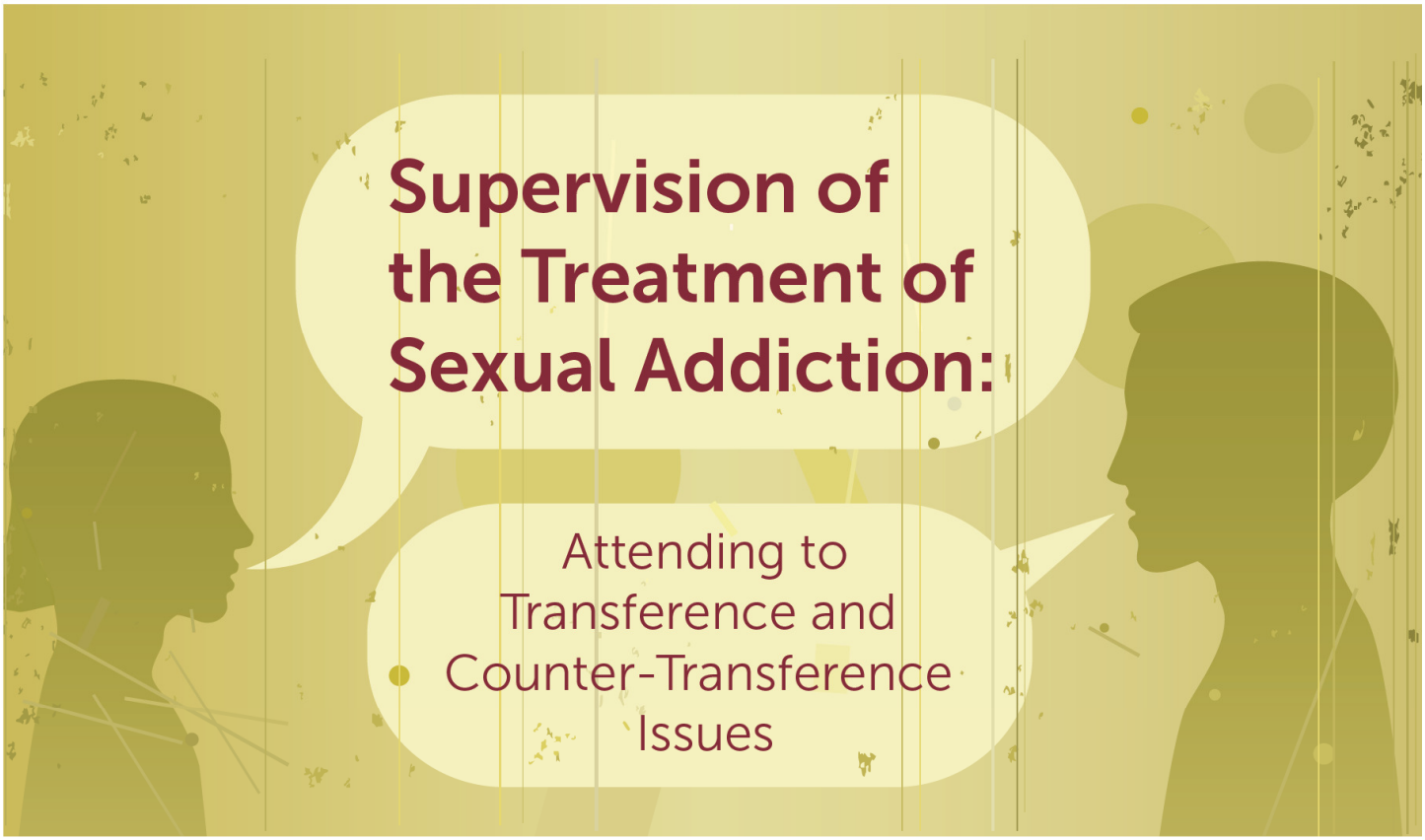

Supervision of the Treatment of Sexual Addiction:

Attending to Transference and Counter-Transference Issues

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A female clinician I supervise stormed into my office, looked me in the eye, and heatedly said, "I hate that patient!" Taken aback by her open show of counter-transference with her male patient, I knew we had a lot of work ahead of us. But I'd come prepared with a model I believed would be helpful.

This scenario warns supervisors of clinicians—especially those new to sex addiction treatment—about the importance of transference and counter-transference issues that might arise between supervisee and patient and even between supervisee and supervisor.

In this field, having explicit conversations between patient and clinician about sexual acting out behaviors is necessary. Yet, these conversations can accelerate the possibility of a patient's transference (and therefore the supervisee's counter-transference) of feelings inappropriately. It is especially vital to look for signs of counter-transference when there's a heterosexual or homosexual gender mix in the therapeutic dyad.

An effective model for supervisors to use when addressing this issue involves a question-answer approach that I adapted from the work of Piercy and Sprenkle (1988). Asked systematically, questions help evaluate how well the supervisee is doing; they may even lead to collaborative patient interventions. Questioning also opens a space for illuminating conversations that address any transference issues between the supervisee and supervisor.

Why Ask Questions?

Asking questions encourages the use of self in therapy. Aponte states that "the primary goal in training on the use of self needs to be the conscious, purposeful, and skillful management of self, as is, in the moment of engagement with the client" (2009, p. 369). In order to facilitate the use of self, the following four fields should be covered when a supervisor asks questions of a supervisee:

1. affective/emotional field
2. cognitive/behavioral field
3. field of insight
4. systemic field

The first set of questions relates to the affective and emotional fields, encouraging the supervisee to think in terms of affect regulation meaning—that is, how the patient uses sexually addictive behaviors to manage moods.

Because sexual addicts often exhibit affect phobia, affect blocking, and so forth, probing into a patient's feeling states is important. So is asking the supervisee to notice her own bodily-based feelings in relation to the patient. Identifying these somatic feeling states can help the supervisee learn to trust her "gut" feelings—and assist the patient in doing the same.

The process of asking how the supervisee perceives the way the patient feels toward her can tell the supervisor if she is caught in counter-transference. And by asking how the patient's reactions are affecting her, the supervisor is able to track the dynamics between the two. These questions can determine if there's an accurate perception of the patient/therapist relationship while setting up an open, honest dialogue between supervisor and supervisee.

Suggested Questions for Supervisors to Ask

As a supervisor, you might ask these suggested questions in each of the four areas:

Affective/emotional field:

- How does the patient express emotion?
- How do you, the supervisee, feel talking about the case with me, the supervisor?
- How does the patient feel toward you?
- How do my reactions affect you?

Cognitive/behavioral field:

- What does the patient say and what is he likely thinking?
- What interventions did you, the supervisee, make with this patient?
- What did the patient do to prompt your choices or reaction?
- Can you describe what just happened between us (supervisee and supervisor)?

Insight:

- What themes are apparent that help you understand this patient?
- Does your reaction to this patient seem familiar to him?
- What approach is best for this patient?
- How is our relationship (supervisee and supervisor) similar to others in your life?

Systemic responses:

- What rules does this patient operate from?
- What rules do you operate from when working with this patient?

- How do these rules guide the therapeutic relationship you have with this patient?
- What rules guide the work we do here as supervisee and supervisor?

Issues Can Take Many Forms

In paying attention to the supervisee's case presentation, the supervisor might consider using a prescribed format to assist in problem solving (Powell, 2004), while listening for any of the supervisee's counter-transference issues. The following forms of counter-transference issues can be part of that format.

Minimization. Upon initial assessment, sex addicts usually minimize their destructive sexual behaviors. Watch for the supervisee siding with this attempt and challenge this. Colluding with minimization can lead to creating a weak, ineffectual treatment plan. It can also have the supervisee doubting whether the patient is really a sex addict.

Anger. "I don't like him" and/or "I want to kill him!" Passive-aggressive and narcissistic personalities are often difficult to like. Supervisees have to be vigilant because unchecked anger can lead to punitive interventions that can have the effect of shaming the patient. Therefore, supervisees need to talk openly about the triggers that block them from being empathic. They should also have a good understanding of narcissistic defenses and examine their reactions in the face of these defenses.

Argumentative/power struggle. Trying to convince, cajole, or demand a patient into recovery leads to power struggles—and a no-win situation. If a patient resists taking direction and doesn't comply with treatment recommendations, the supervisee must reevaluate why the patient is in treatment. Together, the supervisor and supervisee need to assess whether their treatment agenda is ahead of the patient's, or whether the supervisee has fallen out of therapeutic alliance with the patient. If the situation becomes intractable, both parties should reconsider treatment at this time. All possibilities should be discussed between the supervisor and supervisee before taking action.

Disgust. Disgust can arise when assessing pedophiles or any other paraphilia that's disturbing for the supervisee. Supervisees can report feeling "creeped out," uncomfortable, or judgmental. It is recommended processing these feelings in detail so an assessment can be made about continuing to treat the patient. Supervisees who cannot work through the upset are wise to examine their issues in personal therapy sessions. Sex addiction therapists should have the training to work with paraphilias; they should also have the right to choose not to.

Patient admits to sexualizing the therapist. It can be common for sex addicts to sexualize their therapists, coming out in the treatment either directly or indirectly. If it's not stated directly, but the supervisee has an inkling that sexualizing is occurring, it should be discussed with the supervisor when reviewing the case. Sexualizing the clinician in early recovery can occur as a result of either the patient's unconscious processes or conscious manipulation. For the patient, this can be an inappropriate way to try and connect, or a way to devalue the clinician due to feelings of discomfort or anxiety.

Supervisee is sexually attracted to patient. If supervisees find their patients attractive, they can struggle to stay on task or engage in covert seduction with them. If they're not aware of an attraction, they might find themselves relaxing boundaries with assignments or having blind spots in their patients' recovery, harming the therapy process and both parties. That's why it's essential to talk about and deal with sexual attractions early on.

Supervisee is seduced by patient. Early in treatment, the supervisee may report that the patient "is such a nice guy" or "is really trying hard." This could indicate that the supervisee is not recognizing the fear and problematic issues that initially brought the patient into treatment. Sex addicts often develop a false self and can be experts at rationalizing, minimizing, and justifying their behaviors. If the supervisee reports that the patient isn't completing assignments, likely the patient is seducing the therapist to avoid the denial-breaking task work. So the supervisee has to look beyond the patient's facade and confront his denial. This confrontation can bring up issues for the supervisee, which may show why the seduction took place initially.

Idealization as seduction. If the supervisee starts believing "I'm the best therapist ever," beware. It's likely due to idealization by the patient. Supervisees who report feeling special are caught in a trap and lose traction in the treatment process. When this happens, the patient might take control, decide meeting schedules, homework, level of cooperation, and so forth.

Intelligence as seduction. Many sex addicts are intelligent, accomplished professionals—CEOs, doctors, lawyers who are used to being at the top—with qualities that can seduce supervisees into thinking that their patients are on track quickly. However, intellect doesn't measure sexual sobriety, so supervisees have to look closely at their behaviors, emphasizing the patients' real needs first. Supervisees can also be triggered into their own issues of feeling "less than" in the presence of highly powerful people.

Supervisors may need to assist supervisees in identifying personal triggers around intelligence and success.

Humor as seduction. Humor can be a defense against deeper, more painful feelings. If supervisees report having a "jolly good time" with their patients, supervisors should pay attention to how patients might be using humor to divert the treatment and block intimacy and change. Be aware that allowing humor to move to the forefront of therapy can feel like relief to supervisees who have anxiety about their work.

Rescuing or caretaking the patient. Therapists are inherent caregivers who might easily fall prey to the dynamic of "rescuing" their patients. This can arise when a patient is mandated to treatment, or the supervisee wants to advocate for the patient, or the patient prepares for disclosure with a partner. Although supervisees' jobs do include advocating for their patients, their supervisor should watch for any personal investment in outcomes. This could take the form of supervisees wanting to "soften the blow" for their patients when confronting them, or protecting them from a spouse's anger. Problems can arise if supervisees become invested in rescuing their patients and don't understand that facing consequences are part of their patients' unmanageability. Supervisors need to make it clear it's not up to the supervisee to protect patients from the consequences of their actions, but rather to assist them in the change process.

Siding with the patient. Addicts can often villainize their partners and play the victim. If the supervisor hears supervisees siding with their patients by, for example, agreeing that their spouses must be "crazy" or "unfair," that's a red flag. Supervisees must be aware of partner issues and the natural evolution of recovery for a couple. Rather than taking sides, they should confront their patients about their unmanageability and role in creating upset with their partners.

Flight into health. Supervisees should beware of patients who instantly become zealous about their recovery. It can be challenging to confront their denial if they use the 12-step program to "hide out." Supervisors can assist supervisees in looking for the inconsistencies in the patient's recovery by highlighting the differences between what the patient says and does.

Applying this model for detecting transference and counter-transference issues leads to openness between the supervisor and supervisee and an environment that promotes professional growth for both. It's particularly critical to look for these issues early in treatment so that strong boundaries with patients can be set from the start. The result? A more rewarding and productive experience for everyone. ■

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