duration before assigning a diagnosis in order to bypass transient symptoms (APA, 2013; 2013a). Beyond the descriptions of specific sexual disorders, the APA also integrates the following characteristics when discussing forms of addictive behaviours.

Compulsion.

Compulsions are defined as repetitive behaviours or mental acts in which the goal is to prevent or to reduce anxiety instead of obtaining pleasure and gratification (APA, 2000). Furthermore, Guigliano (2009) described compulsive sexual activities as being used by individuals wishing to desensitize feelings of pain, inadequacy, low self-esteem, isolation, and loneliness. In essence, individuals with sexual dependency are repeatedly seeking out sexual acts to achieve a calmer state of functioning by decreasing experienced negative emotions.

Obsession.

Obsessions are persistent thoughts, impulses, ideas, or images (Guigliano, 2009). They differ from compulsions in that acting on them does not necessarily reduce one's anxiety. Obsessions may also perpetuate into fantasies or beliefs that anxiety will only be diminished if certain sexual acts are performed in specific ways or with specific objects (Adams & Robinson, 2001; APA, 2000; Carnes, 2001). Carnes (2001) identified a common sexual obsession as a belief that sex is a necessity for life and must be attained at all costs. Such beliefs result in sex being an individual's primary focus, oftentimes leading to unrealistic expectations in relationships, thus perpetuating individualized acts of sexual exploration and expression.

Impulsion.

The term impulsion can be defined as an increasing tension which can only be relieved once an act or ritual has been performed (APA, 2000; Guigliano, 2009). This tension creates a powerful and addictive urge for individuals struggling with sex

addiction. They are forced to decide between acting out or tolerating their own internal and emotional discomfort. These undesirable options leave individuals in a double-bind, feeling helpless, guilty, and consumed with shame. Within this double bind, individuals can neither win nor escape from their lingering emotional pain.

Dependence.

The APA (2000) defined dependence as behaviours that develop tolerance over time and require increased amounts of time, energy, or money to maintain similar effects. Furthermore, individuals often neglect relationships or responsibilities due to the addictive sexual behaviours and subsequent withdrawal symptoms emerge when the activities cease (APA, 2000; Giugliano, 2009). Dependence can be identified and diagnosed when three of the following seven criteria are met: “Tolerance, withdrawal, behaviour engaged in longer and greater amounts than intended, unsuccessful efforts of control behaviour, significant time spent, important activities reduced or given up due to addictive behaviour, continued engagement in addictive behaviour despite consequences” (APA, 2000, p. 197).

Clinical Definitions

Clinicians and researchers have conceptualized the existence of sexual addiction as being a separate entity from the APA’s established list of sexual disorders (Carnes, 1988, 2001; Carnes, Delmonico, & Griffin, 2007; Carnes, & Wilson, 2002). The established APA terminology may further benefit more comprehensive definitions of sexual maladaptive behaviour as an addiction or dependency. Researchers in the field of

sex addiction have conceptualized additional terms which extend beyond the DSM-V's criterion, providing a comprehensive depiction of sexually addictive behaviour.

Sexual addiction.

Patrick Carnes (1988), who coined the term "sex addicted behaviour", has been influential in identifying sexually maladaptive activities which cannot be explained by the APA's established criteria. His descriptions of sex addicted behaviour includes the following symptoms: (a) out-of-control behaviour, (b) severe consequences due to sexual behaviour, (c) inability to stop the behaviours despite adverse consequences, (d) a desire to limit sexual behaviour, (e) sexual obsession and fantasy, (f) increasing amounts of sexual experience because the current level of activity is no longer sufficient, (g) severe mood changes around sexual activity, (h) inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual experience, and (i) neglect of important social, occupational, or recreational activities because of sexual behaviour (Carnes, 1991).

Carnes (2001) identified three levels of sexual behaviours ranging from socially acceptable to criminal. Sexually dependent acts are considered as level one activities commonly viewed as socially appropriate or acceptable. According to Carnes (2001), these behaviours include: masturbation, pornography, and prostitution. The second level lists spousal abuse, voyeurism, and stalking as offences, while level three highlights criminal offences such as rape or pedophilia. In this paper, the maladaptive sexual activities addressed will specifically focus on online pornographic usage, a level one behaviour.

Hypersexuality.

Hypersexuality is a recently developed term which defines an increasing lack of control regarding one's sexual activities and behaviour. Kaplan (2008) described hypersexuality as a pathological lack of inhibition in regards to one's sexual desires. This description has been discussed as a less stigmatizing term when compared to addiction, yet still encapsulates the addiction–related components of obsession, compulsion, and impulsion.

Intimacy disorder.

Through the theoretical attachment framework, intimacy disorders occur when trauma and the subsequent attachment wounds result in individuals seeking out unhealthy self-soothing behaviours (Carnes & Adams, 2002; Hall, 2008; Schwartz & Masters, 1994). Tronick (1989) postulated that when abandoned or neglected children retreat into themselves for comfort and self soothing, the basis for "adult intimacy disorder" is formed (Schwartz & Galerperin, 2000; & Schwartz & Southern, 2000). Both Carnes (2001) and Schwartz and Southern (2000) have identified marginalized family environments as contributing to emotional disconnection and neglect. These environments, which may include aspects such as low socio-economic status, poor living conditions, minimal income or unemployment, may contribute to individuals withdrawing socially and distancing themselves from important relational connections. Instead of interpersonal connections, individuals may pursue sexual behaviours, which act as a replacement for intimacy. Schwartz (2008) further elaborated on the connection between attachment and developed intimacy disorders, providing the following rationale:

> The importance of using the lens of attachment theory is that sexual disorders can be understood as a manifestation of pair-bonding, courtship, attraction, love, affection, and intimacy. Without adequate parenting, a child grapples with “increased” appetite for nurturing and care-taking, while simultaneously adapting by becoming dismissive of such needs, with expectations of being hurt, disappointed, abandoned, and so on. In this way, needs themselves have become “dangerous” and associated with fear. The solution to both needing and fearing is paraphilia. The person becomes aroused by pictures or objects, rather than people, - the fetish distances and provides a ritualistic illusion of control, in what would otherwise be a terrifying situation. (p. 573)

While Carnes (2001) and Schwartz (2008) have shown the possible sexual repercussions of an intimacy disorder, it is not conclusive that intimacy disorders result in maladaptive sexual behaviours. Some individuals may have relational difficulties yet do not develop sexual dependence. However, underlying attachment issues are commonly see in those who do develop sexual dependence.

Author's Definition

The difficulty in defining these various maladaptive constructs is that the terms can easily be misinterpreted and misidentified. Although these terms have been established, there is no specific term that encapsulates the full meaning and description of what can been seen as problematic sexual behaviours. The author suggests using the term

sexual dependence which has several attributes adapted from Carnes' (1988, 1991 2001) "sexual addiction" and Schwartz's (1999, 2000, 2008) "intimacy disorder".

Sexual dependence.

For the purpose of defining maladaptive sexual behaviour, the term *sexual dependence* encapsulates several attributes, providing a simplified and flexible description. Sexual dependence describes an instance where individuals are dependent on sexual activity or expression in order to function, while being aware of increasing personal concerns and/or external consequences that affect their lives. This definition distances itself from a medical model of symptomatology as seen within the term "addiction".

The term sexual dependence embraces a more post-modern, phenomenological framework. Individuals' experiences and assessment of their behaviours are identified as important, allowing for personal customization of one's experiences. Furthermore, this phenomenological approach allows for simplicity where individuals are given the power to determine if these behaviours are beneficial or a hindrance within their life. Sexual dependence provides a coping mechanism that allows individuals to numb out negative emotional experiences. Schwartz and Southern (2000) posit that individuals who experience dissonance or discomfort may find anonymous and emotionless sexual activities safer than working through relational problems with a spouse or partner. One form of finding relief from painful experiences is in the form of sexual anticipation and release. In essence, sexual dependence becomes a form of escape for psychological suffering, which individuals are not able to solve.

Due to the phenomenological definition of this term, sexual dependence acknowledges widespread influential variables such as social, environmental, and biological factors contributing to maladaptive sexual behaviour (Coleman, 1986, 1990, 1992; Guigliano, 2009). Hence, it is important that sexual activities are viewed with tolerance and flexibility, allowing individuals to use their subjectivity to define dependency. Therefore, the primary prerequisite for a sexual dependency would be that individuals view their own behaviours as ego-dystonic, in that they experience personal conflict and/or external consequences directly due to the sexual activities.

Sexual dependence may include but does not specifically require compulsion, obsession, or impulsion. These components are not required to validate an individual's diagnosis of dependence. On a more concrete level, sexual dependence often displays classic characteristics of addiction including loss of control, withdrawal symptoms, and continuation despite harmful consequences, yet one's ability to tolerate symptoms or comfort thresholds may vary immensely (Briken et al., 2007; Goodman, 1993). Treatment should not be based on the validation of diagnosis and whether or not individuals fit into a certain criteria. Rather, treatment should be a phenomenological interpretation which allows people to seek therapy through personal motivation in trying to curb their problematic sexual behaviours (Orford, 1978). The phenomenological approach to defining sex dependence not only values clients and their experiences, but also initiates a therapeutic journey of exploration.

Highlighting the phenomenological aspect of sexual dependence leaves openness for the exploration of the human experience. Every story of sexual dependency is

different, individuals that enter into the therapy room are often hoping that their life can be better but do not know how to change. The term “sexual dependence” further incorporates the human desire for self-actualization, it acknowledges the efforts of individuals to cope and work through their own pain as a part of creating existential meaning around suffering and striving towards the self-actualizing growth, which is powered by the human spirit.

CHAPTER TWO: CO-MORBIDITY AND ETIOLOGY

When working with sexual dependence, therapists consistently encounter additional, undisclosed mental health concerns and addictive behaviours (Carnes & Wilson, 2002; Hagedorn, 2009; Schwartz & Southern, 2000). Most of individuals experiencing sexual dependencies are married and frequently college educated professionals, which shows high functionality to meet societal norms. The high-functioning nature of these clients often misleads therapists from looking into the deeper abuse or trauma histories. A variety of co-morbid factors commonly exist alongside sexual dependency, with 72% also suffering from affective disorders (Schwartz & Southern, 2000). When addressing sexual dependency, therapists have to be aware of the numerous mental health concerns that contribute to and perpetuate the issue, including depression, anxiety, and obsessive-compulsive behaviour (Longo & Bays, 2006). Clients will often seek assistance for one concern, even though several other factors may be contributing to their dependency. These factors need to be addressed in conjunction with sexual dependence, otherwise the path to recovery will be arduous as individuals continue to rely on their coping strategies. The sexual acting out may simply be the coping mechanism used to cope with the other, deeper undisclosed issues. In order to address sex dependence effectively, therapists need to acknowledge underlying issues that may be hindering clients' success for recovery.

Other forms of addiction regularly accompany sexual dependence. Carnes and Wilson (2002) stated that 83% of individuals struggling with dependence report multiple addictions, including: substance abuse (42%), eating disorders (38%), compulsive

working (28%), compulsive spending (26%), and gambling (5%). Since substance abuse is the most common co-morbid factor with sexual dependency, therapists must be prepared to address both. Schwartz and Southern (2000) state that 74% od with men battling sexual dependency reported chemical dependence.

Etiologic pathways towards sex dependence have socio-economic correlations. Case studies conducted on high-risk groups and sex offenders have found correlations between sexual addiction and both disconnected family interactions and impoverished family environments (Carnes & Delmonico, 1996; Schwartz & Southern, 2000; Perera et al., 2009). Economically and socially impoverished upbringing increases the risk of poor self-esteem and poorer ability to self-regulate emotional distress (Perera et al., 2009), while Carnes (2001) stated that upper social classes often have the financial resources to indulge in addictive sexual behaviours without experiencing negative consequences. Only recently, professionals have wondered whether sexual dependence is perhaps underestimated within the middle and upper income families (Carnes, 2001, Perera et al., 2009). It seems that sexual dependency, may not be limited to one social-economic group but that other groups have had greater resources to cover up their dependence issues.

There are also high correlation rates between individuals with sexual dependence and trauma. Ferree (2002) reported that 78% of self-diagnosed sex addicts were subjected to sexual abuse during childhood. Additional statistics further support the extensive range of abuse experienced by sex dependent individuals: 68%-81% sexual abuse, 72% physical abuse, as well as alarming reports of emotional abuse (Carnes, 1991; Schwartz & Southern, 2000). There are hypothetical correlations pertaining to an individual's

experiences predisposing them to greater vulnerability for developing sex dependence. For instance, religious and social backgrounds may influence the development of sexual dependence (Carnes, 2001). A more pressing emphasis should be the role of attachment and subsequent traumas experienced during childhood.

CHAPTER THREE: SEXUAL DEPENDENCE, ATTACHMENT, AND TRAUMA

As previously stated, multiple factors contribute to the development of sexual dependency. A common thread experienced by many struggling with sex dependence is trauma in childhood. Longo and Bays (2006) estimate that about one in five children experiences sexual abuse. In Canada, one out of every three female children and one out of every six male children suffer unwanted sexual experiences before reaching adulthood (Trocmé, et al., 2000). In a longitudinal study spanning over eight years, researchers found that between 4% and 16% of children are physically abused, up to 10% of girls and 5% of boys suffer severe sexual abuse, and 15% are neglected (Sharples, 2008). Unfortunately, countless instances of child abuse go unreported. Estimates suggest that only one in ten abusive incidents is actually confirmed by social-service agencies (Sharples, 2008). According to Trocmé and Wolfe (1998), abusive incidents are defines as follows:

> When a child's parents or other caregivers are not providing the requisites of a child's emotional, psychological, and physical development. Physical neglect occurs when a child's needs for food, clothing, shelter, cleanliness, medical care and protection from harm are not adequately met. Emotional neglect occurs when a child's need to feel loved, wanted, safe, and worthy is not met. (p. 14)

Of all the reported child maltreatment cases, 33% remain unsubstantiated by police and child welfare investigation (Trocmé & Wolfe, 1998). Trauma is further proliferated when children voice their concerns, which are met with minimization or denial from caregivers.

When facing such concerns, children must learn how to manage and cope with their pain in isolation.

Evidence indicates that early-onset trauma affects the development of interpersonal relationship attachments, coping skills towards stressful stimuli, and emotional regulation (Fosha 2000; Greenberg 2008; Schore, 2001, 2002, & 2003). Unrepaired, painful events experienced within childhood perpetuate traumatic attachment wounds (Schore, 2008). Attachment styles further predict the resilience and resources children develop in the face of difficult circumstances (Schwartz; 2008). It is not only events, such as physical or sexual traumas, that can affect children. Constant disconnected or volatile relationships with caregivers, such as neglect or abandonment, can also be traumatic. The relationship between trauma and attachment becomes reciprocal in nature and individuals learn to adapt according to their circumstances.

Attachment Styles and Sexual Dependence

A major argument in the causality of sexual addition comes from the field of attachment psychology. Bowlby (1973) and Ainsworth (1967) pioneered the attachment theory, as they worked with mothers and infants. Their research has been expanded to include attachment styles and the impact of these styles on sexuality (Schachner & Shaver, 2004). Samenow (2010) discussed the possibility of certain attachment styles as having a higher likelihood towards sexual dependence. Acknowledging the role of attachment styles is crucial to understanding the needs and tendencies of individuals engaging in sexual dependence.

One of the tenets of attachment theory is that an individual's childhood relationships and intimacy develop into schemas. Caregivers are the relational templates that are modeled to individuals throughout their developmental years. These schemas then become an internal working model or point of reference through which internalized expectations are established which govern a person's relational experiences.

Hazan and Shaver (1987) postulated a connection between romance/sexuality and attachment styles within adulthood. They identified four distinct categories: *secure, dismissive-avoidant, anxious-preoccupied, and fearful-avoidant.* Muller and Rosenkranz (2009) further added to the descriptions by adding a descriptive spectrum (low to high) with regards to relational anxiety and avoidance. Recent research has found that two attachment styles are predisposed to sexual dependency. Schwartz and Galerperin (2000) have identified as dismissing-avoidant and anxious-peroccupied attachment styles as more likely to participate in sexual activities outside committed relationships. This suggests that certain attachment styles, which are based on childhood experiences, are more susceptible towards development of sexual dependence. In order to understand why certain attachment styles are linked to sexual dependency, a richer and more detailed discussion follows.

Secure attachment.

These primary relational patterns influence people's ability and outlook on how to function and view subsequent intimate relationships. In a mother-infant dyad, the child learns attachment patterns through affect, which is communicated through emotional connection and is primarily nonverbal (Schore, 2001). Connection and eventual verbal

communication are essential to fostering secure attachment in infants (Papousek & Papousek, 1997). In attachment psychology, a secure relational dyad is labelled as a "good-enough" caretaker, meaning that caretakers are attuned to a child's emotional needs and "assist in processing emotions until the child becomes able to self-regulate" (Fosha & Slowiaczek, 1997, p. 231). Children who have learned how to self-regulate have greater resilience and internal resources when it comes to problem solving and overcoming adversity. Secure attachments to caretakers benefit both child development and self-functions such as self-efficacy, self-esteem, self reflection, and self care (Papousek & Papousek, 1997; Schachner & Shaver, 2004).

In adulthood, individuals with secure attachment tend to develop long, stable, and satisfying relationships (Schachner & Shaver, 2004). This is highlighted by relational traits such as trust and friendship. On a sexual level, securely attached individuals are able to mutually initiate sexual activity, enjoy physical contact, express desires, and demonstrate openness for sexual exploration (Hazan, Zeifman, & Middleton, 1994; Schachner & Shaver, 2004). Overall, individuals with secure attachments have a higher potential of relational satisfaction, in which their needs are met and they are able to meet their partner's needs.

Dismissive-avoidant.

The dismissing-avoidant style describes a second attachment type. Muller and Rosenkranz (2009) equate the denial for attachment needs as a preference developed during childhood, regularly seen in dismissive-avoidant types. In children this is express when they do not seek connection after the return of a caregiver and distance seems to be

the safest place for them (Beatson & Taryan, 2002). These individuals often have high attachment anxiety and low avoidance anxiety, meaning that anxiety increases with intimacy and decreases with relational distance (Muller & Rosenkranz, 2009).

Dismissing-avoidant adults display different sexual patterns than securely attached individuals. Those with dismissing attachment have high attachment anxiety, focusing more on affection and less on sexual intercourse. For these individuals, sex is primarily done to fit in and "show warm feelings towards their partner" (Schachner & Shaver, 2004, p. 191). These individuals show high anxiety towards sexual attractiveness and acceptability, coupled with an intense fear of rejection (Hazan, Zeifman, & Middleton, 1994). People who experience the dismissive-avoidant attachment style will often participate in sexual activities without seeking affection or emotional attachment (Schwartz, 2008). They also tend to have less relational satisfaction and greater break-up rates than other attachment styles (Hazan & Shaver, 1987). These individuals are more likely to engage in pornography due to the safety associated with images, rather than people (Schachner & Shaver, 2004).

Anxious-preoccupied.

In children, this attachment style manifests itself through intense separation anxiety. While seeking close contact with their caregiver, they show anger towards their caregiver for being separated and have difficulties being comforted (Beatson & Taryan, 2002, p. 221). Conversely, individuals who have an anxious-preoccupied attachment style yearn for love. In these cases, the attachment anxiety is low and attachment avoidance is high. This person would be uncomfortable with closeness, exhibiting high avoidance including

contact with others in times of stress, meaning that individuals are eager for relational connection and overpower any concerns for personal needs and well-being. There is a strong sense for closeness, yet these individuals consistently worry about their relationships and have a constant fear of being rejected (Muller & Rosenkranz, 2009). They often function nervously within relationships, always expecting rejection from others.

Schwartz (2008) stated that anxious-preoccupied individuals are often labelled as having sexual dependence issues. They are described as commonly engaging with multiple anonymous sex partners, without achieving satisfaction. This is seen in a strong need for closeness, while being sensitive to rejection and anxious about potential abandonment. Sex is utilized to feel valued and as a way to overcome negative emotions; a way to cope with insecurities (Schachner & Shaver, 2004). Those with this attachment style commonly face frequent break-ups, finding themselves in a cycle of passionate romance and obsession (Hazan & Shaver, 1987).

Fearful-avoidant.

The fourth identified attachment style is fearful-avoidant, in which individuals desire connection but also have a high fear of rejection (Muller & Rosenkranz, 2009). In childhood, the development of this attachment pattern is often associated with complex family environments. This complexity arises in that children are uncertain when they are safe or when they need to protect themselves from their caregiver. The love and connection experienced may suddenly change and be replaced with fear and uncertainty. As children, these individuals lack a cohesive and organized response that allows them to

know when to seek comfort. These individuals were likely subjected to great amounts of stress (Beatson & Taryan, 2002). According to Schwartz (2008), high levels of anxiety and avoidance are combined as main coping strategies that contribute to the development of an intimacy disorder.

A disorganized component has subsequently been added to the fearful-avoidant attachment style (Main, & Solomon, 1990; Main, Kaplan, & Cassidy, 1985). Since the attachment is disorganized, individuals long for meaningful and intimate connections but become instantly fearful once an intimate relationship is obtained. These individuals have high anxiety towards wanting to be in a meaningful relationship, yet once they achieve their desire, the anxiety shifts to avoidance, and they seek to distance themselves from intimate contact with partners (Muller & Rosenkranz, 2009). This disorganized pattern is very confusing to individuals and their partners. According to Liotti (2004), these individuals experiences high level of incoherence between "feeling and thinking while reporting memories of past attachment relationships" (p. 3), making it very stressful to connect in relationships.

Sexually, these individuals seek connection but lack a deeper fulfilment that comes with being able to trust and feel safe within the relationship. Discouraged with high break-up rates, a person with this attachment style may find pornography less anxiety producing (Schwartz, 2008). While willing to sacrifice their needs for intimacy, they are further motivated to avoid anxiety, numbing both needs and pain through sexual dependence.

Attachment Trauma and Attachment Failure

Attachment failures in childhood often cause an increase of traumatic experiences. The absence of an experienced sense of safety and support felt within the family affects a child's resilience and ability to mitigate circumstances in the face of traumatic situations. An infant's basic instinct is for survival. Through crying, infants communicate primal needs, and in their smiles, they hope to endear themselves and attach to primary caregivers. These behaviours strive to preserve the attachment relationship and raise their probability of survival. Survival is so crucial, that infants and children will even deny the very existence of abuse perpetrated by family members (or by a person outside the family). The abused child may collude with a parent's denial and dissociate from the traumatic memory (Bowlby, 1982; Freyd, 1997; Liotti, 2000).

Central to sexual dependence is the inability for individual to adequately bond and attach in intimate relationships. The origin of sexual dependence can be attributed to early developmental attachment failures with primary caregivers (Adams & Robinson, 2001; Carnes, 1991, 2001; Schwartz, 1996). When there is a failure in early developmental care-taking, children are unable to soothe feelings of loneliness, sadness, anger, and fear. In such situations, where individuals are unable to regulate their emotions, to affect dysregulation results, and the need for self-soothing rituals arise (Schwart,1996). Here, sexual pleasuring and self-induced orgasms are used to soothe and comfort states of internal distress. The experienced sexual feelings then become intertwined with the initial feelings of loneliness, sadness, anger, fear, and subsequently, shame, which further triggers the addictive cycle (Adams & Robinson, 2001).

Experienced childhood abuse is traumatic due to the detrimental impact it has on the child's ability to trust and attach to caregivers. Emotional, physical, or sexual abuse suffered during childhood contributes to insecure attachment with the caregiver and is seen as one of the primary causes of psychopathology that causes sexual coping strategies (Mueller & Rosenkranz, 2009). Witnessing or experiencing abuse contributes to insecure attachment. Abuse experienced during childhood is incorporated into one's belief systems, becoming internalized expectations which influence the individual's relational experiences.

Early attachment patterns to primary caregivers may also make men more susceptible towards sexual dependence. Both avoidant and preoccupied attachment stances may use sexual activities in order to avoid intimacy (Schwartz & Southern, 2008). Individuals may also seek sex to fill an emotional void. Sexual activities may provide the perception of pseudo-intimacy, even though it is often practised in isolation or with emotionally unavailable partners. This creates a safe distance, from which individuals can function without being emotionally overwhelmed. If the relationship were to become more intimate, these individuals will likely distance, disconnect, and find someone else.

In a study of 400 college students, Schachner and Shaver (2004) reported that individuals with anxious attachment used sex to reduce their insecurity and create intimacy, while avoidant individuals used sex in order to "increase their status and prestige among peers" (p.181). Attachment deficiencies may decrease an individual's

ability for self-regulation, which increases the search for emotional regulation through outside sources such as sexual activities (Johnson, 2004).

Research pertaining to neurology and emotional attachments identifies secure attachments to caregivers as positively affecting brain development and learning; creating both positive affect functioning and resilience (Greenberg, 2008; Johnson, 2004; Russell & Fosha, 2008; Schore, 2000, 2001, & 2003). The dyadic interaction between newborns and their mothers provides a model for the infant to develop internal regulatory processes, for self-soothing. Ideally, caretakers will assist children to de-escalate from aroused states; an important skill allowing individuals to create internal homeostasis. This means individuals are able to meet their needs through adaptive behaviours coming from either internal or external surroundings. Kohut (1971) believed that certain causes for psychopathology in adults arise by the absence of empathy and regulation in the mother-child dyad in the face of traumatic experiences. Herman (1990) identified that abused children become more likely to exhibit self-destructive behaviour as they may have learned to find release when their emotions becoming dysregulated. This leads to deficits in the infant's development as they are making behavioural adjustments to compensate for attachment deficiencies (Kohut, 1971).

Impact of Attachment Trauma and Sexual Dependence

Sexual dependence can be seen as a relational paradigm based on traumatic attachment. Through this lens, sex dependence is used to overcome traumatic experiences (Carnes, 2001). Central to the dependence is the inability of the individual to adequately bond and attach in intimate relationships. Adam and Robinson (2001) believed that sex

becomes a way to compensate for early attachment failure. Therefore, attachment orientation has increasingly been identified as an important component to therapy process and outcome (Davila & Levy, 2006; Muller & Rosenkranz, 2009).

The attachment theory lens allows sexual disorders to be understood as a manifestation of pair-bonding, courtship, attraction, love, affection, and intimacy. Without adequate parenting, a child grapples with an “increased” appetite for nurturing and care-taking, while simultaneously adapting by becoming dismissive of such needs, developing expectations of being hurt, disappointed, and abandoned. In this way, the needs themselves have become “dangerous” and associated with fear. One solution to both needing and fearing sexual pleasure is viewing online pornography. Arousal can be achieved through pictures or objects, rather than people.

CHAPTER FOUR: COPING MECHANISMS OF TRAUMA

Research shows that infants have two developmental reactions to trauma: hyperarousal and dissociation (Schore, 2001, 2002, & 2009b). These psychobiological responses are closely related and are bottom-line defensive mechanisms learned in early childhood. Hyperarousal, the biological response to danger, activates the parasympathetic system, providing individuals the greatest chance of survival. It is associated with the mid-brain and the amygdala, ensuring the activation of the sympathetic nervous system (SNS), while producing what is known as a fight or flight response (Panksepp, 2012). However, if the body cannot regulate itself after "overwhelming unbearable, emotional experiences," the brain releases chemicals that enable pain blunting, or dissociation, often referred to as "freeze effect" (Schore, 2009a, p. 195). Schore (2009a) further explains the interconnected functioning of hyperarousal and dissociation:

> As the sympathetic system is activated, the body can enter a state of hyperarousal. This active state of sympathetic hyperarousal is expressed in increased secretion of corticotropin releasing factors (CRF) – the brain's major stress hormone. CRF regulates the sympathetic catecholamine activity, creating a hypometabolic state in the developing brain. But a second later forming reaction to relational trauma is dissociation, in which the child disengages from stimuli in the external world. (p. 196)

The connection between hyperarousal and dissociation is that hyperarousal needs to occur before an individual can dissociate. The body readies itself to respond to a stressful

situation, however, when relief is not imminent, the body shuts down, resulting in a freeze state.

In the brain, the dorsal vagal complex controls intense emotional states through immobilization, severe metabolic depression, hyperarousal, and pain blunting dissociation (Schore, 2008). In a frozen, dissociative state, the parasympathetic system takes over amidst stressful situations, attempting to protect the individual. Infants and children use this freezing to avoid being noticed or drawing further negative attention (Powels, 1992; Schore, 2002). This catatonic state protects individuals from further wounding by allowing them to withdraw internally.

The right hemisphere of the brain has more extensive connections with the emotion processing limbic system than the left hemisphere. The limbic system derives subjective information in terms of emotional feelings, which is used by the brain to direct, organize, learn, and, adapt behaviour to a changing environment (Mesulam, 1998; Schore, 2002). The right hemisphere and the limbic region coordinate attachment, affect regulation, and arousal states based on emotions. “A traumatized child is often, at baseline, in a state of low-level fear-responding by using either hyperarousal or a dissociative adaptation – the child’s emotional, behavioural, and cognitive functioning will reflect this (often regressed) state” (Perry, et al., 1995, p. 274). If high arousal states persist, natural adaptation allows for the brain to become sensitized to external stressors often keeping the child in a continuous state of low-hypervigilance (Perry, et al., 1995).

Hyperarousal and dissociation have devastating effects on the growth of brain development structure. The survival mode induces an extreme alteration of the

bioenergetics of the developing brain. Experienced trauma that causes attachment ruptures have growth-inhibiting effects on synaptic growth, especially in the right hemisphere of the brain. Energy that could be used for normative child development is diverted into protective behaviours such as hyperarousal and dissociation. Rather than a child using their energy for the proliferation of synaptic connections, the infant's brain will use its energy to shift into hypometabolic survival modes instead of neurological adaptive growth. In these modes, all energy is diverted to hyperarousal and eventually dissociation, leaving little energy for growth (Schore, 2000 & 2002). Dissociation can be described as a disengagement from stimuli in the external world and attending to an "internal" world. When persons are overwhelmed by life experiences, dissociation facilitates alteration of one's consciousness, which allows aspects of self to be disconnected (Braun, 1988; Schwartz & Southern, 2000).

In states of heightened anxiety, the child's SNS goes into a fight-flight-or-freeze response. If infants are unattended without any soothing affirmation from caretakers, they will enter into a more primitive state of hypo-arousal known as parasympathetic withdrawal, which allows children to conserve energy by shutting down feelings. If this occurs with regularity and frequency, the child will develop a state of dissociation in order to compartmentalize the trauma (Katehakis, 2009; Perry, et al., 1995; Schore, 2003). A child experiencing traumatic events often does not have the resilience to overcome painful experiences without relational support. When this relational support is absent, residual feelings of unbearable aloneness, helplessness, and emptiness further compound the trauma, reducing a child's capacity for effective regulation of emotional

states (Russell & Fosha, 2008; Van der Kolk, 2002). These states leave a child hyperaroused and looking for ways to find relief; hence dissociation.

Hyperarousal, Dissociation, and Sexual Dependence

A way to overcome overwhelming negative feelings is through self-soothing. According to Schaeffer (2009), use of sex can become an inner "safety valve". It allows individuals to temporarily escape problems, reduce stress, and/or fix inner brokenness. Similarly, Levine (1997) posits that humans have a survival function in that the nervous system acts as a circuit breaker, allowing individuals to escape horrendous situations without risking emotional overload (Levine, 1997). Sexuality can allow for such a discharge, letting off just enough pressure to keep the system running, but not able to restore the system (Levine, 1997; Schaeffer, 2009).

When a person is agitated, a natural response is to desire and work towards establishing homeostasis, or emotional equilibrium, as quickly as possible. Caregivers are essential to help infants and young children achieve a calm state after their emotional and psychological systems have been aroused by an alarming event or crisis (Schore, 2009b). This cycle often occurs within one's childhood, during which the absence of caregivers emotionally desensitizes children, causing them to expect abandonment or isolation. This detrimental reality results in hyperarousal and dissociation as alternative coping strategies (Perry et al., 1995; Schore, 2001, 2002, & 2009b).

Through reoccurring traumatic experiences, children develop states of dissociation in order to compartmentalize the trauma (Katehakis, 2009; Perry, et al., 1995; Schore, 2003). As children develop into adulthood, they adopt additional coping

mechanisms to regulate the hyper-vigilant states. These coping strategies are activated when the body's homeostasis is deregulated and the person searches for external activities to assist in controlling negative feelings. The desired outcome is a numbing effect, which will allow the individual to effectively bypass overwhelming experiences. Sexual release through pornography usage reduces anxiety, floods the body with endorphines and induces the desired numbing effects, creating a powerful reinforcement for repeating behaviours.

Sexual Dependence as a Dissociative Experience

Schwartz and Southern (2000) have identified sexual dependence as being a dissociative experience. They posit that "dissociation is present when a person engages in secretive, illicit sex on the computer and then goes to bed with a spouse, without dissonance or discomfort" (Schwartz & Southern, 2000, p. 129). Sexual fantasies assist individuals to dissociate from the demands of life, "as well as the pain and shame of past trauma" (Schwartz & Southern, 2000, p. 127). Both Levine (1997) and Schaeffer (2009) identify unprocessed trauma as being stored within fearful memories in the body. Sex becomes an attempt to release, replay, and prove earlier traumas. However, these attempts are often unsuccessful without therapeutic assistance (Levine, 1997). The individual appear numb and disconnected from self and others, using orgasms as an escape from emptiness (Schwartz & Galperin, 2000). Although they may have initially used dissociation to cope with traumatic events, individuals subsequently dissociate to defend against a broad range of daily stressors, including post traumatic symptoms, which pervasively undermine the continuity of their experience (Allen & Coyne, 1995).

For clinicians it can sometimes be difficult to distinguish between traumatic and dissociative symptoms. There are some symptoms that have similar physical manifestation for both trauma and dissociation. Bradshaw and Cook (2008) have found both traumatic and dissociative artifacts are located in certain areas of the body. Dissociation mainly affects areas of the head and limbs, while trauma's physical effects are felt in the core body, including the chest and abdomen. A list of traumatic and dissociative artifacts is provided for clinicians in appendix A.

CHAPTER FIVE: THE BRAIN AND SEXUAL DEPENDENCE

In the early stages of an infant's life, proper development of brain functions are essential for survival. Post (1992) and Graham et al. (1999) both agree that environmental experiences impact brain development from birth. Even in the fetus, acute changes in maternal hormones can impact a child's brain to the extent of gene expression as early as the first trimester (Beatson & Taryan, 2002; Dowling, Martz, Leonard, & Zoeller, 2000; Schore, 2002). Brain functioning must develop quickly in order to ensure the greatest probability of survival for the infant. The brain informs the rest of the body about changes within the organism, its environment, and how survivable accommodations can be achieved between the organism and the environment (Damasio, 1994).

Both Siegel (1999) and Schore (2000 & 2001) further extrapolate that the maturation of an infant's brain is experience dependent. Experience is a critical component to the brain's wiring. It is conceptualized that lower parts of the brain need to develop before higher brain functions. Higher-level structures are thought to be dependent, in part, on the development of optimal functioning of lower-level structures (Fisher, Murray, & Bundy, 1991; Perry, et al., 1995). A stimulus activates a neural path and the synapse receives and stores the chemical signals (Kandel, 1998). When used repeatedly, the synapse is strengthened, eventually reaching a threshold level and becoming permanent. If the synapse is not used, it is eliminated (Berger-Hepworth, 1999).

The brain's limbic area controls attachment, affect regulation, and arousal. This area serves to derive subjective information in terms of emotional feelings and functions

to adapt to rapidly changing environments and organize new learning (Mesulam, 1998; Schore, 2002). Then, higher structures such as the frontal cortex are developed and used for reasoning and abstract thought (Perry et al., 1995). Changes in the lower structures of the brain affect the higher structure of brain development.

The frontal cortex is used for reasoning and abstract thought, while the limbic areas control attachment, affect regulation, and arousal states. Brain plasticity contributes to nervous tissue and the neurons that adapt and change to external stimuli. "A traumatized child is often, at baseline, in a state of low-level fear – responding by using either hyperarousal or a dissociative adaptation – the child's emotional, behavioural, and cognitive functioning will reflect this (often regressed) state" (Perry, et al., 1995, p. 274). Natural adaptation allows for the brain to become sensitized to external stressors keeping the child in a largely continuous state of low-hypervigilance (Perry et al., 1995). The regulatory function of the newborn-mother interaction may be an essential promoter to ensure the normal development and maintenance of synaptic connection during the establishment of functional brain circuits (Ovtscharoff & Braun, 2001).

The right hemisphere, more so than the left, forms extensive connections with the emotion processing limbic system. An earlier maturing right hemisphere is deeply connected to the limbic system and facilitates attachment connections to caregivers. Parental experiences trigger synapse firing that strengthen neuropathways which causes the transposing of social behaviour and experiences into biological structure, i.e.: brain development. (Cozonlino, 2002; Henry, 1993; Schore, 1994, 2001, 2008; Siegel, 1999). The development of secure attachment can be considered as a biological integration of

both right and left hemisphere functioning, which contribute to self-regulation (Fonagy, Steele, Steele, Moran, & Higgitt, 1991) The right hemisphere is specialized for generating self-awareness and self-recognition and for the processing of “self-related material” (Schore, 2009a). These self-functions are important for clients with sexual dependencies in regards to impulse control and resilience in the face of adversity.

These areas of attachment and self-functioning are often developmentally delayed or stunted in individuals struggling with sex dependence. In these cases, the attachment ruptures experienced in the child-caregiver relationship have hindered optimal development. According to Schore (2009b), these children are in an almost constant state of emotional dysregulation. Without empathy, encouragement, and compassion, children find other behavioural adaptations for coping with their anxiety and stress.

High states of arousal in developmental stages can cause a change in brain structure and the development of neuropathways. Attachment to primary caregivers plays a major role in assisting individuals in creating resilience in the midst of adversity. Tronick (1989) promoted the concept that abandoned or neglected children retreat into themselves for comfort and self soothing. Unfortunately, when children do this, their energy extends towards survival, rather than the development of self. In the long-term, this self-functioning impairment causes individuals to feel insecure, fearful, and alone, leading to the creation of self-sabotaging behaviours that often mimic “the early reflections of self received in primary relationships” (Schwartz & Galperin, 2000).

Brain, Behaviour, and Sex Dependence

From a medical perspective, addiction is a disease of the brain (Volkow, 2011). The brain has two main components to regulate impulse control. The limbic system, often referred to as the "Stop system" and the pre-frontal cortex, the "Go system" (Froemke, 2010). A brain suffering from an addiction experiences difficulty communicating between these two regions, causing the "Go" impulses to overpower the "Stop" impulses. Over time, environmental and emotive states form associations in the brain which act as triggers to perpetually activate the pre-frontal system (Joranby, Frost Pineda, & Gold, 2005). Once this occurs, individuals cannot readily resist triggers, even if they wish to. The inability to engage the "Stop" impulses, leads to increased usage of the activity, making it exceptionally difficult to cease or avoid addictive behaviour.

When sexually aroused or experiencing a climax, the brain releases four major hormones, Dopamine, norepinephrine, oxytocin, and serotonin, comparable to cocaine or heroin usage. Once activated, these chemicals travel along pathways to the centre of the brain, which releases numerous chemicals which result in a one single and cumulative effect: an orgasm. These neurotransmitters provide similar effects to psychedelic drugs such as LSD (Hyde & Christensen, 2009; Katehakis 2009).

Dopamine allows the brain to focus energy on a singular objective, subsiding negative consequences and releasing feelings of ecstasy and arousal. Regarding sexual behaviours, the released dopamine provides a narrowing of focus to whatever the individual is focusing upon. The release of dopamine during the sexual process can be

equated to a cocaine addition that has anaesthetizing effects that further encourages high-risk sexual behaviour (Hyde & Christensen, 2010; Katehakis, 2009).

The brain's release of norepinephrine has the effect of searing details into the mind. This allows individuals to recall vivid images for extended periods of time (Hyde & Christensen, 2010). In the addiction cycle, these images will be consciously refreshed and added to existing ones, allowing a person to recall sexual images and re-enact their sexual fantasies with ease.

Oxytocin allows for inter-relational bonding to occur. This hormone is also known as the "cuddle chemical" that floods parents' brains when holding a newborn child. During an orgasm, a prolific amount of this substance is released creating an influential bond with both inanimate and animate objects. With sex dependence, these bonds perpetuate fantasies and objectification that individuals bond to an image or an idea rather than another person (Hyde & Christensen, 2010). Furthermore this allows the person to feel positive emotions without the commitment, pressure, or expectations required in intimate relationships.

After the climax, the body releases serotonin, creating a deep feeling of calmness and contentment. This can be observed in the stress release experienced after an orgasm. This powerful positive reinforcement cycle allows the brain to learn new coping behaviours when experiencing feelings of stress, loneliness, sadness, and anxiety (Hyde & Christensen, 2010).

Hunger/satiation cycle.

Over time, sexual addictions “hijack” the natural production of dopamine levels in the brain (Keeler, 2009; Volkow, 2011). During repetitive and ritualistic sexual endeavours, the brain is flooded with natural hormones, heightening the threshold for hormonal homeostasis. This leads to withdrawal symptoms as the body copes with a deficiency in natural chemicals. This is also the cause for the phenomenon of withdrawal as the body copes with a lack of natural hormone production and craves the previous elevated levels. One of the symptoms is a state of anhedonia, which is an inability to experience pleasure (Garbus, 2010). This is often experienced for long periods of time as the brain attempts to re-balance its chemistry. Engaging in repetitive sexual rituals has a powerful effect on the brain, comparable with substance abuse, in developing an increased desire for higher levels of dopamine.

Behavioural reinforcement.

An orgasm produces high amounts of natural chemicals, which provide individuals temporary feelings of relief, relaxation, and well-being. Concurrently, these feelings overpower the previously felt negative emotions, therefore reducing unwanted emotions and limiting other means of affect regulation. Neuropathways are trained to trigger sexual impulses in relation to negative emotional states such as stress, anger, fear, pain, and loneliness (Berger-Hepworth, 1999; Schwartz & Southern, 2000). Over time, these triggers become more generalized as individuals find themselves increasingly sexually aroused by environmental or emotional stimuli. The chemicals released through

orgasms act as powerful behavioural reinforcements, a major factor contributing to the addictive nature of sexual dependence.

Neuropathways that fire together through stimulation, wire together (Fredrick, 2009; Siegel 1999). The brain registers relief as neuropathways incorporating both behavioural and environmental circumstances reinforce triggers for sexual dependency. This is how one's emotions, thoughts, actions, and environment become a part of the hunger/satiation cycle. For instance, feelings of loneliness and sexual activity build neuropathways if they coexist in the same moment of time. The orgasmic release causes a decline in loneliness because of chemicals, then becoming a part of the behavioural repertoire (Longo & Bays, 2006). Moreover, the brain recognizes environmental factors such as rooms, music, food, alcohol, or time, which begin to act as reminders for sexual arousal. In time, these factors contribute to a broadening of triggers that activate sexual thoughts in the frontal cortex, increasing the likelihood of following through with the sexual acts, thus perpetuating the dependence.

In completing the brain – body – emotion circuit, an understanding of the brain and its responses to threatening events is important. For individuals with sexual dependence, becoming in-tune with their bodies may be uncomfortable at first, since they are disconnected from their physical and emotional states. This disconnect plays an important survival role, allowing individuals to function despite their intense internal pain. According to Le Doux (1996), neuropathways from the amygdala and limbic system towards the prefrontal cortex are better established than the feedback from the cortex to the emotional centers of the mid-brain. Individuals' acknowledgement of the relationship

between mind, body, and emotions leads to the development of self and the re-conceptualization of relational functioning beyond the sexual acting out.

CHAPTER SIX: CONNECTING THE BRAIN, BODY, AND EMOTIONS

Accessing emotions within therapy provides the opportunity for emotionally corrective experiences. In therapy, clients essentially work on unfinished business, feelings that are “not fully experienced in awareness, they linger in the background and are carried into present life in ways that interfere with effective contact with oneself and others” (Carnes, 1991, p. 234). It is especially important in the recovery from sexual dependency to understand the effects of previously experienced traumas such as: sexual abuse, neglect, and abandonment (Schneider, Sealy, Montgomery, & Irons; 2005). Muller and Rosenkranz (2009) believe that working through trauma is an incredibly vital part of healing. Specifically, connections with others operate as a tool to overcoming one's negative sensory experiences and facilitating these emotionally corrective experiences (Muller & Rosenkranz, 2009). In part, this experience acts as a dyadic experience in which the therapist establishes a therapeutic homeostasis with the individual through empathy and care. This regulates the self experiences and provides the internal subjective affective experiences that strengthen the self (Kohut, 1984).

The entry point for working on therapeutic transformation is through emotions. According to Greenberg (2008), emotions are what guide individuals and “what we make of our emotional experiences makes us who we are (p. 51). In an interview with Mishlove (1998), Virginia Satir stated that family rules may hinder the expression of positive or negative emotions, which cause behavioural incongruencies in a person. Levine (1997) posits that all experiences have levels of energy, with traumatic events often producing overwhelming amounts of energy that cause short-circuiting in the brain.

This energy needs to be released for healing to occur. Emotions are the entry point from which to relieve experiential trauma. Emotions do not need to be fully expressed or re-lived, since they are often integrated in physiological exhibitions such as eye movements, discolouration of skin, shallow or deep breathing, and body posture. These contributing physical responses translate as entry points towards a client's deeper journey.

For sexually dependent individuals, working with emotions is an important part of the therapeutic process. In general, it allows the therapist to incorporate varying avenues of clients' non-verbal communicating. In this, therapists harness the powerful impact of emotions and their natural physiological responses as a part of further therapeutic engagement. As previously stated, emotions are an internal force that bring resolution and act as an entry point for deeper healing (Fosha & Slowiaczek, 1997; Greenberg & Pascual-Leone, 2007). Sexually dependent clients coming to therapy will often have a variety of blocked emotions that they are unable to identify or express. Utilizing the uncovering and validating of these hidden emotions as part of the treatment plan allows for new, adaptive possibilities to form.

Emotions: A Pathway for Healing

Experiencing and processing emotions restructures experiences. The more powerful the emotions, the deeper the resulting changes or developments will be. Individuals experiencing profoundly deep emotions can be encouraged by acknowledging these expressions as powerful agents of change. In essence, the therapeutic relationship attempts to change wired-in adaptive, expressive, communicative aspects of the human experience. Within the safety of the therapeutic alliance, the relationship itself mediates

and bridges human interaction with the client's greater social environment (Fosha & Slowiaczek, 1997). In processing emotions, individuals are able to access, analyze, and experience interactions, while also creating new ways to engage relationally.

According to Fredrickson and Losada (2005), the deepening and processing of emotions has been identified as contributor to positive therapy outcome. Individuals often express resistance to experiencing negative emotions because of the associated pain. In order to overcome negative emotions, clients must replace them by equally intense positive emotions. In essence, new experiences must challenge, change, and repair previous negative experiences (Damasio, 1999). By accessing negative emotions, the intensity slowly fades as the person begins to modulate and deepen their process of understanding. This will often result in the emergence of positive traits such as resilience, courage, trust, and perseverance (Bridges, 2005 & 2006).

Emotions Facilitating Change

The broaden-and-build theory suggests that both negative and positive emotions are evolved psychological adaptations (Fredickson, 2004). Negative emotions limiting behavioural actions create avoidance and limit risks in order to protect and ensure the survival of a person. These adaptive tendencies coincide with the fight, flight, and freeze responses of the brain in which energy is conserved for the survival of the organism (Fazio, Eiser, & Shook, 2004). Positive emotions have an opposite behavioural effect in that they access flexibility and possibilities. Individuals are no longer threatened and return to a state of homeostasis in which they can use their energy to flourish. In her research on vulnerability, Brene Brown (2012) affirmed that creativity, risk-taking, and

innovation can only come forth if the environment is safe enough for individuals to fail. Building safety is crucial for processing emotions. Only in such circumstances will individuals with sexual dependency truly gather the courage to expose their vulnerabilities and risk feeling true kindness and acceptance – perhaps for the first time.

The broaden-and-build theory also has a reflective component. In the process, the client engages with the therapist in a meta-therapeutic process of how it was to experience emotions and allow the therapist to observe such a sacred moment. Andreasen (2001) described these moments as being the most powerful to the psychotherapeutic process. By therapists engaging their clients in new, corrective experiences, clients are able to restructure "the memories and emotional responses that have been embedded in the limbic system" (Andreasen, 2001, p. 314). Additionally, these emotionally corrective experiences also build up and uncover personal resources, coping strategies, and knowledge (Fredrickson & Losada, 2005). Internalizing these newly acquired experiences, insights, and reflections will challenge and change clients' personal belief systems. These changes may allow clients to see beyond the socially restrictive labels projected onto them by peers, society, or loved ones.

In order for holistic integration of experiences, therapists need to regulate negative emotions allowing them to be processed and also highlight positive feelings that emerge during the therapeutic process. Otherwise, individuals have the potential of being re-traumatized. In the safety of a therapeutic relationship, the plasticity of brain allows for new positive experiences to be integrated as memories counteract negative emotional experiences. Russell and Fosha (2008) stated that "suffering through transforming the

negative affects associated with it is essential but not sufficient. To maximize effectiveness, the therapeutic enterprise must also deal, equally rigorously, with the positive affects associated with experiences of transformation, growth, and connection" (p. 168). Hence, treatment of sexual dependence can not only focus on the negative consequences but also needs to highlight positive experiences that emerge out of the pain.

Sexual Dependence Interconnecting Brain, Body, and Emotions

The brain, body, and emotions are interconnected and play an important part when dealing with sexual dependence. This is not to say that a holistic approach is only beneficial to individuals with sexual dependencies, but rather confirms the need for an interdisciplinary paradigm shift towards holistic treatment possibilities (Schore, 2009a, 2009b). The dominance of strictly cognitive approaches is beginning to wane with the resurgence of interdisciplinary cooperation, which facilitates opportunities for deeper, more comprehensive healing (Kahr, 2005). Pointing out the integrated complexity of the brain, body, and emotions is essential for substantial and poignant therapeutic treatment (Fosha, 2008; Levine, 1997; Ogden et al., 2006; Panksepp, 2012; Porges, 2009; Schore, 2002; Siegel, 1999, 2009). This theoretical shift towards holistic therapeutic intervention offers hope for long-lasting outcomes in the treatment of sex dependency. Within a holistic environment, a client's emotional and physiological experiences are accessed, within sessions, as tools for obtaining therapeutic change.

The right hemisphere of the brain is mainly connected to imagery, and emotion, whereas the left side is more dedicated to logic, language, and analysis (Beatson & Taryan, 2002). More specifically, research indicates that the mid-brain is responsible for

regulating heart rate, blood pressure, arousal states, and inadvertently signalling the amygdala and the limbic system, which are a part of the forebrain (Kirmayer, 2004). The mid-brain communicates with the amygdala and the brain's right hemisphere. The amygdala is responsible for emotions and memory, while the right hemisphere is responsible for attachment, affect regulation and aspects of emotion (Perry et al., 1995). Interestingly enough, Fonagy et al. (1991), extrapolated that the development of secure attachment is the optimal integration of both hemispheres functioning, which contributes also to self-regulation. If the mid-brain senses danger, it communicates with the right hemisphere through the amygdala. If the brain has not developed optimally, self-regulation may be inhibited. This means that the left hemisphere, known for cognitive process, speech, and movement, may not be able to balance the emotionally charged right hemisphere through analysis, language or fight/flight manoeuvres.

Le Doux's (1996) research on the emotional brain demonstrated that it is possible for the brain to register the emotional meaning of a stimulus before the stimulus has been fully processed by the perceptual system. This means, that the right brain hemisphere has already a visceral response in terms of feeling or gut reaction before the left hemisphere can formulate it into words. For instance, the amygdala senses danger and broadcasts distress signals to brain and body. The shorter amygdala pathway transmits signals more than twice as fast as the neocortex route, and the thinking brain often cannot intervene in time to stop emotional responses (Greenberg, 2008; Greenberg & Pascual-Leone, 2007; Le Doux, 1996). This research is also consistent with Porges' (2009) Polyvagal theory, which "assumes that many social behaviours and vulnerabilities to emotional disorders

are ‘hardwired’ into our nervous system” (p. 34). Porges (2009) suggests that two branches of the vagus nerve are interconnected with autonomic behaviours in place for both safe and hostile environments. These nerves provide reciprocal communication between the body and brain. Therefore, clients may unknowingly provide numerous physical and emotional cues with regards to their internal states if therapists are attuned and mindful. While clients may not always be able to verbally express their experiences, the provided physical and emotional responses are a vital tool, especially when addressing deeper issues such as accounts of abuse or trauma histories.

When re-living traumatic experiences, or in cases of heightened anxiety, the brain's intense responses may hinder therapeutic processing. For instance, in highly aroused or dissociative states, the Boca’s area, which formulates speech, becomes flooded, allowing individuals to feel without being able to verbally express their internal processes (Rauch et al., 1996). Flooding refers to an increase of blood flow to Boca’s region, which causes this inability of clients to speak and is also often a trait of dissociation (van der Kolk, 2002). In these cases, clients may require more time to formulate their thoughts or may convey a blank, numbed affect, when referencing painful or difficult experiences. This natural response hinders the cognitive processing of traumatic events with clients. However, Schore (2002) stated that emotions are interconnected with the autonomic nervous systems which “generate involuntary bodily functions that represent the somatic components of all emotional states” (p. 442). Once somatic experiences are noticed and accessed, they can heighten physical sensations and facilitate a bridge, allowing for further emotional processing (Levine, 1997). In such

circumstances, therapists can act as guides, querying and identifying body sensations, movements, or emotional states. Therapists can assist clients in reducing emotional arousal by legitimizing clients' experiences which were previously unspoken or unprocessed.

The importance of having an integrative approach connecting the brain, body, and emotions allows for greater personal and relational congruency. Bowlby (1982 & 1998), Kohut (1971), and Rogers (1951) theorized about the healing effect of a positive therapeutic relationship. Specifically, Carl Rogers (1959) believed that the desire for deeper, relational connection was the real reason why individuals sought the assistance of therapists. Virgina Satir (1987) regularly noticed the incongruence between her clients' body language and their spoken words. She labelled these inconsistencies as double binds, which she postulated would eventually lead to double-level messages. She believed that these double-level messages perpetrated dysfunction and negative coping mechanisms, which caused individuals to hide their true thoughts and feelings and thoughts. According to Damasio (1999), there is a cost to an external focus because "it tends to prevent us from sensing the possible origin and nature of what we call self" (p. 28). It is affective feelings experienced in the body that further give clues to past traumas and clarify the creation of self-image.

Focusing on double binds or incongruence provides clues as to how people were unable to fully express themselves. By undoing those binds, clients often experience emotional corrective experiences, feeling a sense of care, lightness, or joy as they expressed their feelings fully for the first time (Alexander & French, 1980). According to

Fosha (2008), this exploration provides knowledge of whether the individual can receive empathy, compassion, kindness, and understanding from others. Using clients' presenting feelings and the body's natural responses, provides the opportunity to uncover blockages that would normally prevent or hinder therapeutic intervention. For individuals with sexual dependence and their therapists, listening to the clients' emotions and body is transformational. This acknowledgement unlocks the deep, denied processes that have yet to be released.

Both the body and emotions are interconnected with the brain and in constant communication (Fosha, 2001, 2004, 2008; Porges, 2005, 2009). Integrating the brain, body, and emotions is essential to developing the definition of self. According to van der Kolk (2002), it is the human mind that is at the pinnacle of integrating brain, body, and emotions into the human experience.

> The human mind is to evaluate the significance of all incoming information and integrate its emotional and cognitive significance. During this process, the mind needs to rapidly scan millions of possible connections and associations to create the proper interpretation about their existential relevance. It then needs to create a response that not only produces internal satisfaction but also is in harmony with the demands and expectations of the environment. (p. 63)

Being able to understand the interplay between these three facets pushes beyond cognitive analysis into deep internal processing, which focuses on core psychopathological emotions (Fosha, 2010). In shifting away from simply listening to a

client's words, therapists can emphasize the human potential for transformation through observing words, behaviours, and physiological arousal (Fosha, 2010). Exploring these expressions provides therapists with opportunities for further query and identification of pathological emotions. Focusing on the deeper physiological or emotional experiences is often a lost concept in the treatment of sexual dependence as individuals often fixate on their external behaviours rather than personalized experience. For therapists, being aware of the brain, emotion, and body interplay is a part of shifting the focus from external problems towards the internal and existential existence of a person (Frankl, 1984).

CHAPTER SEVEN: PROPOSED TREATMENT FOR SEXUAL DEPENDENCY

As previously indicated, many individuals struggling with maladaptive sexual behaviours have experienced relational childhood traumas. Due to their vulnerable states and the lack of support, individuals who have survived traumatic experience the negative after-effects well into adulthood. The overwhelming, flooding impact of these memories is deeply imbedded in one's brain. Despite these experiences, "the potential for healthy emotional responses remains alive within even the most disturbed individuals, awaiting the right environmental conditions to become activated" (Fosha & Slowiaczek, 1997, p. 230)[1].

In order to achieve the potential for the aforementioned healthy emotional responses, therapy must be deeply affective and personal, providing clients with the ability to achieve new possibilities. In essence, individuals must be able to see beyond their sexual dependence. Clients have the possibility for transformation and have the capacity to be the agent of change in their interpersonal and social environments. Discouraging of abstract intellectualization of events and focusing on the emotional undertone of a client's experience may heighten new experiences. These experiences may not seem logical but may have a psychosomatic/emotional connection to the presenting problem (Bohart & Greenberg, 2002). Hence, therapy is truly about inner psychic and life

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1 Also, when discussing treatment options and process for clients, it is inferred that they have sexual dependencies. It seems redundant to restate this label every time the word 'client' or 'individual' is used. The rationale is clearly stated that this is a psychosomatic treatment option for sexual dependency. Therefore, the terms 'client' and 'individual' refer to people concerned with sexual dependency seeking therapeutic support.

changing work, going beyond rationalizing and analyzing into deep affective moments which provide courage to live beyond sexual dependence.

Effective therapeutic treatment for sexual dependence needs to incorporate an awareness of trauma-induced defence mechanisms and pain (Schneider, Sealy, Montgomery, & Irons, 2005). If previously experienced psychological pain is not addressed and healed, individuals will continuously find their lives being controlled by the past. Unlocking repetitive patterns of trauma by overcoming defences allows clients to free energy normally used to contain the trauma and channel the new-found energy into living life (Levine, 1997). This new-found energy can then be used to uncover and develop other parts of one's personality and resilience which has been dormant for years. Despite the strength of defensive tendencies, individuals have a tendency to engage in transformation which is dependent on the surrounding environment (Fosha & Slowiaczek, 1997). For individuals with sex dependency, a safe and supportive environment is essential for psychotherapeutic work.

Besides being able to work through trauma, recovery must also be highly relational. Even though this treatment mainly deals with an individual, the importance of interpersonal relationships must be acknowledged and integrated throughout therapy. Focusing on the healing of relational attachment wounds will assist individuals in repairing relationships with their partners who have been affected by their sexual dependency (Schaeffer, 2009). The priority is to establish a safe dyadic relationship with the therapist before "motivation for transformation can come to the forefront" (Fosha, 2008, p. 5). This includes eventually working with familial and partner relationships,

which are initially more threatening due to the accumulated emotionally and painful laden material.

Therapeutic interventions allow individuals the opportunity for personal development, while also creating a safe environment and receiving support with their sexual struggles. The first step toward healing involves addressing shame while working with clients in "bonding and enduring intimate relationships with others" (Adams & Robinson, 2001, p. 32). The underlying goal is to break pathological emotions such as shame and loneliness that many feel when it comes to their behaviours and its effects.

While many emotionally focused and psychosomatic treatments are available, the focus will be on AEDP. This treatment option has been developed within the last two decades and has valuable tools to repair relational attachment traumas, so commonly seen in individuals with sexual dependency. AEDP provides the theoretical framework for processing interventions. A quick overview will introduce AEDP's clinical strengths, including: valuing the importance of the therapeutic relationship, staying in the "here and now" with the client, using moment-to moment tracking, and allowing for client's reflections. Following the discussion of this trauma-informed treatment modality, clinical interventions will be applied in the context of treating sexual dependence.

CHAPTER EIGHT: EMOTIONS IN THERAPY

AEDP acknowledges and utilizes emotions as an integral part of the therapeutic process. Emotional expression is an additional form of communication, as emotions are integrated throughout the body. According to Diana Fosha (2008), the developer of AEDP, the approach's main goal is to undo “the chronic experience of aloneness”, which often hinder the expression and processing of emotional pain. Unrelieved suffering causes psychopathogenic affect such as anxiety, which individuals alleviate by activating defensive mechanisms. These mechanism are often further protected by maladaptive behaviours such as sexual dependencies. Therapists seek to undo psychic suffering by being present with the patient and helping him bear and process affects” (Fosha & Slowiaczek, 1997, p. 230).

In addressing and working with a client's emotions, AEDP focuses on processing emotions from pathological to tolerable, adaptive, transformative, and insightful. In particular, AEDP fully processes emotions and assists clients in accepting emotional change as they continue their pursuit of healing (Fosha, 2000; Greenberg & Malcom, 2002; Greenberg & Pascual-Leone, 2007). This ensures that clients are able to incorporate traumatic events and the subsequent emotions in adaptive rather than maladaptive ways. The focus of AEDP is in developing strong therapeutic relationship, in which emotions and feelings are given space to exist, while ensuring the safety and processing of deeper emotional content without risking flooding or re-traumatization. This approach gives clients confidence during the therapy process, but assists them to work through painful emotions until the healing process is completed.

The AEDP approach has worked on creating clinical tools and interventions to work with and through emotions. Researchers have hypothesized that unmet interpersonal needs are often expressed by individuals through both arousal and mobilization of unresolved emotions (Greenberg & Malcolm, 2002, p. 407). For instance, pain and grief will only cease once enough attention and care has been given, which is often through a therapist, until a clients needs are met. One concern is that cognitive constructs of emotions are often labelled as either negative or positive. In family systems, this may result in negative emotions being avoided while positive emotions are encouraged. However, it is often the painful emotions that need to be attended to in order to promote healing and personal growth (Greenberg & Pascual-Leone, 2007).

When referencing emotions, an important distinction must be made between primary and secondary emotions. Both Greenberg (2008) and Fosha (2002) here distinguished secondary emotions as “meta-emotions,” which are how clients feel about the emotions and expressing them. For instance, anger may be a secondary emotion to fear because it may seem safer for individuals to express anger rather than fear. Other times, individuals may oscillate between secondary and primary emotions, which demonstrate internal shifts as clients become comfortable in feeling and expressing emotions.

Another distinction must also be made between negative, positive, and pathological emotions. Connotations towards negative or pathological emotions as being “bad” must be avoided. Clients should be encouraged to view their negative emotions as a valuable part of their humanity, as providing protection during dangerous

circumstances. These emotions may seem negative in the sense that they do not always feel comforting, but their conserving and protective nature serves an important purpose within a person's daily functioning. The main positive emotions of joy, peace, love, and excitement are expansive in nature and allow individuals to take risks and further development. Emotions become pathological in the sense that they are maladaptive, eventually resulting in mental health concerns or behavioural psychosis, seen within examples such as: depression, anxiety, phobias, and sexual dependence.

Pathogenic Emotions

Grief/Sadness.

Individuals struggling with sexual dependency often deal with shattered assumptions, hopes, and goals. Their preferred sexual activities soothe the internalized pain, which is commonly unprocessed grief or sadness (Reid, Harper, & Anderson, 2009). There are many levels of experiencing sadness, which can be distinguished by the intensity of the sad feeling. For instance, sadness and grief may seem interchangeable but there are vital differences. Sadness is the actual experienced emotion, whereas grief may refer to a deep, intense feeling of sadness, even to the extent of mourning, or it may refer to the actual process of grieving.

Clients with sexual dependence often have deep sadness in regards to negative childhood experiences. These often have not been acknowledged due to strong familial ties or invalidation of personal needs. Also, therapists need to be aware of individuals' perceived lifespan failures, such as broken marriage, which deeply affect perceptions and aspirations (Frykholm, 2007). According to Skolnick (1979), individuals struggling with

dependency often carry unresolved loss, the pain of which is numbed through self-medication: “The feeling of loss creates a psychic disequilibrium for which the addict seeks relief. The emotional storms and/or the fears of these upheavals are quieted through this false sense of homeostasis” (p. 286).

Loneliness.

A major factor underlying sexual dependence is the attempt to cover up loneliness (Reid, Harper, & Anderson, 2009). This pervasive feeling is perpetuated by individuals’ anxiety towards intimacy (Schaeffer, 2009). Loneliness results from hurtful experiences which have been adapted into an avoidance of vulnerability, rejection, and failure in relationships (Schneider et al. , 2005). However, an individual's loneliness is the substituting replacement for solitude, a positive feeling arising from being alone, or healthy relationships. Individuals with sexual dependence will use pornography to mimic the sexual thrill of a relationship, successfully masking their loneliness.

Boredom.

Frykholm (2007) identified boredom as a naturally occurring response to an overdose of external stimuli provided by work, family, or relationships (p. 21). After a stressful time where the body is both aroused and involved with these outlets, the body needs time to adjust to the absence of these stimuli. This adjustment in vigilance is called anhedonia, which is the absence of feeling pleasure. Therapists need to be aware that individuals with sexual dependence will likely encounter anhedonia or boredom as obstacles throughout treatment. During such instances, clients’ bodies are trying to adjust their hormonal levels which were continually heightened through the sexual acts. Within

these vulnerable moments, clients may experience and express strong urges for sexual activity.

Shame.

Shame is arguably the most important emotion needing to be addressed and processed in recovery from sexual dependence. Carnes (1991) believed that shame is at the core of all addictions. As one of most powerful pathological emotions, it is a direct message that the person is intrinsically flawed in some manner. Individuals with sexual dependence must combat internalized messages which "involve negative self-concepts and are associated with feelings of worthlessness, powerlessness, and personal failure" (Wilson, 2000, p. 229). These individuals may feel as though their intrinsic value as human beings declines because of their sexual acts. Shame indicates remorse from the individual that may seem resistant to forgiveness, acceptance, and kindness. It shows the tremendous punishment of self-worth that a person receives for hurting self or others through their sexual dependence (Meneses Woldarsky, & Greenberg, 2011).

Anxiety.

Anxiety, in conjunction with shame, is another vital emotion to acknowledge within treatment. While anxiety and fear are often used synonymously, anxiety can appropriately be considered as fear on steroids. Small amounts of anxiety can be seen as useful, motivational energy, however, in the therapeutic environment, anxiety is often the cause for psychological blocks. As intensity increases, anxiety can become paralyzing, a feeling so uncomfortable that it becomes a powerful deterrent towards change, openness, and healing (Solomon, Laor, & McFarlane, 2007). Clients' anxieties activate the fears

that they will be overwhelmed by and unable to manage their emotions. While often unfounded, this fear is understood to have originated in overwhelming childhood experiences. During these moments in childhood, individuals were faced with intensely negative feelings which were met with inadequate comfort and care.

CHAPTER NINE: THERAPEUTIC INTERVENTIONS

STAGE ONE: CO-CREATING SAFETY

AEDP highlights the importance of establishing and maintaining the therapeutic relationship. Through the use of moment-to-moment tracking and micro-attunement incorporated within all therapeutic interactions, the therapist prioritizes the client's immediate experience. While treating sexual dependency, therapists must value and prioritize the safety and protection of the client. This is often difficult for clients with sexual dependence to fathom, as they may not know how to accept the value that is being placed on their well-being. Furthermore, therapists need to ensure that their clients are protected from being overwhelmed with pathological emotions and re-traumatized. Since self-functions and effective coping mechanisms are limited for clients with sex dependence, therapists need to modulate the intensity of therapy as clients develop self-awareness which can then be translated into self-regulation of their bodies (Schwartz, 2008).

As emotional content arises within treatment, clients may become overwhelmed with the experience. In these moments, therapy cannot progress if the client remains in a triggered state, a re-activation or re-experiencing of past traumas (Bradshaw & Cook, 2008). According to Bradshaw and Cook (2008), the intense trauma-related responses are “due to a lack of balance between the hemispheres of the brain” (p. 23). Establishing a safe platform on which to successfully navigate deeper emotional processing, requires clients to successfully access a calm state.

When traumatic experiences are re-activated, safety protocols are important to assist in grounding and calming individuals. These techniques are introduced to clients within the first appointment, which affirms the therapist's prioritization of client safety. These tools provide different functions that collectively contribute to an overall sense of safety within the deeper processing. In addition to the foundational tool of a strong therapeutic alliance, these tools include: sensate focusing, release points, empathy, transference checks, and self-disclosure. These terms will be defined in upcoming sections as their use will be demonstrated in clinical vignettes.

Safety Tools

Sensate focus, release points, and transference checks are safety interventions utilized in the trauma-therapy Observational Experiential Integration (OEI). While OEI is not expanded upon in this paper, its prioritization of developing safety within processing compliments the theoretical framework of AEDP. The OEI safety tools are exceptionally useful in grounding clients, especially when a therapist encounters a client reliving intense traumatic experiences.

As previously introduced, trauma-informed therapeutic approaches prioritize clients' safety as a critical part of therapeutic intervention. These safety mechanisms are not only introduced, but integrated and drawn upon throughout therapeutic processing, as necessary for each client. While certain clients require significantly more safety and stabilization within therapy, these integral tools are considered the "fire drill before the fire" (Bradshaw & Cook, 2008). Equipping clients with the necessary tools to ensure their safety empowers them to self-soothe outside of therapy, instilling confidence in their

ability to successfully manage emotional intensity. Although therapists may use other safety tools within their practice, the following tools are provided as the key components for establishing safety for deeper processing, through the aforementioned lenses of treatment.

Sensate focus.

This tool involves clients concentrating on each of their senses, one at a time. Therapists will guide clients through their various senses, hearing, seeing, touching, tasting, and smelling, using exercises that require simple identification of sensory experiences in the here-and-now (Bradshaw & Cook, 2008). Bradshaw and Cook (2008), refer to one such exercise as 5-4-3-2-1, in which the therapist will calmly encourage clients to focus on their senses and identify five items through each sense. Once the client has successfully named five items, the therapist will then request the client to do it again, this time only requiring four answers, and so on. While simple in nature, this exercise enables clients to shift their focus from traumatizing material or past experiences onto being present in the room. This allows clients to re-establish contact with their therapist, further solidifying safety through the reminder of the therapist's continued presence and control over the intensity of processing.

Release points.

There are several release points which relieve physical tension or restriction within the body (Bradshaw & Cook, 2008). The exact point of each release point differ from client to client. However, these points can all be tracked and identified using the client's visual fields. When an individual's gaze is guided to this particular point, a

significant release is experienced which is commonly accompanied with relief and calmness. Physiological trauma responses affect core areas of the body, including the throat, stomach, jaw, and chest. Specific release points can be found connecting to each of these affected areas, identified to as “core trauma symptoms” (Bradshaw & Cook, 2008).

Release points are introduced and practised at the onset of therapy, used as needed throughout intensive processing. For example, if a client reports shallow breathing, a therapist could help the client access the “breath release”, which would alleviate the negative physiological response. Likewise, if a client is unable to speak, experiencing an upset stomach, or locked jaw, these release points can also be accessed, to provide immediate relief. Training is absolutely essential in perfecting the technique of identifying and accurately using release points. These release points can actually prevent clients from experiencing panic attacks, further re-traumatization, and body numbing (Bradshaw & Cook, 2008). These release points are a powerful tool to assist in overcoming physical obstacles within trauma processing. If correctly accessed and used, they can help establish further trust and safety towards the therapeutic process. For a visual demonstration of release points, see Appendix C.

Transference check.

The transference check is a means to understand how various brain hemispheres affect an individual's ability to process information, relationships, and day-to-day responses. The term transference “… is an established pattern of relating”, which are emotionally embedded in past experiences (Maroda, 2005, p. 134). According to Shuren

and Grafman (2002), the right hemisphere holds representations of the emotional states associated with events experienced by the individual. When that individual encounters a familiar scenario, representations of past emotional experiences are retrieved by the right hemisphere and are incorporated into the reasoning process (p. 918).

Since the eyes are connected to the differing brain hemispheres, therapists can access the true extent of clients' transference through their visual field. Deciphering between the brain hemispheres provides valuable feedback as to how clients are perceiving and experiencing others. The easiest way to check for transference is by asking clients to cup their hand and fully cover one eye while looking at the therapist, before switching and covering the opposite eye. Differences in perceptions arise while solely accessing either the right or left-brain hemisphere depending on the covered eye. As the client completes this task, the therapist is able to explore the extent of the transference.

To effectively explore different aspects of transference, the following questions are used. These questions have been reproduced with permission by Bradshaw and Cook (2011) and modified by the author:

1) Do I appear closer or further away when looking through each eye?
2) Are there colour differences when looking separately through each eye?
3) Is there a difference in how I appear to you when looking separately through each eye?
4) Is there a difference in how you feel about or towards me when looking separately through each eye?
5) Is there any sensation in your body that is different when looking separately through each eye?

Oftentimes, discrepancies of perception or behaviour appear when switching between eyes and their connected brain hemispheres. Clients may perceive different emotions, experience somatic responses, or track certain thoughts towards the therapist.

Bodily changes such as shallow breathing or tensing body postures are slightly more difficult to identify, but quite common and important to query. This technique demonstrates how perceptions change and differ between brain hemispheres and allows for the identification of negative responses, which can then be further discussed and processed (Bradshaw & Cook, 2008). This process also clears any hidden bias that the client may have towards the therapist, or the therapeutic process, which results in a more authentic and realistic experience. Appendix D provides an example of a transference record sheet that indicates the varying responses as the client switches between eyes.

The implementation of practical safety tools is vital when addressing deeper, traumatic themes and experiences. Using safety tools within therapy not only solidifies a therapist's ethical obligation, but also strengthens trust and confidence in the therapeutic process. Trust is developed due to the client being able to acknowledge the therapist's care and concern for their safety as processing progresses. Through this, the client is reaffirmed that the therapist is capable of managing and containing the emotional intensity that may arise. With safety tools as a crucial component when treating sexual dependency therapeutically, intervention tools will likely become more effective as clients develop the ability to manage and contain their negative emotions, defensive mechanisms, and anxiety.

Clinical application: Creating safety.

The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and have been modified by the author. These transcripts are examples of how AEDP can be used to with individuals dealing with sexual dependence. Since these

transcripts have already been published, the original authors have ensured that the identities of clients have been protected. Furthermore, this author has modified the transcripts to further generalize the examples, while concretely showing readers how safety tools can be utilized with clients.

In the first excerpt, the therapist comes alongside the client as he or she encounters unwanted emotions. Through empathy, the therapist gives the client permission to explore their defenses while touching on possible underlying emotions of sadness. As sadness emerges, the therapist ensures that the client is not alone in feeling the difficult emotions.

In excerpt two, the therapist creates safety through encouragement and delight. Rather than focusing on the client's anxiety, the therapist highlights the courageousness for the client to show up for the appointment. Rather than focusing on the clients tardiness, the therapist sets a therapeutic tone of support and care, while counteracting any negative preconceived notions the client had prior to entering the therapy room.

Excerpt 1.

Client: It's sad.

Therapist: Yeah. *[Empathically]*

Client: It's . . . I wish things were different . . . on so many levels for so long.

Therapist: Mmm, hmm.

Client: And I think my way of dealing with it is to say, to turn on myself to say, "You don't deserve it."
[Articulates defense against sadness]

Therapist: And if you didn't turn on yourself, what would happen?
[Sidestepping defense and inviting access to imagine a positive alternative]

Client: I don't know.

Therapist: I understand that.
[Invoking safe base of our relationship for exploration of uncharted territory of his emotional landscape]

Therapist: If you just imagined here with me for a minute that we just shared the feeling of sadness together, and we didn't turn on yourself . . .
[Undoing aloneness]

Excerpt 2.

Therapist: First of all, I'm very impressed .... *[big smile]* [Therapist shows delight]

Client: (*giggles, taken aback; sweating*; *shallow breathing*)

Therapist: …with your self-awareness and openness with me
[Therapist "surprises the unconscious," disconfirming patient's expectations of being met critically]

Client: Thanks

Therapist: That's the first thing that's very, very striking as we launch in. But secondly that you have a lot of anxiety (*concerned tone*).

Client: Yeah.

Therapist: … and *had* a lot of anxiety about being here.
[shift focus from defenses to anxiety powering them]

Client: Yeah.

The Dyadic Relationship

The dyadic relationship is perhaps the most important component for therapy for individuals dealing with sex dependencies. It challenges clients' natural tendencies to withdraw and isolate from people (Adams & Robinson, 2001). AEDP reaffirms what therapists like Rogers (1951), Kohut (1971, 1984), and Bowlby (1982) previously postulated about the healing impact of positive attachment-based therapeutic relationships. More recently, Brandes and Cheung (2009) re-iterated how important the

therapeutic dyad is within treatment. Their research claimed that 66% of clients felt that a strong therapeutic relationship was the primary factor to treatment success.

Establishing safety is essential in a therapeutic atmosphere. For clients, "emotional pain represents the sting that makes an experience unbearable. Generally, emotional isolation has made the pain unbearable, so that the connection with the therapist is paramount in healing" (McCullough & Vaillant, 1997, p. 275). The dyadic relationship provides a sense of safety which gives clients permission to take risks in sharing (Fosha, 2000, & 2006). Clients are provided a structured area in which their emotional vulnerabilities are valued, appreciated, and encouraged. When faced with such vulnerabilities, it is crucial for therapists to use interventions that validate the sharing of difficult material with empathy and validation. Therefore, establishing safety and showing commitment for the client can set the tone for how the therapeutic relationship can be healing, providing a model for other relationships. Providing clients with an environment of safety and support allows clients to transform their initial expectations for rejection within interpersonal interactions. These guidelines allow therapists to participate in the natural ebbs and flows of therapy while communicating an overarching acceptance and appreciation for the client. Through this means, therapy is seen as an emotional engagement with clients through relationship, rather than simply a clinical arrangement.

Role of the therapist.

The therapist facilitates emotional engagement, accessibility, and responsiveness with clients. Using empathy, affirmation, validation and delight, therapists connect with clients while instilling a foundation of safety and openness within the therapeutic process. It is unrealistic to assume that clients are open and trusting without therapist modeling this kind of behaviour to their clients. If a therapist is guarded most likely the client will mirror and adopt similar behaviours (Fosha, 2010). Throughout this accompaniment, therapists also monitor and counteract any potential for re-traumatization, which Fosha labels as “pathological aloneness”, by ensuring that clients are aware of therapists' presence, especially during difficult moments (Fosha, 2000, 2010).

Another important aspect integrated within AEDP is the therapist's use of self in connection to the client. This differs from more traditional approaches, in which therapists retain a certain distance, which has been referred to as “maintaining professionalism”. In AEDP, however, therapists are encouraged to engage with clients through self-disclosure, authenticity, spontaneity, and delight for their clients' progress, offering immediate, relevant feedback within the sessions (Fosha, 2000 & 2010).

Role of the client.

Within therapy, clients are encouraged to focus on their emotions and bodily responses, which allows them to re-connect with the “rooted experience” (Fosha, 2000). The term “rooted experience” refers to the body's reaction, either conscious or semi-conscious, in regards to emotionally charged concepts of self and others that are emerging. These profound experiences relate to one's relationships, concept of self, and

potential for achieving transformation (Fosha, 2000 & 2010). Clients are encouraged to express and voice both negative and positive feelings within the therapeutic environment. During this process, clients will become aware of certain emerging anxieties or mental defenses utilized for protective purposes in previous circumstances. For instance, a client may not feel comfortable talking about themselves or able to fully receive compliments because the messages received during their formative childhood years were negative. The internalization of negative messages impacts individuals' ability to respond appropriately in adulthood, causing unconscious responses that clients may not be able to identify or explain[2].

Intervention Tools

The intervention tools assist clients in processing emotional content. Similar to the included safety tools, the intervention tools assist in maintaining a safe environment and strengthening of the therapeutic relationship, yet are used more regularly and intentionally within sessions. These tools are often innately used by counsellors but have been more specifically documented by AEDP. Interventions specifically enable clients to access somatic and emotional painful material which can then be restructured into new adaptive experiences. The following interventions discussed are empathy, self disclosure, delight, and support.

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2 see Appendix B - The internal experience model

Empathy.

Empathy is a powerful tool when minimizing the impact of mental defenses. Research shows that empathy is a building block for society (Adolphs, 2009; de Waal, 2008). This powerful feeling, allows for the concept of morality to exist in individuals (Iacoboni, 2009). According to Eisenberg (1986), empathy differs from sympathy in that a person actually has a vicarious experience of the emotions felt by others. Genuine empathy "remains on the experiences and needs of the other person" rather than one's own response (Tangney, Stuewig, & Mashek, 2007, p. 363). Research has shown that emotions are important for genuine reciprocal sympathy (Trevarthen, 2009, p. 56).

For clients with sex dependency, empathy is the ability to relate with others. It is the initial step of allowing others to care while becoming comfortable with identifying their own feelings and needs. Empathy allows clients to stay with their feelings because therapists are feeling for their clients where the clients are unable to feel for themselves.

Clinical Application: Empathy.

In this excerpt, the therapist acknowledges the pain the client is experiencing. When the therapist gives empathy, the voice and facial features need to be congruent with the statement. If the empathic statement is congruent, the client finds it easier to receive and accept it. However, if a therapist does not feel empathy, it would be more effective to focus on encouragement instead of empathy since clients may register non-genuine empathy. This excerpt is to provide a concrete example of how simple, yet powerful, an empathic statement can be during a therapy session. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: Yep..... I've been alone for my whole life, basically, and just trying to make it.... and now I have a couple of major things that mean that I am not alone but....

Therapist: It comes from a deep painful place.

Client: *(Nods head)* It is…

Therapist: *(Warm smile)* How is it for the pain to be seen by me?
[The therapist discloses impact of patient on his experience]
[Dyadic resonance and mutual affection, admiration, affirmation]

Client: It's like a new beginning. Hard, strange . . . but good. Thank you.

Self-disclosure.

Self-disclosure is a sharing of life experiences as therapists personally connect with parts of their clients' stories (Prenn, 2011). It corresponds and compliments with empathy. However, self-disclosure requires courage for therapists. Treadway (2009) noted that the difficulty with self-disclosure is that therapists risk their comments being misinterpreted by clients. Even if clients react negatively, it provides opportunities for deeper understanding and connection. Therapists have opportunities to repair relational ruptures and model conflict resolution while reinforcing the therapeutic bond. Self-disclosure further communicates and expresses the internal process and provides clients feedback on how they are perceived by others. While empathy can be communicated through basic body language, self-disclosure actually requires words to express the therapist's immediate feelings and thoughts.

This tool can be powerful as clients may hear another person express the feelings that they were never allowed to feel. While self-disclosure is considered an intervention,

it is more accurately a process which makes internal dialogues explicit, inviting clients to be relational in their experience with their therapists (Fosha, 2010).

A spiritual connection can be created through self-disclosure. It perhaps is one of the first entry points, in which both clients and therapists can share the universality of the human experience (Yalom, 1995). In these moments, the distinction between therapist and client become more like a see-through veil, in which both have the possibility to see each other as two equals journeying together through life.

Clinical application: Self-disclosure.

Two differing types of self-disclosure can have varying therapeutic effects. First, there is personal self-disclosure in which therapists share information about their own life experiences. Second, there is the process of disclosing in which therapists talk about their experience while being in the therapeutic process with clients. Both types of self-disclosure can be intertwined throughout therapy and may lead to further expanding on either more personal or process experiences.

Regardless of the type, self-disclosure can be incredibly therapeutic, however, therapists need to monitor their motivations towards disclosing. If used for personal relief, this intervention may loose its therapeutic effect. Therapists also need to anticipate its effect on clients. Some clients may be burdened by their therapists' self-disclosure. Often the client's physical reaction will show how the self-disclosure was received. In the following demonstration, the therapist pushes into hope where the client may feel some despair. In the second example, the therapist shares delight with the client while also acknowledging the client's growth. As mentioned earlier, self-disclosure may require a

measure of courage but have the potential to strengthen the therapeutic relationship, allowing clients to know that their therapist is “in their corner”. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Therapist: I mean that’s certainly how I feel, that we’re going to help you get to a better place and I feel a great desire to encourage you. I’m wondering what that’s like for you to be on the receiving end of this?

Excerpt 2.

Therapist: That really touches me. You’ve really accomplished something amazing here. You are speaking your truth in such a deep, honest way. This touches my heart.

Client: *(Beaming smile)* I know. Me too. Me too.
(In this simple statement brimming with positive dyadic resonance, patient articulates internalization of the secure attachment relationship. He is able to know and embrace the therapist’s positive affects, as well as his own.)

Delight.

Another powerful tool in the therapeutic relationship is the expression of delight. In such cases, therapists are able to vocalize observations directly with the client, appearing in forms such as: joy, playfulness, excitement, and encouragement (Fosha, 2008). The effects of delight on clients are that they often find strength and courage for exploration. Therapists’ expression of delight encourages clients to embrace risks, while being connected to a safe dyadic relationship with their therapist. Clients experience true accompaniment as they are encouraged to experience possibilities beyond their sexually dependent behaviours.

Clinical application: Delight.

In this next segment, the therapist shows verbal delight for their client. In order to further deepen the experience of delight for the client, the therapist may ask reflective questions such as “what was this like to hear such delight for you”. The ability to receive the delight from the therapist encourages the client’s openness and vulnerability while also building trust in the dyad.

In the author’s opinion, delight is not a well known therapeutic intervention. It provides vulnerability as therapists admit their investment in their clients through the expressing true delight and support. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Therapist: Wow! Will you just stay with that for a second? That’s a powerful statement. I just want you to tune in to what that’s like to be saying.
[Again, using affirmation to deepen the experience of having the experience, in this case, of relief and delight]

Excerpt 2.

Therapist: Aahhh! It is so cool that you are trying. [Affirmation and excitement]

Support.

Another important therapeutic intervention to integrate is support. More specifically, the therapist establishes a sense of “we-ness” with the client (Fosha, 2010). When encountering uncomfortable or overwhelming emotions, the therapist focuses on the dyadic support the client has with the therapist. This re-affirms safety within the therapeutic relationship and minimizes fears, encouraging clients to engage with their

pain. The term “we-ness” refers to the therapeutic alliance counteracting any aloneness the client may experience in moments of intense pain or anxiety.

Clinical application: Support.

In this excerpt the client begins to feel overwhelmed with their emotions. At this point the therapist decides to focus on the relationship because in an aroused emotional state it is counterproductive to process emotions. The therapist focuses the client back into the present and asks for permission to explore with the client any emerging feelings, while also undoing aloneness. Support can be powerful especially when clients feel that their circumstances or emotions are overwhelming them. In using this tool, therapists can refocus the session to the present moment while exploring with clients how the therapist's immediate support has been received or experienced. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: *(shaking head)* I can’t go there right now. My brain is buzzing with so many things to say…

Therapist: We don’t have to do anything right now. How about we focus on us just being here in this room.

Client: I think it is just too scary for me
(acknowledging defensive block of buzzing while easing into emotions)

Therapist: Hmm…. Very scary? *(low tone of voice)*

Client: Yeah… *(nods head)*

Therapist: You are so courageous in speaking about this… I am so amazed.

Client: Really…. I thought I was just weak.
(self-criticism and psychic defense emerging)

Therapist: I think this is scary. How would it be for us to ease into this sadness together?
(highlighting alliance, create we-ness)

Client: Hmm… the buzzing is a bit less.

CHAPTER TEN: THERAPEUTIC INTERVENTIONS

STAGE TWO: PROCESSING EMOTIONS

Intensity Markers

One of the mantras upheld by AEDP is making the implicit explicit and making the explicit experiential. As mentioned earlier, clients are oftentimes unaware of their bodies' reactions or visible cues while communicating. These unconscious, yet visible and naturally-occuring behavioural cues have been labelled intensity markers (Greenber, Elliott, & Germain, 2003; Greenberg, 2008). These markers are categorized into verbal, non-verbal, and para-verbal signs (Greenberg, Elliott, & Germain, 2003). Verbal markers are instances when clients verbally express their feelings or internal conflict as indicated through the following words: but, not possible, always or never. Non-verbal markers describe observable shifts in facial and body language, such as eye rolling, crossing arms, or flushing of face. Para-verbal markers are related to shifts in a client's voice tone, pitch changes, significant sighs, or notable pauses. In Yalom's (2009) terms, these small signals and markers are "grist for the mill", providing therapists with opportunities for further accessing the client's internal experiences.

Clinical application: Intensity markers.

The following example depicts the use of intensity markers in a therapeutic setting. The therapist is aware of behavioural cues that may show conflicting messages within the client. In this case, hand gestures and eye movements reveal mixed messages which require clarification from the therapist. Often these markers are signs for deeper underlying emotions that may need some extra attention, time, and space to be fully

understood by the client. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: I don't know what I am feeling right now. Why is this relevant anyways? Aren't you supposed to help me.
(deflects feelings while engaging cognitive reasoning about therapy goals, shakes head and uses hand as a cutting motion across throat)

Therapist: Good question… before I give my opinion, I just noticed your hand move across you throat. Did you notice that?
(acknowledges concerns while inquiring about an intensity marker)

Client: No, really!? I did? *(surprise, eyes lighten up)*

Therapist: Yeah, it was something like this… *(repeats actions)* What is your hand trying to say?

Client: Maybe there is something cut-off *(touching a defensive block)*

Therapist: Hmm…. And when you stay with that… what do you think you are cutting yourself off from?

Client: *(eyes get glazed, voice lowers)* Hmm…. fear.

Therapist: *(sees client physical reactions)* Is the fear coming up a bit?

Client: Yes….

Removing Defensive Blocks

Emotions are powerful pathways towards healing. They are often heavily guarded by mental defences. Feelings of anxiety are often an indicator for the mind to lapse into defensive procedures such as distractions, evasion, minimization, rationalization, or disconnection (Fredrick, 2009). In relationships, these defenses are regularly triggered for individuals with sexual dependence. Therapists must incorporate this knowledge while carefully using interventions to work on maintaining or re-establishing safety for clients

while emotions continue to emerge. Greenberg (2002) sees emotions as neutral, in that they exist as a part of humanity. He further suggests that the negative and positive labels or connotations of emotions are formulated through social constructs in one's family system. Fosha (2000) posits that certain emotions can have a pathological effect on individuals, leading to the building of defences around these emotions in order to avoid them. The resulting pathology becomes evident once individuals' protective efforts develop into hindering habits or mental constructs that limit or block personal growth. For instance, shame and anxiety often have pathogenic tendencies but depending on environmental and cultural circumstance. Even the expressions of joy or anger may have pathogenic effects, when a person limits the expression of these emotions in order to protect themselves.

Therapists need to work through defenses relating to pathogenic emotions in order to facilitate healing experiences. The pain experienced by individuals often requires adaptive behaviours such as denial or rationalization. These defenses are in place to prevent someone from being overwhelmed by negative emotions[3]. While defenses exist to avoid painful emotions, they also hinder the experience of positive emotions. The brain cannot accurately select emotions that need to be numbed. While the brain is able to selectively forget past experiences, it is not so for emotions (Brown, 2000). Looking for pathogenic emotions provides "motivation for meeting unmet personal needs", it provides therapeutic direction on why certain emotions are not allowed to be felt and express and what needs may have not been met through the suppression of these

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3 See Appendix E

emotions (Greenberg & Malcom, 2002, p. 407). In essence, individuals need to work through the pain in order to feel positive affects which result in transformation.

Sexual activity acts as an important escape for clients who experience pathogenic emotions. Individuals using sex to numb feelings, often compromise personal values, resulting in intense guilt and shame (Schaeffer, 2009). Furthermore, their internal and external failures, in regards to managing or discontinuation of sex dependence, compound perceived rejection from peers. This triggers blame for clients, which further perpetuates feelings of inadequacy (Adams & Robinson, 2001). Therefore, a strong therapeutic relationship is of utmost importance for overcoming emotional blocks since it provides a stable and secure foundation throughout the processing.

It is crucial that emotional defenses are processed slowly and with safety so as to not overwhelm individuals. This process often induces resistance since individuals have previously diffused emotional content through sexual behaviours (Adams & Robinson, 2001). As therapists partner with clients on the ‘journey of feeling’, a new space is being created where a safe and trusting relationship allows affect to emerge without triggering the natural, yet negative, defenses. Through this experience, therapists model new rather than defensive ways of relating, ensuring clients that they will not be abandoned as emotions begin emerging (Fosha & Slowiaczek, 1997).

Clinical application: Removing defensive blocks.

In these excepts, the therapist questions, acknowledges, and holds the sadness while waiting for the clients to process and express their experiences. In excerpt one, the therapist allows the defense to exist and engages the emotional client through reflections. This also provides the client space to work through their defenses at their own pace. In both excerpts, the therapist uses the clients' own language in order to deepen the experience around the client's defenses. Through querying, the therapist achieves a greater sense of depth while allowing the client to obtain a clearer perspective on his or her defenses. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Therapist: Do you burst into tears?

Client: Sometimes.

Therapist: Do you fall apart? Or do you feel sad? *(Cognitive restructuring)*

Client: I feel sad. Yeah, it's not like I'm some wailing mourner. It's just, you know, sad.

Therapist: Yeah.

Client: And I think there's just so much . . . the reservoir of sadness is just so huge and I steel up. *(Another round of increasing capacity for self-reflection and defense recognition)*

Therapist: I was just thinking that. No wonder you steel up. There's so much to steel up against. *(Affirming historical value of defense)*

Excerpt 2.

Therapist: So what I'm thinking is your hopping from place to place to place is a long developed, longstanding strategy for protecting yourself in a certain way.

(Defense recognized and affirmed as a strategy for self-protection)

Client: Like walking across hot coals?
(The patient makes it his own and advances the co-constructed, collaborative process)

Therapist: Yeah . . . *(protecting you)* from landing on any one thing that might have at one time been very upsetting or too stimulating or too difficult to handle. That's a perfect metaphor. The thing is, you're not the same guy now that you were whenever any particular coal was added to the pile. So, while it may very well be that now you can handle them and now those things wouldn't be so unbearably upsetting, you're already inculcated into jumping across the coals as if they're still glowing embers and, of course, some of them might still be glowing embers.
(Opening possibility of restructuring the defense while also acknowledging potential for its necessity)

Client: I think you're right. I think one of the things that have been happening is that I'm realizing they're not so hot *(smiles).* I'm realizing that I'm capable of thinking about things differently . . . almost like strange levels of decompression/recompression going on with certain things. You know, I'm trying to be calmer.
(Emergent self-reflective capacities give way to verbal, imagistic, and nonverbal affirmation of defense-relinquishing and emergence of pride)

Moment-to-Moment Tracking

Moment-to-moment tracking or micro-attunements are essential for releasing defensive blocks and deepening the therapeutic process (Fosha, 2010; Bradshaw, Cook, & McDonald, 2011). Throughout processing, therapists are both modelling appropriate ways of interaction and querying changes of physical and verbal expressions of clients. Sometimes these changes may be a shift in the eyes, a change in tone, or a hand movement. As therapists bring these changes to the present, clients begin to shift their focus to their internal state.

If the therapist's internal state can meet the client's, and the therapist's own hopefulness and openness can come to the forefront, allowing them

> to feel free to be as therapeutic as they are capable of being, something profound can happen: *in that moment,* the therapist has the opportunity to go beyond being good enough, to actually be downright good. (Fosha, 2000, p. 214).

The internal state of the client comes into contact with the internal state of the therapist. These two states often differ in which the client sees themselves as not 'good enough', while the therapist sees the client's 'best effort'. The internal state of the therapist exudes hope and affirms clients, bringing them into state of vulnerability. It is in this state that creativity, innovation, and new options begin to emerge from the client.

Tracking emotional shifts in clients is important to notice. These internal changes are often through physical cues that are recognizable by therapists as they query behavioural changes. These shifts are tracked through "face(s), voice(s), gaze, posture and gesture" (Tronick et al,, 1998, p. 293). As clients shift and engage in their narrative, the therapist emotionally tracks and connects with the story. Through their openness and expressiveness, therapists deepen the client's experience (Fosha, 2000). Moment-to-moment tracking in conjunction with therapeutic interventions form a effective platform for deepening and processing emotions.

Tracking emotional shifts allows therapists to interpret and comment on clients' emotional states. It allows therapist to stay in the present with their client while also acknowledging that they are listening as their clients engage with their self-narrative, which are life-stories on how clients have experienced being in their own life. This awareness is about micro-attunement and mirroring as clients experience variations and

slow down the therapeutic process, through which clients can actually process their experience instead of activating their automatic defenses (Bradshaw, Cook, & McDonald, 2011, p. 106). This not only validates clients' experiences but gives further permission for exploration, while also establishing a therapeutic platform from which to check various emotional states and defensive behaviour.

In tracking shifts of emotions, therapists ensure that clients stay present with their narrative. This protects clients from being overwhelmed by the emotional content of the session. Bradshaw (2011) referred to this process as titration, in which clients oscillate between touching their pain and coming back into the care of the therapeutic relationship. In the therapy session, this is often seen as the client being brought from their past experiences into the present, allowing them to see beyond the pain, experiencing the compassion, and empathy of the therapist. As mentioned earlier, this not only validates their pain, but also allows them to go deeper into the experience. It also serves as a re-parenting tool, providing emotionally corrective experiences. Clients receive the emotional stability and consistency that was absent during childhood years (Fosha, 2000). As clients begin to tolerate their emotions, they obtain internal permission to access their core affect, or core state, in which they can discover their true self.

Clinical applications: Moment-to-moment tracking.

These excerpts indicate how therapists can track changes in their clients. In the first excerpt, the therapist does not focus on the client's self-consciousness but rather explores the impact of sharing the sadness. Moment-to-moment tracking, also known as micro-attunement, is about the therapist holding an emotions such as sadness if there is

more sadness to be released by the client. For clients with sex dependency, this may be very difficult to engage in, as they begin to engage with another person, they are going against their tendency to withdraw and isolate themselves. In order to alleviate tension and stress felt by the client, the therapist can offer psycho-education to show its benefits while also acknowledging that such intimate observations may indeed be frightening. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: That I'd always be sad. That . . . I don't see how it helps? *(Defense returns)* Y'know, in many ways I've lived with a woman who thought I was pitying myself the entire time.

Therapist: Right.
(Affirming this element of a more coherent narrative)

Client: And I felt self-conscious that if she's right, I just need to grow up and deal with things.
(Shame invokes defense to repress affect)

Therapist: So what's it like to have me inviting you to be sad with me?
(Challenging dismissive stance of previous attachment figures with accepting stance of the therapist)

Client: I suppose it's like a forbidden action that you want to do but then feel like you're not supposed to. And . . . I spent a lot of time being sad, believe me, a lot of time . . . but just not necessarily with others in a constructive way. I can be depressed or whatever it is, but not in any way that I don't feel guarded or ashamed or,y'know, immediately want to have some sort of post-sad strengthening moment where I pretend that it's not affecting me.
(Exquisite articulation of dilemma and strategy of avoidant attachment)

Therapist: Such a key phrase, right? "Pretend." It brings me right back to you as a little boy.

Client: Yeah, I mean it's just habit.

Therapist: You had so much happen to you that you really earned the right to be sad about. You really did. It's not about being pathetic or weak or incapable or scattered or lazy or helpless . . . It's sad.

Client: It's sad. And you know, I'm not a happy person *(pause).* I resort to humor or I try to make other people happy…
(Affirming,witnessing) (The therapist's affirmation catalyzes the client's reflective self-function and capacity for his own defense analysis)

Therapist: So could we take literally like a minute to check out what it would be like not to try to make me happy, but just to feel . . .
(Titrating challenge to defense)

Client: I'll just fall about *(begins to cry).* I spend most of my time feeling like I could burst into tears.

Excerpt 2.

Therapist: And you know, I just feel.... I feel your feelings about it. That there's a lot of sadness.
(Pressuring toward core affect; anticipatory mirroring: the therapist already feels the affect the patient is struggling against)

Client: Yeah (*sighs deeply, twice*) Yeah, yeah and that's a lot of... I mean she was kind of describing some of your techniques, I don't know how fairly she can represent them, and I was thinking "oh, probably that wouldn't work for me". You know, so I was kind of figuring out ways of not doing this and just sitting around and missing not working with Martha my old therapist. Mmmm ....*(Very clear articulation of dynamic; rise in therapeutic dyad)*

Therapist: Wow, it sounds like you really miss your old therapist. She has meant a lot to you?

Client: Yeah, I guess so…

Therapist: What's happening right now for you? After I stated that I see that she means a lot to you.

Client: *(tearful eyes)*

Facilitating Adaptive Change

According to Goleman (1995), emotions activate the body, accessing its capacity to leap into action, a process which AEDP refers to as emotional action tendencies (Fosha, 2000). Depending on personal and environmental factors, these actions have either adaptive or maladaptive results. Dysregulated, unprocessed emotions are a primary cause for maladaptive behaviours. Allowing clients to notice emotions in their bodies, and subsequently receive validation for the related feelings, results in a strengthening of self, a key aspect of childhood development previously neglected. In essence, clients are given another opportunity to experience secure attachments within the safety provided by the therapist. Throughout this process, the healing emphasis is not linked to the therapist's clinical skills, but rather, the experience, perception, and non-judgemental approach provided (Fosha, 2010). Regulating and effectively processing emotions communicates a person's developing, improving state, providing behavioural motivations for further personal growth.

Emotional regulations occur within a healthy, attached therapeutic relationship, in which, core affective experiences are felt, grieved, and honoured (Schore, 1996). Core affects are the raw, unfiltered experiences that emerge as clients begin to validate and authentically accept their experiences (Fosha, 2010). This process creates an adaptive action tendency, where an “emotion offers a distinctive readiness to act; each points us in a direction that worked well to change the recurrent challenges of human life” (Goleman, 1995, p. 4). When individuals experience and communicate through their core affect, they

are engaging with the therapist in deep, meaningful, and intimate ways. These affective experiences are essential to psychosomatic processing.

Strengthening one's internal self-concept is crucial as core affective experiences begin to emerge. These core experiences are the primary emotions which arise in the absence of defence mechanisms created to withstand painful circumstances. As these undefended feelings emerge, opportunities arise to process these raw emotions to completion. This means acknowledging, working through, and accepting emotional change. As different experiences with one's emotional narrative are attained, new pathways are created towards deeper individual healing and personal change emerge (Fosha, 2000; Greenberg & Malcolm, 2002; Greenberg & Pascaul-Leone, 2007).

The therapeutic effects of safety and micro-attunement facilitate emotional processing in clients, and these emotionally corrective experiences begin to shift clients' perceptions. At this point, clients encounter a crossroads, where resilience can pave the way for unfamiliar, yet promising, transformation (Fosha, 2009). This aforementioned crossroads, or one's internal crisis towards healing, has been called “the tremulous affect” (Fosha, 2009). Alternatively, individuals may recognize the familiar stability and known certainty of a life filled with pain and suffering.

Clinical application: Facilitating adaptive change.

Adaptive change is the main goal for working with individuals who experience sexual dependence. Within this clinical excerpt, the therapist engages with the client’s negative emotions, which have previously led to self-medicating through sexual activity. These excerpts show how clients begin to tolerate powerful emotions such as loneliness

and fear. The therapist monitors and joins the client in those intense moments, while further strengthening the collaboration within the therapeutic dyad. The author believes that it is vital for therapists to highlight the emergence of new behaviours and feelings. Essentially, therapy is about change and it can easily be forgotten or overlooked rather then celebrated. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: And I want so much not to feel this way.
(Emergence of adaptive action tendencies)

Therapist: What way?

Client: I don't want to feel alone.

Therapist: Do you feel alone right now?
(Offering reality of secure base of therapeutic dyad)

Client: Less so.

Therapist: Do you feel my presence with you?

Client: Yeah.

Therapist: What's that like for you? What's it like not to be abandoned or having an ulterior motive with you?
(Inviting meta-therapeutic processing of the patient's experience with the therapist)

Client: Unique.

Therapist: I bet.

Client: I've had people who wanted to be there for me. It's, but, unless you . . . most people who want to be there for you then need you to tell them what to do, and its hard then not to feel like you're putting people out or dragging them along when you can't really explain it to them.
(Big green light—patient articulates his attachment needs—for help,

guidance, organizing)

Therapist: Are you sensing that from me?
(Affirming validity of these needs)

Client: No.

Therapist: So if you stay with me right here in this moment.

Excerpt 2.

Therapist: Stay with lonely and scary.
(Gentle redirection to remain connected to deep affect)

Client: Like ... at this stage, you're a very nice person but the alternative of me just trying it on my own doesn't feel very different than this at this second... It kind of feels like....

Therapist: … kind of feels like.... '
(Staying present with client and being empathic)

Client: … like I am totally alone (*crying, voice breaking)*

Therapist: That's a very old feeling.
(*Very sympathetic sad non-verbal communication through noises*)

Client: Yeah, I felt that for a long time (*Crying, but calmer*)

Therapist: Mmmmm…(*More sympathetic noises*)

Client: (*deep sighs, more crying*)

Tremulous Affect: Moving From Old to New Experiences

Trauma often causes self-dissonance. The earlier the traumatic experience, the more damaging the experiences causing disorganization in clients' self-narratives. Therefore individuals create self-functions, which are tools to negotiate interactions with others, manage the intensity of the experience, and balance inner and outer experiences. Clients with sexual dependency limit their self-function abilities such as: social skills,

appropriate affect, listening abilities, anger management, problems solving, tolerance, and empathy (Schwartz, 2008). In order to integrate distorted self-narratives and strengthen self-functions, therapy needs to facilitate experiences that challenge clients' self-construct. These experiences are healing and validating in nature, highlighting new possibilities of how they view themselves. In therapy, a rhythm exists in which both therapist and client move between old and new experiences as slow changes begin to emerge in the client.

The tremulous affect highlights the possibility of healing while encountering barriers to change. This confluence of family rules and healing experiences cause trepidation in clients. Past relational experiences and expectations have encouraged avoidance, often resulting in fearing the unknown. Experiencing the unknown is a very intense time, as clients are on the cusp of transitioning from a life dictated by their dependency to new possibilities (Bridges, 2005). Working through the emotional pain underlying sexual dependency uncovers deep losses and memories of pain. Clients with sexual dependency can only shed maladaptive action once they have been given experiences that challenge their individual perceptions and instill in them a sense of purpose and meaning. The old self-image ceases as an emergent true-self comes to the forefront (Fosha, 2000). This part emerges as undefended painful experiences encounter a caring, empathic, and encouraging therapist. As clients effectively process their experiences, change is achieved as they transition between old belief systems and new, promising possibilities.

Therapy provides a holding place for clients to discover their true-self. Processing core emotional states linked to trauma (e.g. fear, grief, or hurt) begins to create coherence and flow in clients' personal narratives (Fosha, 2008, p. 9). Therapists stay present and monitor this process for individuals. In essence, the therapeutic holding place, allows individuals to integrate their feelings, experiences, and insights (Fosha, 2000). According to Lipton and Fosha (2011), pain may develop into experiencing profound sadness, and as sadness dissipates, hope may emerge:

> For many patients, first experiencing and then reflecting on the experience of secure attachment, with the very person with whom it is being felt, often spontaneously catalyzes healing experiences of adaptive grief; the new process of positive relating sheds light on old attachment traumas which can then be mourned and worked through to completion, a kind of mourning for the self. (p. 264)

Slowly, emotions and feelings shift while clients begin to integrate the healing experience into their current paradigm. Harnessing one's emotional energy is the nexus of personal change. As new feelings and experiences emerge, clients are on the path of transformation.

CHAPTER ELEVEN: THERAPEUTIC INTERVENTIONS

STAGE THREE: TRANSFORMATION AND REFLECTION

Transformation

In the early 20th century, James (1902) made a phenomenological observation on the powerful effect of emotions, writing “emotions that come in this explosive way seldom leave things as they found them” (p. 198). As clients encounter positive feelings and thoughts, a phenomenon emerges: transformation. The feelings of transformation are present in every day life, but commonly pass by, unnoticed. Greenberg (2007) identified emotional peaks as primary emotions, whereas Fosha (2002) considers them to be core affective experiences. Either way, these powerful, natural feelings contribute to the transformative potential of completely processed experiences. In therapy, these moments must also be highlighted and effectively processed, similar to negative reactions.

When clients with sexual dependency enter therapy, they often look for behavioural or environmental changes. However, changes occurring within this therapeutic approach is a transformation of self. Many terms have described transformation, such as Ghent's (1990) term of surrender, which holds spiritual connotations, or Frankl's (1984) description of suffering, which implies a deep, existential focus. Fosha (2008) promotes the term “transformance” to highlight the personal phenomena of change, which describes a “motivational force… that strives toward maximal vitality, authenticity, and genuine contact. Residing deeply in our brains are wired-in disposition for transformance” (p. 3).

In facilitating transformation, therapists move between negative and positive experiences. Hope is a key ingredient in developing courage, and courage provides the possibility for change. Therefore, therapists need to highlight affective breakthroughs and emotionally corrective experiences for their clients. Progressively, a resonance is created between therapist and client, in which both are capable of seeing transformation. This synchronicity becomes a part of the therapeutic process and amplifies the positive energy (e.g., emotions, experiences, and insights) that powers change. Even as new challenges appear, the therapeutic relationship functions as a regulatory process for affect, especially negative arousal, while strengthening healthy attachment (Schore, 2002).

Transformation occurs on various levels of experience but its impact translates throughout the entire body. For instance, forgiveness can be seen as a transformation of a negative emotional state to an affinitive stance characterized by compassion and empathy towards a perpetrator (including self) (Meneses & Greenberg, 2011). Through this, individuals strengthen such self-functions as: worth, esteem, reliance, and soothing. Also, clients are able to challenge assumptions and limits of self while gaining a more realistic picture of their personhood (Muller & Rosenkranz, 2009).

The therapeutic intervention for sexual dependency does not focus on cessation or limiting behaviour but on the transformation of the individuals. As traumas are resolved and self-function abilities strengthened, a new self-image begins to emerge for clients (Fosha, 2000; Schwartz, 2008). In this image, the individuals come into contact with their true-self, a self that expands in value, meaning, possibilities, and hope. This self releases itself from the limited identity of its sexual dependency and incorporates other

parts that have often been lost or forgotten. These individuals begin to see their feelings and needs as important as those of others, while expanding in love and courage to take risks in developing relationships that are truly satisfying to them.

Clinical application: Transformation.

Transformation is an incredible process to witness with in the therapeutic relationship. As much as there are scientific reasons to explain this process, there seems to be a mystical aura around the process of transformation, during which clients overcome their past perceptions as they integrate new parts of themselves. Appropriately, transformational moments are often described as metaphors since clients oftentimes do not have the vocabulary to express the momentous changes that are occurring within them. It is important not to rush through the process towards change, but rather trust in the process. In these excerpts, the therapist holds and highlights the transformational moments in order to deepen the effect on the clients whom are striving for change. Similar to facilitating adaptive change, emergence can also be highlighted as indicators of personal growth within clients' experiences. As new glimmers of hope and change appear, therapists push into and expand these adaptive shifts when expressed by their clients. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: *(Haltingly)* It's . . . how to describe it? I still feel like I'm underwater in a Certain way . . . . *(Muscles in his chest twitch),*
(Somatic communication of something)

Therapist: *(Gestures to chest, gently, with curiosity)* Did you just notice . . .

Client: Yeah, twitches . . .

Therapist: Yeah, so maybe there's still something stressful . . .?
(Attempt to attune and help organize nonverbal experience)

Client: It's like, all right, it's like there's some pit and you're telling me I can walk Across and I'm like, "No, it's a pit." And you're like, "No, there's an invisible glass floor". (*Laughs with mixture of anxiety and evident delight)*

Client: I'm like, "OK, there's an invisible glass floor. . . . *(pause)* And I'm starting to walk across it . . . in my time. I'm starting to believe more and more there's an invisible glass floor. Or I guess it could be an invisible steel floor, if it's invisible".
(Patient and therapist laugh together, resonant in delight and simultaneously dyadically regulating the patient's anxiety about what is newly emerging)

Client: Um . . . I feel like in many ways I'm coming out of a nightmare, but I'm not all the way there. Um . . . it's almost like I have this smidgeon of hope or something.
(This is the territory of transformation in the facilitating safety of the securely attached therapy dyad. Something new, simultaneously scary and exciting, is emerging)

Therapist: Yeah, can we just stay with that for a minute?
(Recognizes an opportunity to deepen transformance strivings)

Client: It's like I'm becoming more aware of, of . . . um . . . . It's one thing to know how you operate or that you have certain defensive mechanisms, but this is like getting past that certain point of pain . . . . Like . . . playing something over and over and over and over again without doing something about it is really a waste of brain power and time. It's like being mentally anaerobic and suddenly you're filled with lactic acid or something, I don't know *(laughs).*

Excerpt 2.

Therapist: How are you feeling?

Client: I feel some of the release of having felt that emotion.
(Post affective breakthrough affects)

Therapist: Tell me
Client: It's a little freeing.
(Post affective breakthrough affects)

Therapist: A little more relaxed

Client: Yeah. (*Head nodding*)
(The head nodding is a somatic marker of being on the right track, of being in sync)

Therapist: How does it make you feel about *you?*

Client: (*Long reflective pause* and *moved to tears*) Kind of reminds me of the real me.
(Healing affects: affirming recognition of self by self)

Therapist: Mm…huh *(Empathic response that shows connection)*

Client: That the real me is like not necessarily this performer,... has all those attributes and skills but is a little more incisive than just always trying to be jokey.

Therapist: So what's it like to make contact with the real you?
(Further metaprocessing and the next wave of exploration)

Client: That always feel really good (*nice relaxed smile*)
(Vitalizing positive affective marker associated with healing adaptive experience)

Client: There is something very real about it.. You're right there....
[The language of affective transformation tends to be simple, from the heart]

Therapist: Right

Client: Kind of like getting pissed at people, you're feeling it and you're doing it and there is something empowering about that… (*motions with his fists muscled motion*)
(Declarative expression of experiencing an adaptive action tendency; vitalizing positive affective marker)

Therapist: Right.

Client: The wheels are on the pavement. (*Declarative tone*)
(Very significant statement, given that he described his experience of loss and aloneness as "the training wheels came off": this current experience is a direct healing of that experience)

Therapist: Which means what?
(Transformation: more exploration of newly articulated experience of "the wheels being on the pavement")

Therapist: Notice...

Emotions Catalyzing Transformation

The primary goal within therapy for treating sex dependency is to allow individuals to access their core state of being. Therapists use the term "drop-down" to guide clients into their feelings, which has a psychosomatic component, rather than staying in an analytical/cognitive state (Fosha, 2000). Moving towards a core state experience is achieved by slowing down the therapeutic process and addressing emotional shifts as they appear throughout sessions. When negative emotions arise, therapists use empathy and disclosure to undo the client's aloneness, while actively highlighting glimmers of positive affective experiences.

In this state, psychic defenses are at a minimal as clients experience a deepening within the therapeutic relationship. For clients, this is a moment when they are able to receive and process empathy, awe, and compassion. The care and kindness provided by the therapist shifts the client's self-perception as transformation emerges. The glimmers of transformation originate as little nuances when clients begin to express empathy and kindness towards themselves resulting in greater resilience in the face of adversity (Fosha, 2000). A resilient self has greater energy to participate in life. It strengthens clients' courage and determination to explore themselves and the world around them.

Two results emerge as clients engage with their core being. The first healing effect is that clients feel moved "from within the self, and [show] gratitude, love, and

tenderness toward another" (Russell & Fosha, 2008, p. 175). The second result is seen within an existential shift that occurs as calm transcendence "in which truth, persona, meaning, and a core sense of self emerge" (Russell & Fosha, 2008, p. 176). This emergence of the core self instills the possibility for further change. As clients engage with kindness towards self and others, the plague of sexual dependence loses its importance to the adaptive possibilities becoming part of their behavioural repertoire.

Clinical application: Emotions catalyzing transformation.

As much as AEDP is processing about emotions, it is very important to engage both right and left brain hemisphere is the therapeutic process. This process oscillates between emotional experience and rational reflection in order to completely integrate new adaptive experiences. As already mentioned the meta-therapeutic process, in which the client enters and emotional experience and then steps out of it to reflect upon it, is crucial. For clients with sexual dependencies, this process would strengthen emerging identity as they shift from external to internal experiences. In these excerpts, the client is given time for emotional experiences using their right brain and then reflect upon those experiences using the left brain. Emotions are useful in showing clients that they are experiencing change. This includes the absence of painful emotions or the emergence of empowering, positive emotions. It is useful for therapists to prioritize time for clients to fully experience and reflect upon the emotional shifts which will occur over the course of therapy. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Therapist: I mean you're saying such important stuff. And I want to bring you back for just a minute, to your experience. [After a round of reflection, the therapist invites the patient to join in another round of right-brain experiencing]

Therapist: You were just saying that you were evolving. And I notice that in between your articulating these really important thoughts and ideas that you've been articulating there have been these pauses. I don't even know if you were aware of them because you were trying to think.

Client: Right.

Therapist: But in these pauses there just seemed like a lot of feeling present, a lot of emotion present. [*Patient nods*, a signal from the right-brain that the therapist is on target]

Client: Mmm, hmm.

Therapist: And I'm just wondering, when you kind of tune in to that idea that you are evolving and that you're being more compassionate with yourself, what does that feel like, what's it like to just take a moment to connect with that? To not think about it, but to feel it . . . to drop down below the neck and breathe. [Therapist responds contingently to green light and invites patient to deepen his awareness and felt-sense experience]

Client: It's a relief *(Big sigh and laughs with delight).*It's like the monster that's been stalking the neighborhood is caught.
[So the body also tells the story of relief and delight as intra-psychic safety comes on line in the context of the secure attachment of the therapeutic dyad]

Reflection

AEDP highlights the importance of reflecting at the end of therapy sessions (Fosha, 2000). Reflections can occur at any time, especially after an intense experience, and provide clients with opportunities for profound insights. "Continuing to experientially explore the patient's changing experience", after having articulated them in therapy is a vital component to deepening the therapeutic process (Fosha, 2008, p. 10). It is important to integrate and process experiences where clients' have break-through

moments which involve adaptive behavioural or cognitive changes (Fosha, 2000). Therapists alternate between experiencing and reflection on the experience as existential shifts occur for clients in order to provide further depth to the experience. These shifts can be emotional, physical (release in pain), cognitive, or spiritual in nature.

As mentioned previously, clients reuniting with their core self is a transformative experience. Personal truths that have been buried emerge, finally becoming part of clients' identities. These truths may have existed as discouraged unrealized potential in a semi-conscious state, but remained dormant, and were too frightening to be internalized as possibilities by individuals. When processing is completed, individuals obtain access to "deep emotional resources, renewed energy, and adaptive repertoire of behaviours" (Fosha, 2004, p. 33).

The importance of reflecting is to integrate the new experience into both left and right brain hemispheres (Schore, 2009b). Emotional processing mostly connects with the right hemisphere of the brain, in which analysis and reflection integrate the therapeutic experiences into a personal self-narrative. In this, a person is able to reshape personal beliefs and meaning through newly attained experiences. In these moment individuals with sexual dependencies will see the causes for their actions and their underlying needs. Instead of emotional self-flagellation if sexual slip ups occur, clients are able to access empathy and care. Eventually, this integration allows clients to associate sexual desires with emotional states such as loneliness or sadness, giving them new options in how to address their needs in adaptive ways.

CHAPTER TWELVE: THERAPEUTIC INTERVENTIONS

STAGE FOUR: INTEGRATION AND SPIRITUALITY

Integration

Integration of the therapeutic process for individuals with sexual dependence allows for closure to the healing experiences. Sexual dependent behaviours are limited ways of viewing sexuality in regards to oneself and others. In the minds of clients, these behaviours often exist on an all-or-nothing spectrum as it pertains to the primary purpose of finding sexual release (Orford, 1978). Clients' experiences of secure attachment with therapists can be very transformational as individuals often find themselves "broken at the core" (Lipton, & Fosha, 2011, p. 265). Therefore, integration is crucial as new experiences establish linkages between various parts of the human body (brain, emotion, body, and spirits) (Siegel, 2009).

Similar to reflection, integration can occur numerous times throughout a single therapy session. During such moments, internal states of a client's experience will be made explicit by bringing it into the present. At this point, it becomes a shared state. Through openness and feedback, therapists engage in making the explicit state experiential, as both therapist and client become "collaborative partners in the journey toward healing" (Siegel, 2009, p. 165).

Clinical application: Integration.

Integration is often interspersed through out a counselling session. Clients will converse and examine momentous experiences and often reflect automatically about their comments. This is the ebb and flow of therapy, in which integration occurs through

reflection almost naturally. For clinicians, this cycle is observed more diligently as some reflections can be defensive mechanisms to avoid going deeper into the emotions, while other reflection may be cut to short. Metaphorically speaking, reflections assist in giving intense counselling sessions a therapeutic breath of air, in which insights, musings, and questions can be integrated through reflections. As mentioned earlier, integration is used to facilitate both left and right brain stimulation. It provides clients with a cognitive and rational opportunity to reflect and discuss their experiences throughout the therapy session. The following excerpts have been reproduced with permission by Lipton and Fosha (2011) and modified by the author.

Excerpt 1.

Client: *(Begins to cry deeply and powerfully)*

Therapist: I'm right here. Right here. *(Secure base affirmed)*

Client: *(Sobs)*

Therpist: So much grief, so much held in for so long.

Client: Thank you. Wow! *(Deep sigh and body relaxes)*
(More crying for some time. Then, the wave completes—as waves of core affect always do. Shy smile. Shy look up into the therapist's eyes)

Therapist: You are so welcome. What are you thanking me for?
(Deepening self-reflection)

Client: I think I've been needing to do that my whole life. I knew it, but I didn't know it. Whew. What it's like, huh? *(Warm smile)*
(Long pause, patient clearly integrating this experience and reworking his capacity to accept and honour his attachment needs)

Excerpt 2.

Client: And… you're always trying to cut me some slack.
(Affirmation signals attunement; the patient articulates his experience of the

therapist's kindness and good will toward him)

Client: … Or encouraging me to cut myself some slack. And I think I am trying to do that a bit. Umm… or becoming more conscious you know. I know that I've done some things pretty well in my life. I've gotten a lot of accolades for a lot of the things I've done well in the past. There's never any swelling tide for that sort of feeling, though. It's very ephemeral. It may last for, like, 20 minutes and then go back to a neutral state . . .
(The patient goes on to speak about conversation with current business partner who challenges his underestimation of his professional capacities.)

Client: It comes down to feeling bad about any need for encouragement and I think, going back to the early issues, I didn't get any encouragement.
(Safety of and acceptance within therapy dyad allows for reflection, by contrast, upon the cost and origin of shame)

Therapist: So, what's it like being with me as your therapist, who, I think, is very encouraging? *(Leaning forward)*
(Begin meta-therapeutic processing of the new, better experience in the therapy dyad)

Integrating the True-Self

Clients must not only integrate the individual experience but also the integration of new ideas towards sexuality. Sexual acts always require relationship with either self, an object, or a partner. Even in the illusion that sexual expression is a purely solitary act, "there will always be a pressure to find someone to share it with, through projection and reintrojection," thus making the sexual behaviour communal again (Target, 2007, p. 523). Underlying the gradual diminution of sexual dependence is the process of integration. This requires the conscious awareness that the self is more than its ability to achieve sexual expression. In these moments, the self actually expands into the full potential of the integrated self. The previous labels under which clients have lived fall away, and out of the chrysalis, emerges the integrated self. It is only with all this information about the

complexity and wonder of their own being that clients can fully understand and incorporate their sexuality.

This integrated self can be compared to Rogers' (1951) concept of self-actualization. The healing journey for clients does not necessarily create new beings, as much as it assists clients to uncover their latent potential. These experiences develop new insights, which lead to new risks, which will lead to new, more beneficial behaviours. In the meantime, "effective experiential integration brings lasting changes in that synaptic connections rewire themselves to include new experiences" (Siegel, 2009, p. 158). This promotes the well-being of clients as their integrative state results in harmony and coherence. Integrations of new experiences create meaning in an emerging new self-concept.

Integration and Beyond

The substantial processing facilitated within the therapeutic relationship may provide deep and meaningful spiritual insights. In this case, spirituality is the possibility of the unexpected. Both transformation and reflection are important practices that create movement towards exploration and insight (Killen & De Beer, 2010). It further contributes to a habit of mindfulness, in which therapists and clients are aware of themselves and the co-existing environment. Essentially, this acknowledgement allows for the emergence of acceptance in which one is not defined by race, sex, or social status, but rather a unified journey. Engaging in each others' narratives diminishes the status difference between the therapist and client, as both participants partake in life's celebrations, sufferings, hopes, and disappointments (Lartey, 2003). According to Frankl

(1957), “the self does not yield to total self-reflection. In this sense, human existence is basically unreflectable, and so is self in itself” (p. 30). In itself, the human experience is exceptionally difficult to define or convey. However, in a joint experience, a synergy is created that goes beyond the “I” and works with the “Us” (Frankl, 1957). Meaning that in these moments, clients shift from a self-narrative to a communal narrative, engaging with those around them.

When clients commence therapy, they are often in crisis and desire stability amidst the chaos. Engaging with clients' uncertainty and not taking control can be difficult for therapists as both expectations and personal triggers may lead therapists to problem solve rather than simply accompanying the journey. Therapy can become something bigger than just a clinical arrangement, as the dyadic relationship offers an opportunity to repair, transform, and re-capture one's true existence.

For clients experiencing sexual dependency, feelings arouse a creative energy, that, when attended to will uncover “… unspoken, unrecognized questions, values, and wisdom and the key to their conceptualization” (Killen & De Beer, 2010, p. 31). Once these are uncovered, profound insight, healing, and transformance appears. As much as therapists may know that change will occur, they cannot predict what form it will take and how one's improved existence will affect one’s relationships to self, community, and environment.

The key for relational transformance is faith. A therapist's ability to believe in the latent goodness of their clients is critical to providing the foundation for deeper change. Therapists focus on the positive aspects and strengths of clients that may have previously

gone unnoticed. In this process, both the therapist and client create a partnership, which works on undoing psychopathological emotions and their detrimental effects (Fosha, 2000). Unfortunately, individuals' defences are strong because culture often values control and minimization of emotions. A part of the need to control is fearing the unknown. Killen and De Beer (2010) state that, “we live in a culture where control is highly valued. The uncontrollability of feelings makes them scary and problematic” (p.31). This existential angst needs to be acknowledged as part of human anxiety, as clients face their fear of the unknown.

The spirit of exploration creates an open and safe environment. Within this environment, latent emotions begin to emerge in clients as the importance of embracing the unknown is juxtaposed to the individual’s control issues which are often shrouded in secrecy (Carnes, Delmonico, & Griffin, 2007). This lens shifts the focus from diagnoses towards a powerful accompaniment of vulnerability and honesty in experience. This shift allows therapists to be reflective in their relationship with clients (Kottler, 1993). In psychosomatic therapy, the focus shifts away from symptom alleviation to exploring the power of human emotions. This power has transformative potential for human relationships, in that clients may experience love, joy, and peace without feeling guilty or ashamed. Through this process, the fear of the unknown subsides as the body incorporates the new experiences into its behavioural repertoire. As clients remove imposed limitations, the full power of transformation is released. Yalom (2009) stated, the concept of being “fully seen and fully understood” is a powerful and memorable emotionally corrective experience. However, the experience multiplies in potency as

clients are not only seen and understood but feel that they are fully accepted by their therapist. For individuals with sex dependency, this experience challenges the devastating realities of the trauma likely experienced during childhood (Carnes, 1988; Schwartz & Southern, 2000).

Once blockages are removed and emotions begin to flow, empowerment and confidence emerge. This emergence has a purifying effect. As mentioned earlier, fear of the unknown can be experienced by both clients and therapists. This fear can have many underlying causes such as emotions, performance, and acceptance. However, therapists must draw on their faith, believing that deep healing will cause holistic change to emerge. Again, a therapist's faith instills hope and trust that unblocked channels of emotions and awareness allow the individual to correct itself. This further engenders trust in clients' abilities to self-regulate, as they slowly individuate from the therapeutic relationship and attain a more authentic and congruent existence. The fear of the unknown is replaced with new feelings of courage, resilience, hope, or openness that contribute to the transformative experience. Individuals suffering with sexual dependencies shift away from their problems and into the expansiveness of their human potential (Fosha, 2010). In this transition, a fresh awareness appears and knowledge increases, as clients redefine themselves by who they are as relational beings rather than simply through their actions (Killen & De Beer, 2010).

Spirituality and Transformation

The spiritual nature of this treatment approach for sexual dependence is inadvertently expressed as a message of compassion, care, and hope. This message tries

to be free of judgement and willing to accept individuals where they are at, while not forgetting that being human carries responsibility. This responsibility is both a reality and a decision in how individuals chose to live their life (Frankl, 1984). A part of this responsibility lies in whether individuals have the courage to push into the potential of their own transformation, which is a part of the adaptive nature of humanity.

Change often only comes with mindfulness of a person's own limitations. In his book, *Becoming Human,* Vanier (1998) stated "only when all of our weaknesses are accepted as part of our humanity can our negative, broken self-images be transformed" (p. 26). Therapists must strive to help clients find a place in which the good, the bad, and the ugly does not have to be exhorted, changed, or covered up but rather can just exist (Chödrön, 1994). It is in this place of being, that individuals encounter their own pain and in this pain, "there is a lot of room for openness" (Chödrön, 1994 p. 37). In achieving this state, individuals will not need to hide or perform, but can simply begin to learn to accept and love themselves for who they are and have become.

Faith communities have to potential to become a supportive part in any individual's transformance journey from sexual dependence. However, it does require a lot of acceptance as often these individuals may not have adhered to sexual standards of a given faith community. Vanier (1998) discussed ideas about faith communities rigidly adhering to their dogma may be endangered of becoming an idealogy rather then a community.

Laaser and Machen (1996) voiced their concern about misinterpreting religious texts in a way that induces "feelings of shame, guilt, and worthlessness among religious

sex addicts" (p. 184). It can be argued that feelings of guilt and shame are a natural consequence for individuals' dependence on sex. However, these unaddressed emotional states are often the force behind sexual dependence (Goodman, 1993; Kwee and Hoover, 2008; Schwartz and Southern, 1999). It is often fear of risking further isolation or rejection that hinders individuals to embrace the possibility of hope and change that comes through therapy. Engaging in the therapeutic process requires courage to believe that change is possible. Change will only become a reality as individuals courageously embrace their reality and step out in faith. In order for this risk-taking to be productive, surrounding communities, especially religious and faith communities, must take the step to love and accept the brokenness of individuals, choosing to support through the healing journey towards healthier sexuality and spirituality.

CHAPTER THIRTEEN: FINDINGS AND CONCLUSIONS

Psychosomatic processing has alleviated suffering and provided significant improvements in functioning for highly traumatized individuals (Bradshaw et al., 2011; Fosha, 2004 & 2006; Lipton & Fosha, 2011). Often, clients with sexual dependency issues have experienced intense childhood traumas and prolific attachment wounding. The experiential nature of these approaches provides a non-intrusive, yet immensely meaningful avenue for clients to integrate deeply-seeded emotional pain. Throughout therapy, individuals are given the opportunity to acknowledge and explore the hurts underlying their impulsive, maladaptive sexual acts. Within the safety of the therapeutic alliance, clients experience an empowering process of acknowledging and overcoming the underlying contributors to their dependency. While therapists practice a stance of openness and acceptance, they remain ethically responsible to protect clients from self-harm and harm of others. Utilizing trauma-informed approaches ensures clients' safety, by therapists assisting them to stay present and regulate their emotions and providing the best possible opportunity for success.

Kopp (1985) stated, “I practice psychotherapy not to rescue others from their craziness, but to preserve what is left of my own sanity: not to cure others, but to heal myself” (p. 12). In essence, this process is steering both therapists and clients out of self-indulgent disenfranchisement and towards community (Doherty, 1995). When working with clients, therapists provide opportunities of healing and growth for both involved parties. For the practitioner, the effectiveness to utilize and facilitate these opportunities stems from one's own ability to navigate through self-awareness and reflection. Clients

may "… profit enormously simply from the experience of being fully seen and fully understood. Hence, it is important for [therapists] to appreciate how [the] patient experiences the past, present, and future" (Yalom, 2009, p. 18).

Therapeutic relationships provide emotionally repairing circumstances that heal attachment wounds. The safety and intervention tools outlined in this paper, in conjunction with the various stage of psychsomatic processing, facilitates attachment repair through therapeutic relationships. It creates space for resolving "unfinished business" and providing clients the opportunities to experience attachment in secure relationships (Carnes, 1991). In these relationships, clients are able to lower their defenses, reduce their anxiety, and begin experiencing unconditional regard. As relational ruptures occur, both therapists and clients work towards mending the dyad by communicating in an open and safe manner. As transformation begins, the client adopts and receives the care exuded by the therapist.

Sexual Transference

The author's view is that sexual dependency is a subject often feared, misunderstood, and subsequently avoided, in therapy. Due to rapidly increasing sexualization in North American culture, therapists will increasingly begin to encounter and be called upon to process sexually related issues with clients (Kottler, 1993). Target (2007) raised an interesting question pertaining to the sexual diversity seen in Western society: "how come in psychological circles the discussion in regards to sexuality has diminished?" (p. 523). Perhaps an exception is the pathology of sexuality. However, the question remains as to why the psychological community is invested in the

psychopathology, rather than the psychology, of sex. Perhaps therapists are more comfortable focusing on sexual dependency as a diagnosable problem rather than the phenomenological experience beneath the individual's dependency.

Counselling associations have strict ethical standards when it comes to the therapeutic relationship between client and counsellor. Throughout therapy, many clients develop sexual feelings for the therapist because of the caring, respectful, and attentive environment presented (Yalom, 2009). In therapy, sexual feelings are a result of intimacy. In essence, it speaks of the therapist's ability to create a safe and caring environment. When dealing with sexual dependency, the likelihood for sexual transference increases. Therefore, therapists' own reflections on sexuality, intimacy, and relationships are an important part for professional and personal development. Therapists must be aware of their own vulnerabilities and constantly monitor their comfort levels while working through these deeper, more fragile issues.

Therapists practising AEDP need to accept the likelihood of sexual transference. For therapists, effective conceptualization and information gathering is vital. Therapists must explore and question clients' sexuality, however uncomfortable or anxiety-provoking the issue may seem to them. Perhaps the associated anxiety with sex explains the tendency to view sexually maladaptive behaviours as a disease of the mind rather than a transformative, holistic healing opportunity. In these circumstances, therapists encountering sexual dependency have two options: 1) Use the presenting anxiety for professional growth or 2) Refer to another therapist.

Personal reflection on one's personal and professional paradigms requires courage. Doherty (1995) affirms this sentiment, sharing that "… it takes courage to be a good therapist. The best have a good supply of it" (p. 139). This statement seems simple but poignant when working with sexual dependency. It takes courage to ask hard questions, show vulnerability, and allow flexibility, especially when clients expect and express a desire for miracles to occur within therapy. Schlauch (1995) proposed that, "suffering exposes...limits and inadequacies while revealing areas of healing... [while] healing involves gaining contact, making connection, and restoring relationship with others and self" (p. 141). Therefore, therapists have one of the greatest gifts to offer to sexually dependents individuals: modelling consistency and courage within the relationship.

Conclusion

In the beginning of the paper, pornography was discussed as a contributor to the sexualisation of society and objectification of individuals. The author's primary concern is not the viewing of pornography but rather its effects on individuals. Using one's sexuality as an adaptive response to disconnect from unwanted emotions, while also facilitating isolating behaviours in that individuals may hide parts from themselves, their partners, and peer groups. Unlike social context appropriate boundaries, these behaviours have become noticeably maladaptive to individuals and/or their peer groups. It is when this cycle of personal suffering is perpetuated without any sign of reprieve that individuals may be willing to seek change in their lives.

The primary intention of this research was to contribute to the discussion of sexual dependency and associated maladaptive behaviours, moving away from a clinical view focusing on symptomology and towards a phenomenological experience of sex dependence as inter-relational. The focus should lie in assisting clients in their struggle with their sexual behaviours. Commonly, these people experience immense shame and rejection from other social situations. Amongst individuals struggling with substance-misuse, sex dependent individuals are stigmatized as “perverts”, even though both groups share common goals of recovery (Rory, Harper, & Anderson, 2009). However, through this discussion, the author hopes that alternative treatment considerations have been provided for sexually dependent clients. This treatment approach assists clients to unlock their human potential, instilling opportunities for transformation unattained before coming to therapy.

The author is of the opinion that considering the effects of both trauma and attachment needs are vital components for successfully treating sex dependency. Research continues to confirm that individuals caught within sexually dependent behaviours have often endured extensive childhood abuse and trauma. Therefore, maladaptive sexual behaviours are more then a choice; they are purposeful coping strategies through which individuals find relief from terrifying, uncomfortable feelings. If treatment only targets behaviour modification, relapse or alternative forms of self-medicating are likely to occur. Treatment plans for sexual dependency need to incorporate its often traumatic roots, acknowledge attachment wounds, and assist clients

in resolving their deeply hidden emotional experiences while strengthening self-functioning.

The purpose for proposing AEDP as a beneficial treatment option for sexual dependence is to stimulate conversation for additional possibilities. Research on neuroscience and psychotherapy has substantiated the positive effect that therapeutic relationships can have on clients. This reaffirms theories originally proposed by Rogers (1951), Bowlby (1973) and Satir (1987) that positive regard in therapeutic relationships activates human healing potential. The treatment of sexual dependence with AEDP acknowledges the power of emotion within a cognitive-behavioural dominated therapeutic field. It advocates for the power of complete transformation, in which clients are seen as more than just their maladaptive behaviours. As painful experiences are processed and integrated new, healing experiences, clients begin to adopt adaptive behaviours. As pain subsides, energy is released. Rather than individuals investing in maintaining their psychic defense, their energies and focus can be redirected towards an exploration of self. This process in itself has a spiritual dynamic to it, as both clients and therapists push into the unknown of the transformative potential, trusting that their connection becomes something bigger than themselves as it morphs into life-changing experiences.

As this is a concept paper, there are no empirical findings and validations specifically in the area of sex dependence. However, potential areas of future research would include the creation of an AEDP-specific treatment plan and measure the relapse rate over specific time periods. The next step would designing a qualitative research

project that would focus on whether an attachment-based therapeutic approach is a viable treatment option for sexual dependency. Other related areas of interest include: a focus on women, homosexual, bisexual, and transgendered clients' experiences with sexual dependence, and how these experiences compare to those of heterosexual men. Furthermore, this deeper comparative look would address whether there are similarities in sexual motivation and attachment style injuries between the various groups.

The areas of study in regards to sexuality and potentially maladaptive behaviours provide several significant opportunities for further exploration. As the discussion continues and additional research advances are made, it is important to maintain the dignity, respect, and acceptance of individuals struggling with sexual dependence. May continuing dialogues pertaining to this issue result in the provision of hope for those seeking freedom from their personal suffering.

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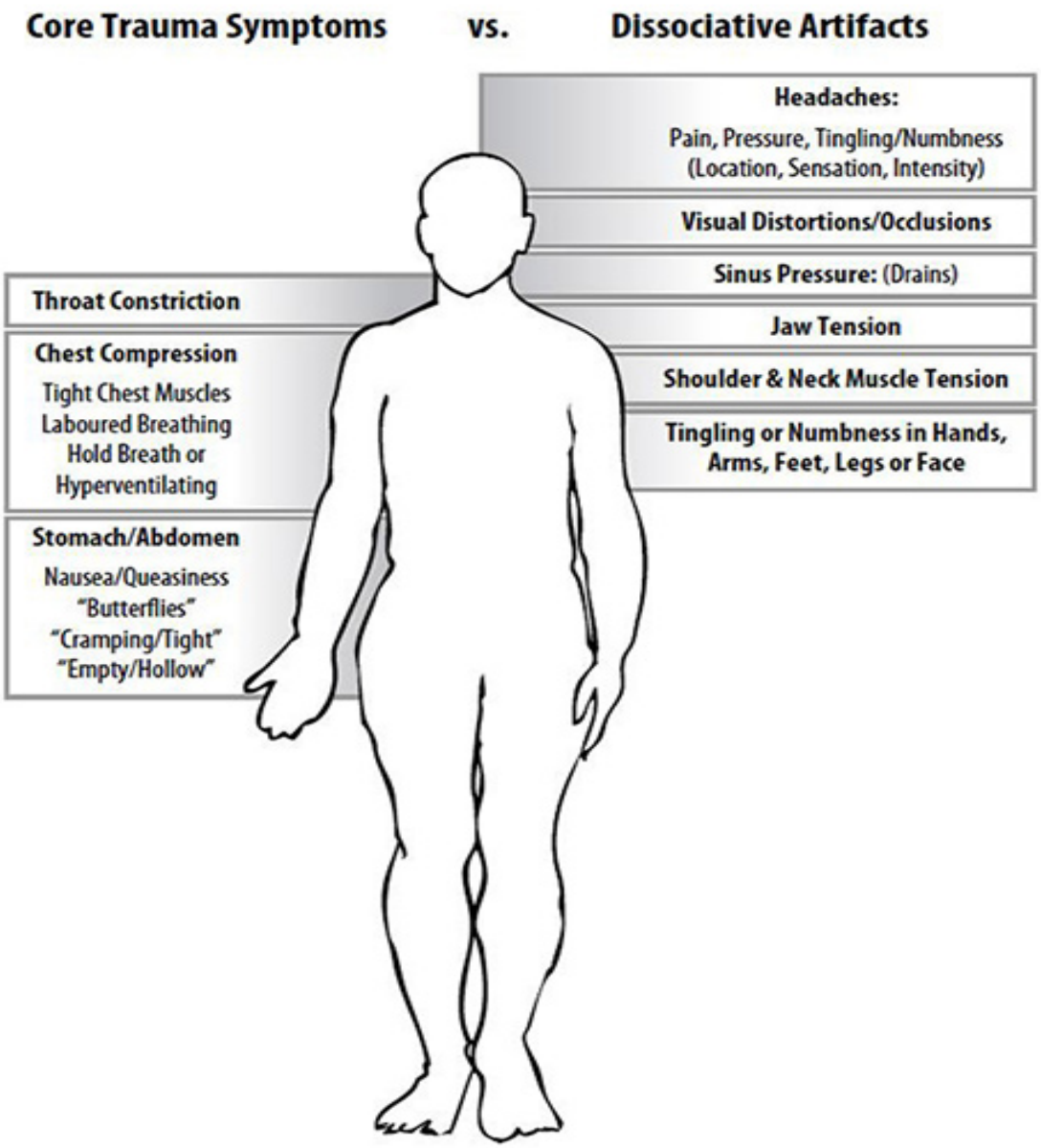
APPENDICES

Appendix A



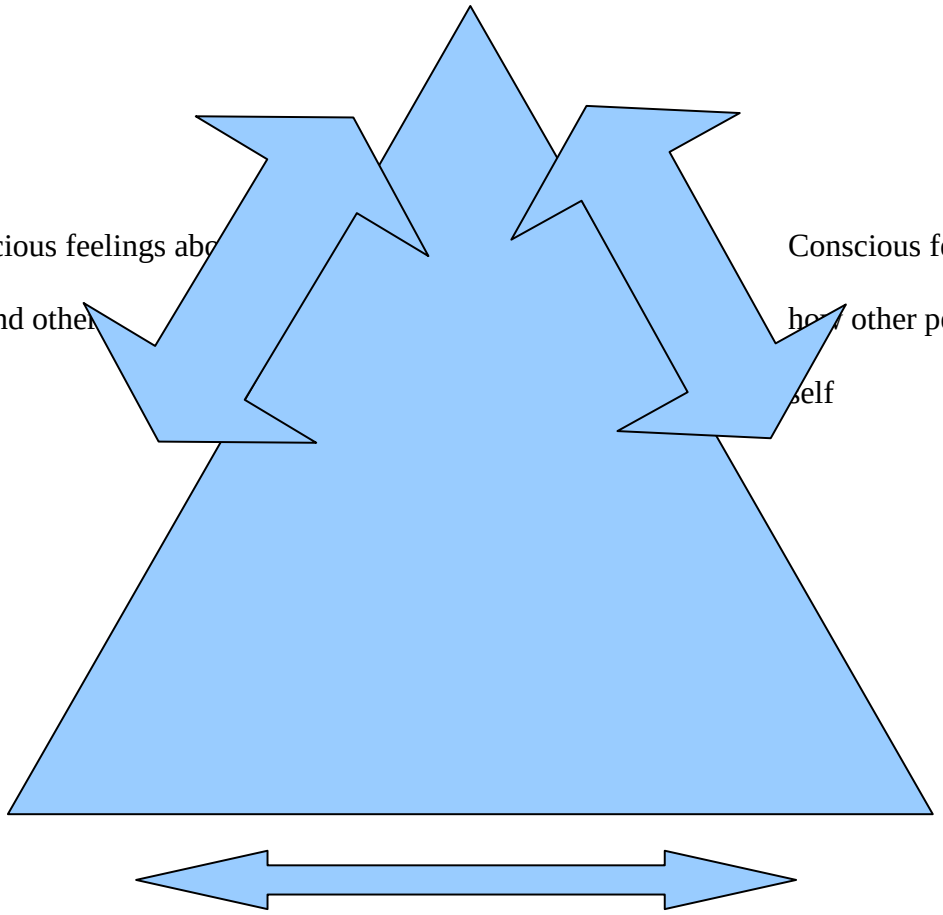
Core Trauma Symptoms vs Dissociative Artifacts

This diagram depicts traumatic and dissociative somatic symptoms. (Bradshaw, & Cook (2008); modified by author)

Appendix B

Diagram of Internal Experience models the influences that perceptions of self and others, in this case the therapist, can have on the client.

EMOTIONS



SELF Interactions OTHERS

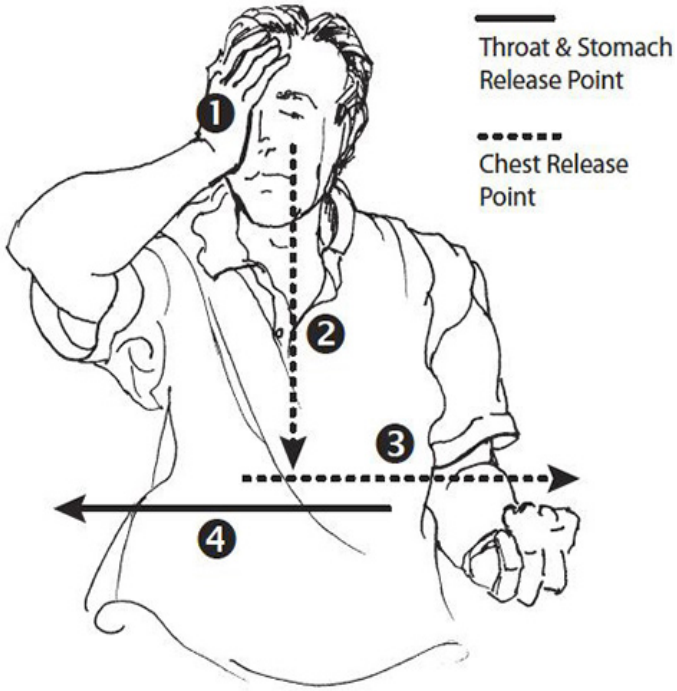
(Feelings influence interactions)

Positive feelings and perceptions facilitate openness
Negative feelings and perceptions facilitate resistance

(Fosha (2010); modified by author)

Appendix C

Tension Release Points



Release Points

This diagram indicates how to use release points when alone. These release points reduce tension within the chest, throat, or stomach that may be experienced by clients throughout therapeutic sessions.

(Bradshaw, & Cook (2008); modified by author)

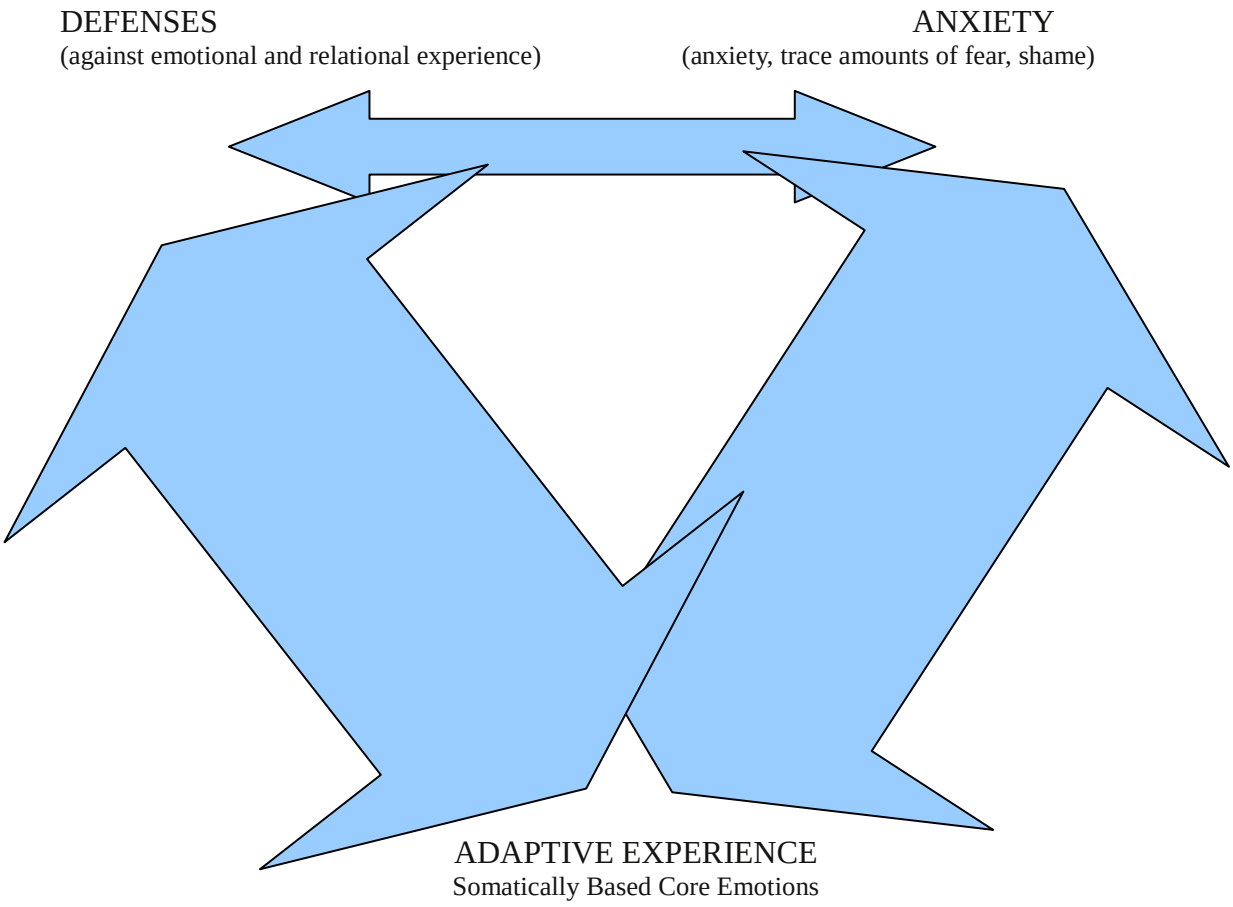
Appendix D

Transference Reaction Record	
Right Eye	Left Eye
1) Proximity: (difference in distance) Near 1 2 3 4 5 Far	1) Proximity: (difference in distance) Near 1 2 3 4 5 Far
2a) Colour: (Changes in colour or shades) Light 1 2 3 4 5 Dark Colour: _____	2a) Colour: (Changes in colour or shades) Light 1 2 3 4 5 Dark Colour: _____
2b) Therapist Appearance: (How client perceives therapist) Emotional state: _____	2b) Therapist Appearance: (How client perceives therapist) Emotional state: _____
3a) Personal emotional State: (How client feels) Emotional state: _____	3a) Personal emotional State: (How client feels) Emotional state: _____
3b) Bodily Sensation: (Look for constriction) Chest: 1 2 3 4 5 Throat: 1 2 3 4 5 Head: 1 2 3 4 5 Jaw: 1 2 3 4 5	3b) Bodily Sensation: (Look for constriction) Chest: 1 2 3 4 5 Throat: 1 2 3 4 5 Head: 1 2 3 4 5 Jaw: 1 2 3 4 5
4) Projected thoughts/feelings about therapist: Perceived thoughts: _____ Intensity: 1 2 3 4 5	4) Projected thoughts/feelings about therapist: Perceived thoughts: _____ Intensity: 1 2 3 4 5

(Bradshaw, & Cook (2008); modified by author)

Appendix E

Triangle of Experience



The two main barriers for individuals to enter with their core emotions are defenses and anxiety. As safety and support is established, these barriers may dissolve and individuals may enter into their core experience with assistance of their therapists.

(Fredrick (2009); modified by author)