
Theses, Dissertations, and Projects

2013

Hooked on a feeling : clinician views on the construct of love addition in treatment

Zehara J. Levin
Smith College

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Levin, Zehara J., "Hooked on a feeling : clinician views on the construct of love addition in treatment" (2013). Masters Thesis, Smith College, Northampton, MA.
<https://scholarworks.smith.edu/theses/631>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Zehara Jambalos Levin
Hooked on a Feeling:
Clinician Views on the
Construct of Love Addiction
in Treatment

ABSTRACT

This qualitative study was inspired by the gap between discussions of love addiction in pop culture versus academic literature. The data was derived from 45-minute, open-ended interviews with eight clinicians (six LCSW's and two LMFT's) in the San Francisco, Bay Area. This thesis discusses the preexisting literature, analyzes data from the interviews, and explores differences and similarities between the two. Participants tended to view love addiction patterns as related to early caretaking dynamics and, regardless of the participant's personal views on love addiction, they felt that 12-step-groups, such as Sex and Love Addicts Anonymous (SLAA), are beneficial. Participants also discussed the natural drive for love and the spectrum from healthy to maladaptive which love can manifest. A majority of participants suggested love addiction may be useful as a framework and can be normalizing, but also spoke to the worrisome potential of pathologizing an individual's desire to seek love.

**HOOKED ON A FEELING: CLINICIAN VIEWS ON THE CONSTRUCT OF
LOVE ADDICTION IN TREATMENT**

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

Zehara Jambalos Levin

Smith College School for Social Work
Northampton, Massachusetts, 01063

2012

ACKNOWLEDGEMENTS

I would like to thank my advisor Pearl Soloff for her constant support and feedback throughout the year. Her words and advice bolstered me throughout the sticky, tricky parts.

As always, endless gratitude to my parents and grandparents, without whom I would not be here - literally and beyond.

Thank you to all my friends who had to endure the emotional fallout of my thesis-writing madness, with an extra dash of thanks to Anna for being a steady sounding board, to Roger for helping me keep on truckin', and to Ryan for reminding me of my priorities.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	iii
TABLE OF CONTENTS.....	iv
CHAPTERS	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	5
III METHODOLOGY.....	19
IV FINDINGS.....	25
V DISCUSSION.....	42
REFERENCES.....	52
APPENDICES	
Appendix A: Informed Consent.....	55
Appendix B: Interview Guide.....	58
Appendix C: Recruitment Flier.....	59
Appendix D: HSR Approval Letter.....	60

Introduction

Addicted to Love by Robert Palmer (1986)

You can't sleep, you can't eat
There's no doubt, you're in deep
Your throat is tight, you can't breathe
Another kiss is all you need...
You know you're gonna have to face it, you're addicted to love

Your Love is my Drug by Ke\$ha (2000)

Maybe I need some rehab...
Because your love is my drug
I'm addicted...
The rush is worth the price I pay
I get so high when you're with me
But crash and crave you when you leave

Toxic by Britney Spears (2004)

I need a hit
Baby, give me it...
I'm addicted to you
Don't you know that you're toxic

Just Can't Get Enough by Black Eyed Peas (2011)

Boy I think about it every night, and day
I'm addicted; want to jump inside your love...
I'm addicted, and I just can't get enough
Your love is a dose of ecstasy

Honey by Mariah Carey (1997)

Oh baby I've got a dependency
Always strung out for another taste of your honey...
One hit of your love addicted me
Now I'm strung out on you darling

The metaphor of love as an addiction peppers our collective airways, as exemplified by the lyrics above from songs that have ranked on the US Billboard Hot 100. Love addiction is a nonclinical concept that makes an appearance in various pop culture mediums, from LMFT Robin Norwood's New York Times' #1 Best Seller *Women Who Love Too Much*, to Dr. Phil discussing love addiction on Oprah. There is additionally a worldwide 12-step community for Sex and Love Addicts Anonymous (SLAA) with a website that has been translated into 17 languages.

Despite its presence in common jargon, there is a dearth of academic foundation around the construct of love addiction. There has been limited empirical exploration into the use of this construct in treatment with individuals who feel trapped in their style of romantic patterns, or around the validity of whether or not a style of love can take on a similar presentation of a substance addiction.

A fundamental difficulty in an exploration of love addiction is the ambiguity of the term in it of itself. For the purposes of this study, love addiction will be loosely framed as a romantic style in which an individual feels a compulsive, repetitive, lack of agency in their romantic relationships, alongside the awareness that their romantic pattern is causing significant distress in their daily functioning. The latter part of these criteria is key to the definition, as the former description would not be an uncommon experience of an individual in love; in addition, "significant distress" is the criteria used in DSM classifications of abuse and addiction.

A common theme amongst academic articles on love addiction is the concept of falling in love as a "high", a process that is well depicted in the song lyrics above. Bruehl (2003), Kasl (1990), Mitchell (2000), Sussman (2010), and Timmreck (1990) discuss the

natural euphoria of falling in love and describe love addiction as the process of struggling against moving away from that early stage. The SLAA website describes using this feeling as an “escape” from daily life (SLAA, 2010). Aron et al (2005) investigated this experience using fMRI’s with 17 participants who were “intensely in love” and found that romantic love was associated with the dopamine reward region, which is a neurotransmitter often connected to drugs such as cocaine.

Attachment style has also been explored in relation to love addiction. Self-diagnosis questions from SLAA include criteria that mirrors descriptions of insecure-ambivalent attachment style; for example fear of solitude, pattern of unhealthy relationships, and uneasiness at separation (SLAA, 2011); similar to common descriptions of interpersonal interactions of individuals who have an insecure attachment style, such as being fearful of solitude, overly dependent, and having patterns of enmeshment with intense relationships (Berzoff, 2008, p. 189-196). Empirical studies by Eglacy et al (2009) and Feeney and Noller (1990) explored the possible connections between attachment style and love addiction, with significant support that insecure-attachment style may be connected to love addiction. These studies will be further described in the Literature Review Chapter.

In non-empirical discussions of love addiction, Mitchel (2000) and Keane (2004) describe the romantic patterns theoretically in terms of object relations. Mitchell (2000) suggests that individuals who do not have a safe holding environment in their youth later seek an idealized holding space in their romantic partner; a process that Mitchell views as a fool’s errand, as any human partner will be unable to match the standards of an

idealized object. Keane (2004) echoes these sentiments in a description of process addictions as a manner of internalizing a formerly absent idealized parental figure.

There is a significant amount of space for growth and further research on the topic of love addiction. There is little written on the effects of the matrix of identities on the presentation of love addiction; there could be more collection of information on the importance of how gender identity, age, sexual orientation, country of origin, ethnicity, religion, and socioeconomic status play into the construct of love addiction. In addition, there are no academic research studies or interviews conducted with the individuals who attend SLAA groups; an exploration of members' shared experiences and uses of the groups may help add depth to this topic.

Lastly, there is not a great deal of information from clinicians who do not specialize in love addiction, as the academic articles written on the topic tend to come from clinicians who are already interested in the topic. The purpose of this study is to create a conversation with eight therapists about their views on the advantages and drawbacks of the construct of love addiction in order to begin bridging the gap between popular culture and clinical discussion. As love addiction has some presence in our zeitgeist, it is beneficial to explore clinicians' individual reactions to how this topic relates to their work with individuals reporting maladaptive romantic relational patterns. The following Literature Review chapter will delve into a more in-depth analysis of the pre-existing literature, including empirical studies, theoretical articles, and clinician's personal experiences with their clients.

Literature Review

There is limited academic literature and research on love addiction. Included in this section are literature on process addictions, the neurobiology of love, and common themes arising from these discussions, such as the importance of “falling in love” in the conception of love addiction and the effects it has on daily living. In addition, topics that crossover with the concept of love addiction will be defined, notably: attachment style, codependence, object relations, and sex addiction. These themes will be discussed in terms of their similarities and differences with love addiction; the similarities will be used to suggest areas that could be important in an exploration of love addiction.

Behavioral or Process Addictions

Love addiction fits into the category of process addictions — the idea that a process which produces a short-term reward can create a pattern of persistent, compulsive behavior which continues in spite of the knowledge of its adverse consequences. Other examples of common process addictions include gambling, food, sex, internet, and spending. Process addictions are not classified in the DSM-IV, nor are they universally agreed upon as a true addiction by clinicians. Those who do not believe in the capacity for a process to become addictive describe addiction as a pattern that “must involve the self-administration of an agent to alter the experience of self or the environment” (Martin & Petry, 2005, p. 1). Others in the field view addiction to be related to the diminished control over behavior associated with craving, and thus expand the definition to include processes and behaviors. This perspective views addiction as an issue in the brain's

impulse-control functions. In terms of similarities between addictions, Grant et al (2010) write a lengthy discussion on how process addictions are similar to substance addictions in “natural history, phenomenology, tolerance, comorbidity, overlapping genetic contribution, neurobiological mechanisms, and response to treatment” (p. 233).

The Neurobiology of Love

Those who view maladaptive romantic relational patterns as a potential addiction issue have the opinion that the brain can become reliant on the neurobiologically rewarding aspects of love. Aron et al (2005) used fMRI studies on 17 participants who were “intensely in love” to examine what parts of the brain are romantic-love-activated by having participants alternate between viewing a photograph of their beloved, versus a photograph of a friend. The results supported the Aron et al (2005) hypothesis that intense romantic love “is associated with subcortical reward regions that are dopamine-rich...and the motivation system involving neural systems associated with motivation to acquire a reward” (p. 332). Reynaud et al (2010) write about the neurobiological mechanisms utilized in mediating sexual and loving behaviors; two key contributors, dopamine and oxytocin, are also found to be important in the brain’s process around substance addiction. Martin & Petry (2005) write that both substance and behavioral addiction are based on the brain’s process around learning and memory, stating that, “cravings are triggered by memories, affective states, and situations associated with both the out-of-control behavior and drug use” (p. 3). Thus the suggested process in love addiction is that the brain associates love-relationships or one’s beloved with extreme satisfaction, and thus continues to seek the stimulus, despite signs that the relationship may in reality no longer fulfill those needs.

Themes Arising from the Literature

Sex Love Addiction Anonymous (SLAA) has created descriptions and questionnaires to aid with detecting or diagnosing their concept of love addiction. The information is helpful in constructing a general picture of what love addiction can manifest as, but the descriptions tend to be fairly subjective. Symptoms of love addiction described by SLAA include: becoming emotionally attached relatively quickly, staying in painful relationships to avoid loneliness, believing someone can “fix” you, investing increasingly greater amounts of resources into romantic activities to achieve “emotional or physical relief”, using relationships to “escape” from problems of daily life, feeling “desperation or uneasiness” in the absence of one’s partner, and believing a relationship will “make life bearable” (SLAA, 2011).

In academic articles, there are a number of repetitions of the sentiments listed in SLAA literature. But before that discussion, it is important to note that the majority of the literature is theoretical or derived from the personal experiences of the clinicians and their clients; there is extremely limited empirical research. In addition, there is no investigation of the effects of culture and context on the definitions of love addiction. Further discussion and research on the importance of intersections in identity, such as race, religion, sexual orientation, age, country of origin, gender identity, and socioeconomic status are important to seek a more comprehensive perspective on what theorists believe love addiction is or is not.

In their writings on love and love addiction, Evans (1953), Kasl (1990), Mitchell (2000), Sussman (2010), and Timmreck (1990), all touch on a common theme of the concept of “true love” being a panacea or the feeling that one’s romantic partner can

“complete” them. Sussman (2010) describes this concept as believing that “somehow, romantic relations are magically potent” in their ability to heal an individual’s emotional struggles in other arenas of life. Theodor Reik, one of Freud’s original psychoanalytic students, writes in *Love and Lust* (1957) that “love has all the characteristics of recovery from the unconscious discomfiture under which the ego suffers” (p. 33), delving into a lengthy description of how love can intermittently bolster the ego and create a feeling of connecting with one’s own ego ideal via an idealized partner. In the theme of self-healing, Kasl (1990) discusses love addicts as believing that in their partners they have “found ‘the One’ who will ‘make’ them happy” (p. 53).

Tying into the concept of ideal love is the discussion of the process of “falling in love” and describing it as a “high”. Bruehl (2003), Kasl (1990), Mitchell, (2000), Sussman (2010), and Timmreck (1990), write about the significance of the early stages of love in creating the process of love addiction, positing that individuals may continue to attempt to rekindle the pleasure of “falling in love”. Kasl (1990) notes that in healthy relationships, the “initial high” of love evolves into a more stable baseline, while for a love addict, the “romantic illusion becomes an unrealistic goal” that the love addict is unsuccessfully attempting to reach (p. 63). Timmreck (1990) calls falling in love “an emotional high” that in love addiction can cause an individual to continue seeking to re-experience the “high”, comparing it to “drug addicts without their fix of a drug” (p. 516). Bruehl (2003) also calls falling in love a “high” and writes “we are falling into a stream of naturally occurring amphetamines running through our very own brains” (p. 279). Sussman (2010) similarly notes the neurobiology of the pleasure of falling love, opining, “fixation on early phase relationship neurobiology is definitive of love addiction” (p. 35).

In *Can Love Last*, Mitchell (2002) describes falling in love as “an altered state of consciousness” (pg. 94), that couples must slowly let go of in order to transform into healthier, reality-based relationships.

The academic literature also discusses similar effects on daily living as those described by SLAA. Reynaud et al (2010) notes experiencing “negative mood, anhedonia, and sleep disturbance” when separate from the love object (p. 262). Reynaud et al (2010) also add that a person suffering with love addiction struggles with intrusive uncontrollable thoughts and problematic behavior that leads to clinically significant impairment. Timmreck (1990) writes from his own experience as a clinician, recounts seeing clients experiencing “dysfunctional emotional conditions... and self-defeating behaviors”, noting helplessness, distrust, loss of self-worth, and intrusive thoughts (pp. 515-520). Sussman (2010) writes about love addiction as “cycles of elation and craving” that affect an individual’s regular functioning; describing behavior such as spending increased amount of resources on love or the love object, being unable to stop engaging despite the aspiration to, sleep disturbance, and heartache (p. 34).

Attachment Style

Attachment style describes an individual’s dynamic of relating with others. Attachment theory conceives infant dynamics with their caretaking dyads as the template for their future relational style. The four patterns described by attachment theory are secure, ambivalent/insecure, avoidant, and disorganized. Secure attachment styles start from early, stable relationships with the caregiver; ambivalent attachment start from unsteady relationships with an inconsistent caregiver; avoidant attachment begins with a child whose caregiver is discouraging or provides little response; and disorganized

attachment often occurs when a child is subjected to frightening behavior or abuse from their caregiver (Berzoff, 2008).

SLAA describes love-addicted relationships with similar traits as those typically related with insecure-ambivalent attachment style. Questions from the self-diagnosis section of SLAA include criteria such as whether an individual feels “desperation or uneasiness” at separation with their partner, feels fear at the possibility of solitude, has a pattern of unhealthy relationships, and “feels like nothing” without a romantic relationship in their life (SLAA, 2011). These descriptions mirror relational patterns described by those with insecure-ambivalent attachment styles, for example: being preoccupied with attachment needs, overly dependent, fearful of solitude and abandonment, and having patterns of enmeshment with intense relationships (Berzoff, 2008, p. 190).

Issues of love and attachment in adulthood have been examined together in empirical articles by Eglacy et al (2009) and Feeney and Noller (1990), but there have been limited studies on the concept of love addiction and attachment specifically. The two concepts differ in that attachment is a method of describing an individuals’ method of connecting with others in relation to their experiences with their primary caregiver, while love addiction is specific to romantic relationships and does not necessarily call in issues of childhood. Eglacy et al (2009) conducted a quantitative study on “pathological love”, which Eglacy et al define as “abandoning activities and self-development” in order to provide “care and attention to the partner in a romantic relationship” (p. 268). The study included a sample of 89 self-selecting participants who filled out, amongst other surveys, the Adult Attachment Types (AAT) survey. Eglacy et al (2009) reported a

significant difference in frequency of “pathological love” across the attachment styles; the breakdown of individuals presenting pathological love in each attachment style was 24 percent for secure, 14 percent for avoidant, and 62 percent for anxious ambivalent. Feeney and Noller (1990) in a quantitative study of 374 self-selecting undergraduates found that “love addiction” (which the authors measured using 13 variables relating to “reliance on partner” and “unfulfilled hopes”) broke down between the attachment styles as 13 percent in the secure group, 17 percent in the avoidant group, and 20 percent in the ambivalent group. Ambivalent attachment had the highest correlation with love addiction, but it was not significant at the .01 level used by Feeney and Noller.

Each of these studies includes a similar possible bias in their samples due to how the studies were advertised, or how participants were selected. Eglacy et al (2009), advertised their study as being for people who “felt their form of loving was causing them suffering” (Eglacy et al, 2009, p. 270), and offered group therapy sessions specific to love addiction in exchange for participation. Feeney and Noller (1990) advertised their study to undergraduates, explaining that they were exploring “love addiction” and “love styles”. These studies advertising issues surrounding maladaptive love patterns may create a confounding variable amongst the self-selecting participants, in that participants are already cognizant or thoughtful about problems in their relationship patterns; this leaves out individuals who have significant struggles in their romantic patterns but are not at a stage where they are confronting or aware of these patterns. A possible method of circumventing this issue would be to advertise the study using different terminology, or to not use a self-selecting population subset.

A strength and weakness of both these studies is that they employ a quantitative self-report model. The quantitative approach allows for a more standard measure of the issues explored. A pitfall of the quantitative measure is that it can be restrictive and not allow for themes that arise outside of the numerical questions. In addition, both of the studies rely on self-report, and there is a potential for bias or lack of accuracy. This researcher uses a qualitative method in order to allow more space for all ideas and concepts that may tie into the construct of love addiction. By interviewing clinicians, as opposed to love addicts, the possible risk of bias due to self-report is shifted; ideally clinicians will be able to accurately describe an individual's love addiction and attachment patterns without the bias of self-report; though as always when employing a qualitative interview method, there will be the clinician's individual perspective to factor in, and this may lead to a different type of bias.

Object Relations

In an academic exploration of love addiction, Mitchell (2000) theorizes that a love addict's behavior comes from early attachment traumas in an infant's primary caregiver dyad; this leads to a person's internalization of an absent holding environment, which is then sought to be resolved through future romantic relationships. The process of love addiction is then viewed as a perpetual mission to find a partner who is so idealized that reality is likely to disappoint. In addition, Mitchell (2000) theorizes that an individual does not fall in love with a whole object but is creating an illusion of the ideal holding environment that they lacked as a child.

Also in the realm of object relations Keane (2004) writes broadly about process addictions, specifically choosing to include love addiction, as originating from childhood

neglect and leading to an eventual development of intense attachments with “objects” (in psychodynamic theory, the word “object” means a literal object or a human). Keane (2004) draws a number of parallels between process addictions as methods of self-soothing, escaping loneliness, and boosting self-esteem. This theory then views love addiction as a process similar to any other process addiction, and thus similar methods of treatment can be implemented.

Codependence

The concept of codependency originated from Alcoholics Anonymous; the term was used to describe relationships in which a codependent individual is overly passive and excessively caretaking of the identified alcoholic. Since then, the term has expanded to include any relationship in which an individual is overly devoted and submissive to their partner. Springer et al (1998) describes it as a pattern of behaviors aimed at receiving a partner’s approval in order to gain a feeling of identity and self-worth; this can become a vicious cycle in which the individual’s low self-esteem is reified each time the partner’s approval is not sufficient to provide the codependent individual with the desired affirmation. In *Women, Sex, and Addiction* (1990) Kasl describes codependency as “an addiction” in which a person’s “core identity is undeveloped or unknown” (p. 31), and thus an individual will define his or her self through their external relationships, as well as use their partner as the sole provider of security.

There is fair crossover between codependency and love addiction. Both concepts attempt to describe relational behavioral patterns in which individuals are attached in a manner that is maladaptive to their own individual needs. Both concepts describe compulsive behavior and an individual’s need to describe and heal themselves through a

potentially destructive relationship. In addition, both concepts are used frequently throughout popular culture while not being acknowledged in the DSM-IV.

The literature on the etiology of codependency can be used as a guide for further analytical exploration in a discussion on love addiction. In an anecdotal analysis of ethical issues in love addiction treatment, Griffin-Shelley (2009) discusses self-confidence, family of origin, and comorbidity with other mental health issues; these are all issues also found to be important in the treatment of codependency. In a study of 95 undergraduates enrolled in an introductory psychology course, Lindley et al (1999), low self-confidence scores on the Adjective Check List (ACL) was the strongest predictor of a high score of codependency on both the Spann-Fischer Codependency Scale (SFCS) and the Co-Dependent Anonymous (CoDA) Checklist. The self-report structure is potentially an issue, depending on the participants' abilities to accurately describe themselves on the questionnaires. The non-random, classroom sample may lead to a potential bias as all the participants had been attending the same introductory psychology course together. This researcher's study will attempt to circumnavigate this bias by interviewing clinicians from a variety of agencies, though this study will also employ a non-random approach.

In terms of family of origin, Fuller and Warner (2000), in a study of 257 undergraduate students in an introductory psychology course, found significantly higher scores on the Spann-Fischer codependency scale (SFCS) amongst students who reported "family stressors", which were defined as families with an alcoholic, physically ill or mentally ill parent. Participants with "stressed families" had a mean codependency level of 46.6 percent as compared to participants with "unstressed families", who had a mean

of 43.5 percent; this was significant at a .01 level. As with Lindley et al (1999), this study used a non-random sample from an introductory psychology course, which may lead to a potential bias and limit generalizability. In addition, as this is a study and not an experiment, one cannot assume causation from the correlation.

And lastly, in the vein of comorbidity, Walfish et al (1992) found significant results in their study on 73 women involved in a 1-day codependency residential program. Using the Minnesota Multiphasic Personality Inventory (MMPI), with 50 being the average score of the general population, Walfish et al (1992) found clinically significant elevations in issues such as “odd thinking and social alienation” (74.6), “depressive symptoms” (72.8), and “worry, anxiety, tension” (70.2). A limitation of this study is that women entering a residential program may not have a high generalizability to the overall population, both due to their unique clinical presentations and their gender. This study will attempt to avoid these limitations by interviewing clinicians who work with a broad population representing individuals of all gender identities and clinical presentations.

A key difference between the two issues is that the codependent relationship has ascribed roles, while love addiction is a broader construct. Codependency defines the codependent individual as taking care of their partner and remaining passive about asserting their own needs. The definition of a love-addicted individual, on the other hand, does not necessarily need to be set on taking care of their partner; for example, a love addict could be the person who is being taken care of in the romantic dyad.

In addition, while love addiction has many traits of codependency, there is a difference in the emphasis of each concept. Codependency tends to focus on how an

individual is coping with issues of weak ego and low self-esteem through attaching to another. Love addiction, while it can include individuals described as codependent, is not limited to that description. In love addiction, the focus is more on how an individual views love and romance, and uses the idealized fantasies of love as a coping mechanism.

There is a significant feminist critique of the concept of codependency, as it is a term that has historically been ascribed to women. Goldhor Lerner (1990) notes that because codependency views dependency issues as stemming from a woman's individual struggles, it can depoliticize the pervasive issues that systematically explain why dependency issues might spring up more amongst females. In addition, some feminists suggest that there is a victim-blaming aspect to codependency, as the codependent behaviors could be viewed as a realistic coping mechanism for surviving in an abusive relationship and by labeling the individual as codependent, there could be an air of stigma attached (Collins, 1993). Love addiction differs in that the literature does not typically focus on gender normative or heteronormative romantic dyads.

Sex Addiction

As discussed with codependency, the empirical studies on sex addiction can be used as a starting point in the love addiction exploration due to the amount of potential for crossover between the two. Descriptions of sex addiction read similar to love addiction (and other process addictions), with the word "love" replaced with "sex". For example, Klontz et al's (2005) list of sex addiction symptoms include: a pattern of out-of-control behavior, severe consequences due to sexual behavior, inability to stop behavior despite adverse consequences, sexual obsession and fantasy as primary coping strategy, and inordinate amounts of time spent on sex or thinking of sex (p. 276). A key distinction

between love and sex addiction is that love addiction behavior can occur completely independent of any sexual behavior and vice versa. Reik (1957) describes the difference as two “emotions” that often coincide, but do not necessarily occur in conjunction. More informally, Reik explains “whisky is usually taken with soda, but the mixture of the two does not change whisky into soda nor soda into whisky... a confusion between whisky and soda is unlikely, except of course when you have had too much of them” (pg. 17).

Comorbidity with mental health issues is a concept that arises throughout the literature on sex addiction. Bancroft and Vukadinovic (2004) in a study of 31 self-identified male sex addicts found a significant level of depression and anxiety in relation to sexually compulsive behavior. Amongst the group of self-identified sex addicted, 87 percent reported that their “sexual acting out... was predictably affected by their mood” (p. 228) specifying anxiety and depression as key triggers. Weiss (2004) in a study of 418 self-selecting male participants who receive a free sexual recovery email from sexaddict.com found significantly higher levels of depression in correlation with sexual addiction. Of the 418 participants, 220 scored high enough on the Sexual Addiction Screening Test (SAST) to be defined as sex addicts; of the 220 sex addicts there was a 28 percent prevalence rate of depression, which is significantly higher than the DSM-IV’s estimate of the 12 percent male depression rate in the general population (American Psychiatric Association, 2000).

Similar to love addiction, there is the hypothesis that attachment style may play a role in sex addiction. Zapf et al (2008) in a study of 71 self-selecting male participants from a sexual addiction recovery website, found higher levels of insecure attachment styles amongst the participants who identified as sex addicts. The breakdown of

attachment styles amongst identified sex addicts was 19 percent, 17 percent, and 43 percent respectively for secure, avoidant, and insecure.

Bancroft & Vukadinovic (2004), Weiss (2004), and Zapf (2008) have parallel limitations in their empirical studies. All their participants are male and members of some sort of online sexual addiction recovery community. Both the lack of diversity and lack of control group could create a myriad of missing or confounding aspects in the data. In addition, the studies are primarily based on self-report with limited space for objective variables. Further studies including all genders and pulling from non sex-addict specific forums would be useful in expanding the depth of the data.

In terms of treatment, Klontz et al (2005) assessed the outcome of brief, residential, multimodal group treatment for 38 self-identified sex addicts. The treatment program included experiential, cognitive-behavioral, and mindfulness based treatments focused on reduction of shame and resolution of underlying traumas. In follow up tests, participants showed significant decreases in an analysis of variance (ANOVA) on each of the Garos Sexual Behavior Inventory (GSBI) subscale scores of discordance, sexual stimulation, sexual obsession, and permissiveness. In addition, there were decreases in the Global Severity Index (GSI) scores for anxiety (1.37 to .81 in males, 1.58 to .5 in females), obsessive-compulsion (1.35 to 1.08 in males, 1.68 to .8 in females) and depression (1.57 to 1.0 in males, 1.65 to .45 in females); all statistically significant at a .05 level. The study suggests that a brief, multimodal, experiential treatment approach can significantly decrease distress and discomfort related to sexual addiction. The effectiveness of this type of treatment for sexual addiction may suggest possible

approaches for treatment of love addiction. In terms of limitations, the study is primarily self-report, as well as lacking in any control group or random selection.

Summary

The previous sections discussed the significant themes, theoretical lenses, and concepts relevant to love addiction. Key issues that warrant further exploration are: insecure attachment style, the possibility of comorbidity with other mental health issues such as depression and obsessive-compulsive disorder, how codependency and sex addiction are different or similar to love addiction, the formation of early object relations, and the importance of “falling in love” in the love addiction process. These topics will be used as starting points for the interviews with clinicians. Open-ended questions will take into account important themes found in the literature and explore whether the lenses discussed above are useful in a clinician’s practice. This study will provide information about clinician’s perspectives on love addiction. This will fill gap in the love addiction literature, as there are no existing empirical studies with therapists’ views on the benefits and drawbacks of love addiction. In addition, it may be useful to explore love addiction with clinicians who do not specialize in it- in contrast to previous articles written by therapists who have a prior interest in the topic. The following Methodology section will describe how this researcher went about recruiting clinicians and collecting empirical evidence.

Methodology

Introduction

The purpose of this study is to explore clinician's thoughts on the benefits and disadvantages of using the construct of "love addiction" in treatment with clients who struggle with maladaptive romantic patterns. This exploration was conducted using 45-minute-long, qualitative interviews with a non-random snowball sample of eight clinicians. Due to the dearth of academic literature on love addiction, the study was exploratory and was kept qualitative and open-ended (Appendix B) to allow room for discussions of any pertinent issues related to the pros and cons of using love addiction as a construct in therapy; the theme of the questions was around the participant's views on whether "love addiction" is a beneficial construct in treatment, and how the clinician generally approaches his or her work with clients displaying a pattern that would theoretically fit into the love addiction definition. Interviews were transcribed and interview transcripts were analyzed for important themes and patterns that arise.

Sample

Participants included eight mental health clinicians in the San Francisco Bay Area who are fluent in English, over the age of 18, and who have had at least one year of experience working with adults. Clinicians whose work experience is limited to children were excluded from the study, as their exposure to issues of sex and romantic love is restricted. Participants were limited to the San Francisco, Bay Area due to the proximity to this researcher. The desire was to achieve a diversity reflective of the clinician

population of the Bay Area, but due to the snowball sample style of data collection, this goal was not specifically targeted. The final sample included six female LCSW's, one female LMFT, and one male LMFT. Their clinical fields were: psychiatric inpatient, psychotherapy for female veterans, couples counseling, intensive outpatient program, a love addiction recovery center, and outpatient private practice. Due to HSR comments on the irrelevance of a clinician's demographics to their opinions on love addiction, participants were asked no further demographic questions.

Participants were recruited using a snowball sample. This investigator has professional relationships with several clinicians in the San Francisco Bay Area who were willing to participate in an hour-long interview. These clinicians were asked to email a recruitment flier (Appendix C) and informed consent form (Appendix A) to colleagues whom they believed may be interested in participating in an open-ended interview. The recruitment email contains this interviewer's contact information for any clinician eligible and interested in participating.

Researcher and potential participant then had a brief discussion via phone or email to explore the potential participant's appropriateness for the study. Unfortunately, there was limited ability to achieve diversity because this investigator was glad to interview any clinician gracious enough to donate time and I did not have the resources to deliberately seek out clinicians with varying backgrounds. The issue of lack of diversity and its effects on the data will be explored in the Discussion chapter.

Data Collection

A goal of the data collection process was to protect the participants' confidentiality. Clinicians were first asked to avoid any client identifying information during the

interview. In addition, the clinician's name and place of work was not included in any written document after the interview is transcribed. A pseudonym was used in any write-up or presentation. All informed consent forms have been stored separately from interview tapes and documents; all data has been kept either in encrypted files or in a locked area. All tapes and transcripts will be kept in a locked file for three years and destroyed if no longer being used, according to regulation. If needed still, it will continue to be kept in a locked file and destroyed when it is no longer needed. This researcher performed her own transcription, so there will be no one else who will hear the interviews. The research advisor only had access to typed transcriptions after the identifying information had been removed.

Data was collected by tape-recording 45-minute-long interviews with individual participants; the tapes were later transcribed by this researcher. The time and location of these interviews was decided at the participant's convenience. The only personal demographic question about the participant was related to the type of clinical work they practice. The remainder of the interview was a set of open-ended discussion questions about the construct of love-addiction, as this researcher hopes to provide space for participants to openly discuss any of their thoughts and reactions (Appendix B). Examples of topics to be covered in the open-ended questions include: general thoughts on process addictions, opinion of the construct of love addiction, and ideal treatment goals for clients with maladaptive romantic patterns. Examples of specific questions used: what are your general thoughts on process addictions?; what have you heard about love addiction in the past?; what has been your approach in the past when working with a client entrenched in a maladaptive romantic pattern?

Qualitative methods provide openness and space for exploration, but this can also create a limitation in this study. Clinician's responses cannot be standardized and may be influenced by biases of their own or of this researcher. In addition, time and resource constraint led to a small sample size which calls into question the generalizability of the data to the larger clinical population.

Data Analysis

The first step of data analysis was to transcribe the 45-minute-interview tapes into a two-column Word document, wherein the participant's name was replaced with a pseudonym to protect confidentiality. On the left-side column, this interviewer transcribed the verbatim interviews. After all the interviews had been converted into text, the right-side column was used for short phrases or words that would indicate specific topics arising in the text; the terms in this column, for the purposes of this study, were named *Themes*. For example, in an interview one participant spoke about "that powerful feeling of being in an early relationship and feeling that limitless possibility, which sometimes I think is the more powerful stuff of the love addict piece"; on the right hand column, this was denoted as *falling in love*. Quotes were able to fall into multiple categories, so for example "I don't think a 12 step program would work very well for it because there's too many variations, I don't think the population is homogenous enough" was denoted on the right-hand column as: *12-step groups* and *overgeneralized*.

After all the interviews had been analyzed in this manner, a new Word document was created to group together quotes about various themes. There were over 60 *Themes*, but many of them only had a limited amount of quotes, such as *psychodynamic*, *personality disorder*, or *socioeconomic status*. Some of the more commonly discussed

Themes included: *12-steps, growth before love, euphoria, bad relationship pattern, childhood, normalize, reality, idealization, and daily functioning.* All of the *Themes* were written on individual index cards and splayed out to visually group them into larger connecting patterns, which for these purposes were named *Concepts*. Various groupings of *Themes* were experimented with until the important *Concepts* began to shine through. The primary *Concepts* that the *Themes* fit into were: *definitions of love addiction, descriptions of individuals, experiences of childhood and dynamics with caregivers, descriptions of love, benefits of using the construct of love addiction, drawbacks of using the concept of love addiction, and how to treat.* The quotes from the *Themes* were then grouped together into their larger *Concepts*. The last step of data analysis involved reading over the quotes in each *Concept* and culling out the reoccurring patterns that arose from the interviews. In the following Findings section, this researcher will lay out the primary themes that arose from the interviews: definition of love addiction, clinical presentation of a self-identified love-addict, descriptions of love, benefits of using the construct of love addiction, downsides of using the construct of love addiction, and how the clinician would personally approach treatment with the theoretical individual.

Findings

The purpose of this qualitative study was to explore clinicians' opinions on the construct of love addiction and their views on the benefits and pitfalls of using this framework in treatment. The open-ended interview questions (Appendix B) provided space for participants to discuss their views on love, the individuals who would theoretically fit into the category of love addiction, and what their personal approach to treatment would look like.

The findings section will present the six salient themes that arose from the eight 45-minute interviews: The clinician's definition of love addiction, descriptions of an individual who may be reporting love addiction, descriptions of love, benefits of using the construct of love addiction, downsides of using the construct of love addiction, and how the clinician would personally approach treatment with the theoretical individual.

For the purposes of maintaining confidentiality, all of the names of the participants have been replaced with pseudonyms.

Definitions

Clinicians had varying definitions and opinions on the validity of the construct of love addiction: One clinician (12.5%) firmly believed that love addiction is not a valid construct, two clinicians (25%) firmly believed that it is a valid construct, three clinicians (37.5%) expressed ambivalence on the issue, and two clinicians (25%) said they would be willing to use the construct of love addiction only if the client described his or herself

this way. Regardless of whether or not the clinician believed in the validity of the construct, they were asked to describe what they believed the idea of “love addiction” is meant to entail.

Don, a male LCSW who co-runs a sex and love addiction recovery center, believes the construct of love addiction and has used it before in his treatment framework. Don defines it as:

The inability to form relationships where [the individual] is able to individuate and have intimacy... A person is trying to have a relationship no matter what. It doesn't matter if the person is right for them or not, they'll stay in it.

Ava, a female licensed marriage and family therapist (LMFT) who has a private practice and runs a group for “women who love too much”, endorses the construct of love addiction, and has used the concept in treatment. She describes it as, “if somebody says that they can't survive without their partner, boyfriend... It's whether they can function alone.” She adds that:

Most addictions have something to do with hiding from some part of yourself that you're not wanting to face... People who are addicted to love, addicted to relationships, cannot choose. I think that's very crux for me, is can you choose what you're doing.

Mirah, a female LCSW who practices couples counseling with veterans, had only heard of love addiction vaguely in pop culture. Mirah stated that she does not believe love addiction is valid, and defined it is as:

That powerful feeling of being in an early relationship and feeling that limitless possibility is the powerful stuff of the love addict piece, like substance use. There's a sense of emptiness pushing inside that you grow up with the adoring gaze of being loved or feeling loved or having someone be in love with you.

Miranda, a female LCSW who works on an inpatient psychiatric unit providing crisis intervention and CBT, had heard of love addiction amongst her social circle but not in a clinical setting. She expressed ambivalence about love addiction, and described it as:

Your relationships become the center of your life. It's what you're all about. And this is the part that matches the idea of an addiction. Because with an addiction, you're so focused on that and it affects your functioning. With love addiction, if you can't be alone, or if you're not in a relationship you drink more, or don't leave the house, this is how it has a direct effect on your life.

Sierra, a female LCSW who runs dual and psychotherapy groups in an intensive outpatient program, had heard of love addiction before from clients but had not used it in treatment. She expressed ambivalence and defined love addiction as:

A compulsion to be in a relationship, whether destructive or healthy. Similar to the definition for alcohol abuse versus alcohol dependence; look at the intensity over time. Are there more relationships to fulfill? Is it one relationship that you keep going back to no matter how destructive or painful or how many problems it caused? Does the tolerance increase over time and is the relationship interfering with your daily duties of life and self-care?

Zelda is a female LCSW who provides individual and group therapy for female veterans. Zelda had heard of love addiction only from pop culture; she expressed ambivalence about love addiction and described it as:

Staying in that honeymoon phase beyond the honeymoon, consumed by the relationship and just having that become the person's whole world at the expense of everything else. It's less of a honeymoon and has more of a quality of desperation, kind of seeking the next fix.

Harry, a male LMFT who runs outpatient psychotherapy in his private practice, reported that he would use the construct of love addiction only if the client initially described his or herself in that manner. Harry had heard of love addiction from pop culture and friends; he defined love addiction as:

Someone who finds the experience of being in love, you know that kind of high emotional state of exhilaration and excitement and anticipation that people often

feel when they first fall in love – the early stages of a relationship. Someone finds that emotional state so compelling that they have a hard time tolerating when it begins to fade. And so they seek ways to keep it intense.

Julie, a female LCSW who runs an intensive outpatient program with dual diagnosis and psychotherapy, reported ambivalence about the construct of love addiction and said she would only use it in treatment if the client introduced the issue. Julie has heard of love addiction through clients and described it as:

[The individual] is in a repetitious compulsion where they feel their self-esteem is suffering; they're not able to actualize their own goals because it colors their entire experience. Because there's an early deficit where they didn't get to internalize enough love. I could see someone feeling addicted to needing it because they're so hungry.

Descriptions of the Individual

In this section, participants described actual clients who had spoke of love addiction or discussed theoretical individuals who would fit clinician's definitions of the proposed pattern of love addiction. There were a number of issues that clinicians mentioned, such as maturity (two clinicians, or 25%), attachment (two clinicians, or 25%), sexual orientation (two clinicians, or 25%), comorbidity with other addictions (three clinicians, or 38%), insecurity (two clinicians, or 25%), and fear of loneliness (three clinicians, or 38%), but this section will focus on the two primary topics that all or almost all clinicians touched upon.

Experiences of childhood and dynamics with caregivers.

All eight (100%) of the clinicians said that they believed that an individual's early childhood experiences would be significant in the etiology of a presentation of the love addiction pattern.

A desire to seek what was absent in childhood.

Seven clinicians (88%) referenced individuals seeking in their partner a love that had been absent in the individual's dynamics with their primary caregivers in childhood.

Mirah described individuals as:

Searching for, in our partner, some aspect of what we didn't get from our parents, and that's part of what we fall in love with. And I would imagine if you didn't get it, it's got to be a lot more slippery falling in love because you never really saw it before.

Zelda described her experiences of clients matching her definition of love addiction as, "looking for a love that they never really got... looking for ways of getting that as adulthoods, but going about it in a way that makes things worse for them instead of better". While Don similarly described clients seeking "a corrective emotional experience... what should have happened in childhood". Miranda echoes this with her suggestion that love addiction patterns could arise from "a lack of good parental attachment and early relationships that were unstable". In Sierra's words, the patterns might arise from "early abandonment. An individual seeking comfort or soothing from some external resource; however weird a way that is to talk about another human being. [The individual] is seeking that early initial wound to be fixed or soothed". Julie, similarly, described "an early deficit where [the individual] didn't get to internalize enough love. Someone feeling addicted to needing it because they're so hungry". Ava, discussing specifically her female clients, believes, "it's common for women who grow up in our culture to crave attention from men, because the generation of fathers has been absentee. There's a lack in their upbringing, a lack of male presence, a lack of male affection".

A desire to recreate dynamics that occurred in childhood.

Five clinicians (63%), described clients recreating what had been modeled for them in their youth, or continuing an already entrenched relational pattern. Miranda explained it as “a whole process that normally starts in your childhood and then carries on into your adulthood”. Mirah interpreted it as an issue of “family of origin relationships, that make [an individual] keep looking for people who are going to have the same trouble ultimately that [the individual] found earlier in life”. Zelda feels some of her clients with these patterns have:

A bond toward their partner, although it’s an unhealthy bond, it’s still a bond. And especially with a lot of patients who have had pretty horrible histories of childhood abuse, that unhealthy bond is kind of familiar to them. So even though it doesn’t feel good to them, it’s very familiar and they’re not thinking that they deserve something better or different.

Don hypothesizes that with clients reporting the patterns of love addiction, “[the relationship] feels familiar to a childhood experience of what they saw modeled in relationships, the intensity, the danger, maybe the betrayal”. Don described a specific case example of a client seeking help with love addiction; the client’s mother was a prostitute and as an adult the client was spending thousands on prostitutes, later realizing that “what he was really looking for one of these women to be his mother”.

Gender.

Six participants (75%) mentioned being cis female as a factor that may play a role in the presentation of a love addiction pattern; notably, four (50%) of the clinicians who mentioned gender tied in issues of cultural expectations, a topic that will be covered in the *Descriptions of Love* section. Miranda felt that “in terms of returning to maladaptive relationships, you’re going to find that more in women”. As I discussed earlier, Ava

noted that “it’s very common for women who grow up in our culture to crave attention from men”. Julie added that in treatment with someone matching the description of love addiction, it would be important to think about “women and gender issues around love. How women have been labeled and how men have been rendered invisible if they show love in certain ways”. Don feels that “there is a huge pressure put on young women to be in relationships. Women are told that they need to be in relationships, they need to nurture men and have children”. Mirah visualized someone reporting love addiction, as “somebody who didn’t have her father’s adoring gaze as a small child and constant presence no matter what, maybe has to constantly search for that or maybe hunger for that”. Lastly, Zelda touched upon her female clients and the:

Cinderella fairy tale that women are saved by Prince Charming... a lot of the women I work with so desperately want to believe that someone else can come in and whisk them away from the horrible things they’ve experienced in their life.

Descriptions of Love

In various ways, all clinicians spoke about love — its norms, expectations, and stories. The primary themes that arose from clinicians’ attempts at describing and explaining love were: falling in love, cultural narratives of love, whether what the client is describing is actually love, and love as a natural drive that one cannot abstain from.

Falling in love.

Six of the clinicians (75%) spoke about falling in love and referred to the “euphoria” or “high” of the initial stages of a relationship. Mirah spoke about falling in love as “the romance, the magic. Falling in love is special and neat and wondrous... there’s the beginning rush of falling in love where there’s all of the beautiful things that you imagine are going to happen with this person”. Harry described the “high emotional

state of kind of exhilaration and excitement and anticipation that people often feel when they first fall in love”. Miranda described falling in love as a “euphoria” that “provides that instant gratification, that chemical change. It gives you that something”. Zelda spoke about the “honeymoon” quality of falling love and described clients seeking “the next fix” from their partners. Don spoke to the neurobiological process of falling in love, suggesting, “it’s related to the chemicals that we want to generate in our body, so with the intensity there’s an increase of dopamine in the body”. Lastly, Julie spoke about “the euphoria and high of falling in love”.

Cultural narratives.

Six of the clinicians (75%) noted that larger cultural narratives of love and romance might be a factor in a client’s presentation of the love addiction pattern. Miranda described, “archetypes of idealized love, a love that could never be. And how that’s somehow better than the love that is. It’s very bizarre, it’s almost like our collective unconscious.” Don said, “I often see women who will just read a lot of romantic novels and try to get that feeling of dopamine, of the romance, of the good feeling in the body. And have difficulty being themselves in a relationship”; adding that he felt narratives about love tend to be “more about craving and need and dependencies than about real love”. Ava believes the media narrative of “I need to suffer for my man... It’s really out there in the culture: if I just stand by you, even though you leave, that will prove to you that I really love you”. Mirah believes the cultural narratives are “coming from psychoanalytic thinking that have been popularized in culture” as well as “for example, watching celebrities marry eight times”. Sierra reflected on “the larger culture of love, that it’s this really intense fairy tale thing and is supposed to look a certain way. And

that's supposed to last, that feeling of euphoria, like that's what love is what it's all about". And lastly, Zelda spoke about:

The Cinderella fairy tale story of these women who are saved by their Prince Charming... I think that that definitely affects the relationships and the hoping he'll change because of how love and Hollywood is portrayed. People get the impression that love is always going to be easy or happy and then are surprised when they find out that even healthy relationships take work actually.

Love as a natural drive that one cannot abstain from.

Seven clinicians (88%) in some manner discussed love as a natural drive.

Grouped into this category is also the question of, if using the concept of love addiction in treatment, how do the clinician and client formulate what "abstinence" looks like in light of the natural drive for human relationships. Julie feels that "we have to be really sensitive and careful if you say someone's addicted to love because love is so primary and there's nothing wrong with it. And I think people need it". While Harry suggests that "healthy relationships could be confused with [love addiction] because the instinct to bond is very strong and there'd be a risk of pathologizing that...I wouldn't want to confuse that with something pathological. You can be dependent on the attachment in a healthy way". Zelda believes that patterns around love are "all on a continuum" and noted that some of the worrisome aspects of love addiction pattern, such as "not spending as much time with friends or leaving work early, would in a way seem to be very common and natural". Similarly, Ava noted that, "It's hard with relationships because you need them... it's difficult because we're human beings and we need to have relationships". Don spoke about the difference between approaching a substance versus a love addiction:

Substance addiction it manifests in similar ways. A person needs the drug like a person needs the relationship in order to feel good. A person changes their

biochemistry with something other than oneself. Where it gets confusing is that we don't need substances. We can put it aside, not drink, not use drugs. But with relationships we can't, our nature is to be in relationships.

And lastly, Mirah spoke at length about the value of the human drive for love:

I think we as human beings have a drive for connection, for intimate connection. I think everyone wants that, and needs that, has that natural drive... There's an inherent strength if you're going to keep on swimming upstream or keep on looking for a relationship even after they're not working out. And I think it really speaks to the human drive for connection; they're going to keep on trying, bless their hearts, and I think that's beautiful... It's our most powerful life force to find that and cultivate it and have it in our lives.

Is it love?

Five clinicians (63%) discussed whether the experience of an individual describing love addiction was actually love. On the women who attend her group for "women who love too much", Ava reported, "I don't think it's actually love, I think it's men... But I don't think they know what love is". Don described the love addiction pattern as "a façade of love; it's not real love". Zelda reflected that, "they're almost in love with the emotion rather than the other person. They're not seeing the other person. There's a preoccupation with the other person, with the relationship". Miranda simply stated that with her clients enmeshed in these patterns, "people don't know what love is. That's not love". And Mirah spoke about how:

It's not the true love, which we talk about in attachment. True love is this feeling of this person sees me, sees me when I don't look, sees me when I'm sick, I can fart and they still love me.

Benefits of Using the Construct of Love Addiction

Two major themes arose from the discussion of benefits of using love addiction as a construct in treatment: creating a framework for recovery and normalizing. Clinicians tended to discuss these issues in the context of individuals attending groups, especially 12-

step Sex and Love Addicts Anonymous (SLAA). Notably, there tended to be a fair amount of crossover in the discussions of normalizing and the framework of using addiction for recovery.

Creating a framework for treatment.

Four clinicians (50%) discussed the value of using love addiction as a guide for recovery. Zelda noted that for “[the client] to see it as an addiction, that could be helpful in normalizing and validating and giving me then some sort of framework to work with it”. While Sierra felt the 12-step groups would be “good in terms of accountability and self-reflection and acceptance and challenging denial”. Miranda felt the groups would be useful for:

People to see their problem as not so unique and as part of something bigger and that there’s actually a potential support system for that. Helping people normalize their experience and validate where they’re coming from, and also see how people may have broken out of these patterns and found a healthy relationship.

Harry, in thinking about previous experiences with clients, suggested that:

It's a useful way of conceptualizing it because it means control set programs have been successful for others... There are some people who find the concept of addiction is less pathologizing, and if you think of an addiction as a disease like a cold or flu something you catch, you can now just treat it as such and not kind of look for deeper roots to it. So thinking as the relationship problems as being an addiction may be more acceptable for people. And they may be more willing to enter into treatment around that. If that's what addiction means to someone, they can say "yeah I'm addicted to being in love", so you know it's something you can cure like being addicted to alcohol.

Normalizing.

Five of the participants (63%) discussed the benefits of clients feeling their issues are normalized via the support groups and the framework of addiction. Miranda spoke of the 12-step groups “helping people normalize their experience and validate where they’re

coming from, and also see how people may have broken out of these patterns and found a healthy relationship”. Zelda felt clients might find comfort in knowing:

[They are] not the only one doing behaviors that they are really secretive about. And then being in a place where other people are saying “I’ve done that too” and they’re recognizing it as how bad my addiction gets. Seeing that they’re not the only person and it doesn’t have to be so shameful.

Don in his experiences speaking with members of SLAA groups and his center’s groups for love addiction found that the love addiction framework “is helpful because they get to hear from others who are suffering the same consequences”. Sierra, echoed this sentiment stating that groups would aid in “knowing that there are people in that space who can relate to what you’re going through or at least there are parts of their story that you could see in yourself”. Lastly, Julie noted, “it must be helpful to be with people in a safe place where their feelings and experiences are normalized. That’s incredibly therapeutic”.

Drawbacks of Using Love Addiction in Treatment

The two primary drawbacks that clinicians discussed were the risk of a client feeling pathologized by the term addiction and that it might be an oversimplification of the constellation of issues that a client is struggling with. Clinicians tended to discuss these issues in terms of individual treatment.

Pathologizing.

Five clinicians (63%) discussed the risk of pathologizing the client, or the client feeling uncomfortable with the term addiction. Julie explained she “wouldn’t use the word addiction unless the client is using that word, because it’s loaded”. Mirah, in thinking about the construct of love addiction said, “I think we as human beings have a drive for connection, for intimate connection. So I guess I wouldn’t pathologize it so much”. Harry, in thinking about what relationships would fit or not fit into the criteria of love addiction

noted “healthy relationships could be confused with [love addiction] and I guess that'd be a concern I have, is that the instinct to bond is very strong and there'd be a risk of pathologizing that”. Miranda stated simply that “we overuse the word addiction and I'm not sure how helpful that is”. Lastly, Sierra spoke to the idea that with the framework of love addiction, an individual's pattern of seeking romantic relationships:

Could get pigeonholed into a bad thing. When someone is trying to relate to someone else and they don't know how else to do it. Or they don't know other ways to do it. It could get really boxed in.

Oversimplification.

Four clinicians (50%) spoke to the idea that the construct of love addiction might be an oversimplification that would not leave space to explore the other struggles a client might have. Mirah feels that “I think the love addiction construct could be explained by lots of different things. It's a more complicated issue”. Julie voiced the concern that with any individual showing a pattern of love addiction, “there could be so many different variations... so many variables that would affect how you would intervene”. In that vein, Miranda pointed out that:

The concept is too simple. It's trying to oversimplify something that's pretty complicated... it's limiting the individual's situation because there are people who have pretty nasty childhood backgrounds and need a lot of work around childhood and self-esteem, they don't realize they're capable of having a healthy relationship.

Lastly, Harry felt that:

This concept could very easily be used much more broadly to cover a lot of situations, that I think perhaps there are better ways of thinking than as an addiction. There are a lot of people that have a lot of trouble with relationships and I wouldn't want to clump them all into thinking of that as an addiction.

How to Treat

All clinicians said they would approach treatment with an individual displaying love addiction patterns with an insight-oriented approach and an exploration of the past. Two additional themes that arose from the interviews were the idea of confronting the individual's denial or dissonance and fostering the individual's self-growth and ability to know her or his self.

Increasing awareness, or lessening denial.

Four clinicians (50%) said they would work with the client to reduce denial or increase the client's awareness on possible ways that their relationship pattern may be having negative or undesired effects on their lives. Sierra reported that if working with a client on issues of love addiction, "part of the work would be looking at the danger of the relationship, or the dangers of the pattern. And similar to motivational interviewing, start by having that person look at what they want and what they're doing. Miranda would hope to:

Increase awareness about their behavior and how it affects other people and themselves... Look at what the relationship is doing; the concrete and day-to-day. Just focus on the behavior. And then they can come down and see "this is how I feel" versus "this is what's actually happening". You could also focus in on how they're thinking about their relationship versus what's actually happening in the relationship.

Zelda spoke about how she may consider viewing love addiction from a similar lens as she would substance abuse, and said she would:

Start to gently introduce some patterns that I see. I would approach it in a similar way [to substance abuse] by kind of testing out the waters slowly to see how receptive the person would be to thinking about it, or if they are so defended against it that they just don't want to go there or hear that perspective, or whether they're able to start thinking of the relationship pattern... Start slow and not challenge too much in the beginning so that there's some trust built before starting to challenge and get into the more charged territory.

Don, in the same vein, would begin:

Setting up a non-judgmental atmosphere in terms of being curious about the relationship. Take a real good look at what the behavior is getting them. What are the consequences, what are the secrets they keep? What are they actually feeling? How do they deal with it? Do they feel anger? What is the anger about? Are they ever disappointed? Are they trying to control the person? In other words, gently probing their defenses.

Self-growth, or self-knowledge

Five clinicians (63%) discussed fostering self-growth or self-knowledge with their clients. This tactic could involve either working with a client to hone their skill of getting in touch with their own feelings and security, or creating growth in the client's sense of agency. Don would encourage his client to "build a relationship with oneself and to build secure attachments with others, not insecure attachments... help them learn how to attach and connect with their inner voice and selves". Similarly, Mirah would use sessions "to help people become more related and more ready for a relationship and to seek one out. Or to also respect themselves so that they expect healthy things in relationships". Miranda's hypothesis with her clients who have displayed this pattern was "maybe they're more insecure and they just need a building up of their self-esteem... You have to be good first. If you're trying to fill in a hole, you'll fill it with something unhealthy", thus her approach would be around finding a way for the client to understand what the "hole" is and how to fill it in ways that are ego-syntonic. Zelda's work would be focused around furthering the client's sense of agency in the relationship:

Reminding them that they have choices. And hopefully empowering them to know that they have a choice, that whether they choose to stay or to leave, either one of those are choices and that staying, if that's their choice, that I'm going to support that overall. And seeing the woman who decided to stay, seeing that as a choice can be more helpful and it allows for the thought of that choices can change too so that

right now being is the right choice and they'll stay. But in two years from now you might make a different choice.

Lastly, Ava spoke about how she would encourage her client to:

Make yourself the most important thing, and for some clients, that's groundbreaking... I try to advise them to look at their tendencies and be more patient with themselves. So that they know what they're doing and they know what they're getting into. Similar to [an eating disorder], am I really hungry? Can I stop right now? To be able to choose who they're with and be able to be ok if they're not with that person. To remember that they're still ok, they're still valuable; they're still loveable, even if somebody chooses not to be with them.

This chapter has mapped out the primary themes that arose from the clinicians'

responses. In the following Discussion section, this researcher will delve further into the meaning of each section discussed: definition of love addiction, clinical presentation of a self-identified love-addict, descriptions of love, benefits of using the construct of love addiction, downsides of using the construct of love addiction, and how the clinician would personally approach treatment with the theoretical individual. In addition, this researcher will explore the impact of racism/sexism/heterosexism, her own personal biases, and lastly, future directions for research and practice.

Discussion

Introduction

The objective of this qualitative study was to explore eight clinicians' opinions on the construct of love addiction and its use in treatment. Due to the limited amount of academic foundation around this topic, clinicians were asked open-ended questions and were given a wide amount of space to explore their reactions. This chapter investigates findings that came from these dialogues, with more in-depth discussion of results from the Findings chapter, and links those findings with the themes that arose in the *Literature Review*. In addition, limitations of the study, implications for social work, and directions for future research will be included after the results are discussed.

Definitions

The clinicians gave varying descriptions of love addiction with themes of: inability to withstand intimacy, a pressing need to be in a relationship despite knowledge of its negative consequences, using relationships as the only strategy for coping with life stressors, and a fixation on the early euphoria of love. These themes, along with their range, match the descriptions of love addiction that are described in the *Literature Review*, such as: staying in painful relationships to avoid loneliness and using relationships to “escape” from problems of daily life (SLAA, 2011). The literature and the findings similarly suggest that there is no one singular, definitive method of

characterizing what love addiction theoretically presents as; it appears more as a constellation of issues arising in an individual's romantic relational patterns.

Descriptions of Individual

The literature provides a limited picture of what an individual with love addiction may look like. The majority of the literature is focused directly on attachment style, a topic that was only mentioned directly by two (25%) of the clinicians who were interviewed, though majority of clinicians (88%) references early childhood dynamics.

Experiences of childhood and dynamics with caregivers.

A desire to seek what was absent in childhood.

Seven clinicians (88%) referenced individuals seeking in their partner a love that had been absent in the in their relationship with their primary caregivers in childhood. Though clinicians did not directly reference "object relations", their descriptions of an absent loving caregiver in youth leading to an overidealized expectation of partners in adulthood was in line with Mitchell (2000) and Keane (2004), who both write about the desire to seek an ideal holding environment in a partner and the process by which the partner will be unable to fulfill such unrealistic expectations.

A desire to recreate dynamics that occurred in childhood.

As opposed to seeking an ideal holding environment in a partner, the other childhood issue that clinicians discussed was the potential reenactment of early dynamics. Early patterns of neglect, abandonment, or abuse were mentioned as early templates for future enmeshment in maladaptive romantic relationships. This concept may somewhat go along with the issue of attachment style that has been explored in the literature by Eglacy et al (2009), Feeney and Noller (1990), as attachment style creates an early

framework for an individual's future relationships. The clinicians did not directly reference attachment style, but their exploration of these dynamics may be further extrapolated as a related concept to Eglacy et al (2009) and Feeney and Noller (1990) findings that insecure-attachment style may be related to love addiction patterns.

Gender.

The majority of the participants spoke about gender, specifically being cis female, as an issue that would play into the concept of love addiction. Clinicians spoke about societal expectations and gender-normative trends that may cause women to be more susceptible to fitting into the patterns of love addiction. This was an unexpected result, as the literature had limited discussion of gender as a related factor to love addiction.

Descriptions of Love

Falling in love.

Six clinicians (75%) spoke about the role that “falling in love” and “euphoria” may play in the issue of love addiction; this was in accordance with Aron et al (2005) study on the intense neurobiological reward system associated with being in love, as well as Bruehl (2003), Kasl (1990), Mitchell, (2000), Sussman (2010), and Timmreck (1990) writings about the significance of the early stages of love in the process of developing love addiction. The clinicians spoke about the possibility that an individual may feel compulsively drawn to the “high” that is often associated with a burgeoning romance. Clinicians and the literature suggested the theory that an individual may feel the need to fall in love in a similar manner that some individuals feel the need to ingest a substance.

Cultural narratives.

The topic of cultural narratives arose from the interviews, but was not thoroughly explored in the literature beyond passing references such as, “romance is an altered state of consciousness; in our Disney-created idiom, it turns the monochromatic into technicolor” (Mitchell, p. 94). Interestingly, clinicians referenced different cultural narratives, including: “the impossible love”, “the perfect love”, “suffering for my man”, being saved by a lover, and the general euphoria of love. These various stories of love may sometimes serve as a guiding template for what individuals expect love to look like. Two clinicians also mentioned the concept of love as a healer, a topic discussed in the literature – the idea that love can inspire an individual to seek self-improvement, which Evans (1953), Kasl (1990), Mitchell (2000), Sussman (2010), and Timmreck (1990) touched upon in their literature. As Reik (1957) puts it, “love has all the characteristics of recovery from the unconscious discomfiture under which the ego suffers” (p. 33).

Love as a natural drive that one cannot abstain from.

The concept of love as a natural drive arose in clinicians’ doubts around the validity of love addiction. Seven clinicians (88%) spoke about the basic human drive to seek love as a counterargument to the concept – if we are naturally inclined to seek love, then it is problematic to pathologize it and how can one expect to abstain from an instinct? As this is an argument against the validity of love addiction, it was not a topic touched upon in the literature supporting love addiction. SLAA does little to navigate this paradox and defines sobriety as a “willingness to stop acting out in our own personal bottom-line addictive behavior on a daily basis” and “a desire to stop living out a pattern

of love addiction" (SLAA, 2012); a description that leaves the concept of abstinence and recovery ambiguous.

Is it love?

Five clinicians (63%) voiced their opinions that the patterns being described in love addiction are not love. Four clinicians (50%) spoke about gently probing the denial around the negative consequences of the love addiction pattern without explicitly confronting with the client the veracity of their experience of love. In *Love's Executioner*, Yalom (2000) muses over the puzzle of love and psychotherapy while working with a woman trapped in a painful obsession over a previous lover:

I do not like to work with patients who are in love... Perhaps it is because love and psychotherapy are fundamentally incompatible. The good therapist fights darkness and seeks illumination, while romantic love is sustained by mystery and crumbles upon inspection. I hate to be love's executioner (p. 17).

Yalom well captures the dilemma discussed by the clinicians interviewed; there is a struggle between the therapist's desire for truth and the fantasy that often tends to be a part of both healthy and maladaptive love, and the therapist's job is to find a proper balance negotiating the two.

Benefits of Using the Construct of Love Addiction

Creating a framework for treatment.

Half of the clinicians spoke theoretically about the concept of love addiction being valuable as a method of creating a template of recovery for clients. They spoke about how their clients in the past have found strength in embracing 12-step approaches and viewing addiction as an illness. There is no literature on the efficacy of 12-step approach when working with love addiction or how the addiction model can be beneficial

for self-identified love addicts, directions for future research will be discussed in final section of the Discussion chapter.

Normalizing.

Five (63%) of the clinicians spoke about the importance of normalizing in treatment, especially in the context of reducing shame and loneliness. The concept of love addiction provides a larger community to identify with for those who may feel isolated in their patterns of romantic style. In this case, it is not the actual concept of love addiction that is beneficial, but rather the larger context in which an individual feels placed. Due to the limited literature on love addiction, there are no studies that support or go in contrast to this concept.

Drawbacks of Using Love Addiction in Treatment.

The drawbacks discussed by clinicians speak to the importance of treatment specificity; there are patterns that are oft encountered in treatment but it is important to approach each client in a fashion that is unique to their personality. For example, while alcohol abuse is a fairly universally accepted concept, the individuals who fit the DSM-IV criteria experience a range of reactions to the concept: Some individuals embrace the identity of an alcoholic and find solace in Alcoholics Anonymous meetings, while others express resistance to the term and choose to approach their recovery on other roads.

Pathologizing.

Five participants (63%) spoke about the concern of individuals feeling pathologized by the term “addiction” or pathologizing the natural instinct to love by giving it a diagnosis. If an individual is concerned that they are being judged, it might lessen their ability to genuinely engage in treatment. In addition, the concern of

pathologizing a natural instinct ties back to the section on *Love as a natural drive that one cannot abstain from*; if love is to be viewed as a potential addiction, where is the line on the continuum from healthy love to maladaptive? The concern about an individual feeling judged by the term “love addiction” is in contrast to the potential benefit of individuals finding comfort in a framework and a larger community.

Oversimplification.

Half of the clinicians spoke about the drawback of oversimplifying an individual’s life. As majority of the clinicians felt that love addiction arises from earlier life experiences – as opposed to being born in the vacuum of their neurochemistry – participants suggested that by only targeting love addiction in treatment, the therapy may neglect an array of other issues that the individual is struggling with.

How to Treat

Like the previous sections on *Benefits and Drawbacks of Using Love addiction in Treatment*, there is no solid academic literature on the treatment of love addiction, so the findings will be discussed independently. Additionally, the topics discussed by clinicians tended to be larger goals that they would have for almost any client in therapy; further directions for research will be discussed in final section.

Increasing awareness, or lessening denial.

Half of the clinicians spoke about gently probing the individual’s denial around the negative consequences of their relationship pattern. Clinicians felt this tactic was not specific to love addiction and employ this method commonly in therapy.

Self-growth, or self-knowledge

Similar to the strategy of increasing awareness, clinicians felt that encouraging self-growth in clients is a fairly common practice that would not be specific to love addiction.

Limitations of Study

The primary limitation of this study is the small, non-random sample size, as the eight clinicians were chosen via snowball sample from this researcher's colleagues. This method of recruiting did not provide for an ability to achieve diversity and there may be hidden variables amongst this researcher's colleagues that could create bias in the findings. In addition, such a small sample does not provide for a high degree of confidence as to the universality of the findings. Future studies with more resources could attempt a stratified random sample model and integrate clinician's demographic information.

Another limitation of this study was that many clinicians had not spent time thinking about love addiction before the interview; their 45-minute conversation with this researcher was the longest they had ever spent thinking about the topic. For future studies, participants could be given examples of the questions covered so they could have more time to think over their responses and tie in past clinical experiences.

Lastly, the inherent ambiguity of love addiction may have caused a lack of reliability throughout the interviews. There are a number of ways that love addiction patterns can look and when clinicians shared their thoughts, they may have each been envisioning a different type of client. Future research could address this problem by focusing on one specific presentation of love addiction, or including a case vignette.

Biases of the Study

Due to inherent structural racism, classism, sexism, and heterosexism in who receives mental health treatment, there is a potential risk of bias in the data. Therapists were asked to speak about their clinical experiences and there is a possibility that their clientele does not reflect the diversity of the general population. In not asking clinicians about the diversity of their clientele, this researcher may have done a disservice to individuals who have limited access to mental health support. Future studies would benefit from including questions about the demographics of the clients being discussed as a form of acknowledging how intersectionality can play into the topic of love addiction.

In addition, there is potential risk of this researchers' own biases. The simple act of choosing to study love addiction suggests that this researcher may find value in exploring the topic further, though my opinion on the validity of the construct tended to shift drastically throughout the year. Participants in the study provided insightful and interesting feedback about the positives and negatives of using this construct, and I often felt my opinion shifting when hearing the thoughts of seasoned clinicians. My primary opinion at the end of this study is that SLAA 12-step-groups have a great potential for helping, regardless of whether the construct itself is valid. Continued studies on the neurobiology of attachment and love may help to illuminate the validity of whether individuals have the capacity to feel "addicted" to a natural drive.

Directions for Future Research

As suggested earlier, future research could be invested in the role that gender and cultural narratives play in the love addiction pattern, as these were topics brought up by numerous clinicians. This question could explore the top-down process in which

individuals form their conceptions of love and build the framework for romantic expectations, in that therapy often delves into how an individual's personal experiences shape their current situations, but an exploration of larger societal structures and narratives around love could add light to the norms which people may feel pressure to conform to.

Further studies would benefit from interviewing the individuals who self-identify as love addicts by contacting SLAA groups. Much of the literature that exists about love addiction arises from the perspective of the clinician, which lends to a more theoretical analysis. Research with love addicts could cull together a concrete base of knowledge about how people experience love addiction, what is beneficial about the 12-step groups, how it relates to issues of childhood, how love addicts conceptualize abstaining from love addictive patterns, and what they would find helpful in individual treatment.

Future Directions for Practice

Findings on treatment with individuals reporting a love addiction pattern tended to be vague, as majority of clinicians described a treatment planning approach that would mirror their general practice. A majority of the clinicians agreed the Sex and Love Addicts Anonymous (SLAA) 12-steps group would be beneficial. For future practice, it may be of use for clinicians to be informed about SLAA as they are about Alcoholics Anonymous (AA), Codependents Anonymous (CodA), National Alliance on Mental Illness (NAMI) and other popular support groups. Clients may benefit from their therapists being able to provide pamphlets and light psychoeducation.

Participants tended to agree that while love is a basic human need from which there is no abstinence, there are also patterns of loving and conceptualizing love that can

become maladaptive for a client. For future practice, clinicians may benefit from continuing their intellectual exploration of the continuum of love presentations and pinpointing where the blurry line is after which a healthy pattern of love can become a painful process which a client may need support creating shifts.

References

- Aron, A., Fisher, H., Mashek, D., Strong, G., Haifang, L., & Brown, L. (2005). Reward, Motivation, and Emotions Systems Associated with Early-Stage Intense Romantic Love. *Journal of Neurophysiology*, *10*, 327-337.
- Bancroft, J. & Vukadinovic, Z. (2004). Sexual Addiction, Sexual Compulsivity, Sexual Impulsivity, or What? Toward a Theoretical Model. *The Journal of Sex Research*, *41*(3), 224-234.
- Berzoff, J., Melano Flanagan, L., & Hertz, P. (2008). *Inside out and outside in: Psychodynamic clinical theory, practice and psychopathology, in multicultural contexts*. Northvale, NJ: Jason Aronson, Inc.
- Bruehl, E. (2003). Where Do We Fall When We Fall in Love? *Journal for the Psychoanalysis of Culture and Society*, *8*(2), 279-288.
- Castro V, Fong T, Rosenthal RJ, & Tavares H. A comparison of craving and emotional states between pathological gamblers and alcoholics. *Addict Behav* 2007; *32*:1555–1564.
- Eglacy, C., Tavares, H., Marina, B., Pereria, A., Lorena, A., Mello, C., Gorenstein, C., & Zilberman, M. (2009). Pathological Love: Impulsivity, Personality, and Romantic Relationship. *CNS Spectr*, *14*, 268-275.
- Feeney, J., & Noller, P. (1990). Attachment Style as a Predictor of Adult Romantic Relationships. *Journal of Personality and Social Psychology*, *58*(2), 281-291.
- Grant, J., Potenza, M., Weinstein, A., & Gorelick, D. (2010). Introduction to Behavioral Addictions. *The American Journal of Drug and Alcohol Abuse*, *36*, 233-241.
- Kasl, C. S. (1990). *Women, Sex, and Addiction*. Location: William Morrow Paperbacks

- Keane, H. (2004). Disorders of Desire: Addiction and Problems of Intimacy. *Journal of Medical Humanities*, 25(3), 189-203.
- Fuller & Warner (2000). Family Stressors as Predictors of Codependency. *Genetic, Social, and General Psychology Monographs*, 1, 5-22.
- Goldhor Lerner, Harriet (1990). Problems for Profit? *Women's Review of Books*, 15-16.
- Klontz, B., Garos, S., & Klontz., P. (2005). The Effectiveness of Brief Multimodal Experiential Therapy in the Treatment of Sexual Addiction. *Sexual Addiction & Compulsivity*, 12, 275-294.
- Lindley, N., Giordano, P., & Hammer, E. (1999). Codependency: Predictors and psychometric issues. *Journal of Clinical Psychology*, 55(1), 59-64.
- Martin, P. & Petry, N. (2005). Are Non-substance-related Addictions Really Addictions? *The American Journal on Addictions*, 14, 1-7.
- Mitchell, L. (2000). Attachment to the Missing Object: Infidelity and Obsessive Love. *Journal of Applied Psychoanalytic Studies*, 2, 383-394.
- Mitchell, S. A. (2002). *Can Love Last: The fate of romance over time*. Location: W. Norton & Company
- Reik, T. (1957). *Of Love and Lust: On the psychonalaysis of romantic and sexual Emotions*. New York: Farrar Straus.
- Reynaud, M., Karila, L., Blecha, L., & Benyamina, A. (2010). Is Love Passion an Addictive Disorder? *The American Journal of Drug and Alcohol Abuse*, 36, 261-267
- Springer, C., Britt, T., & Schlenker, B. (1998). Codependency: Clarifying the construct. *Journal of Mental Health Counseling*, 20(2), 141-158.

Sex and Love Addicts Anonymous (June, 2011). 40 Questions for Self Diagnosis.

Retrieved from: <http://www.slaafws.org/>

Sussman, S. (2010). Love Addiction: Definition, Etiology, Treatment. *Sexual Addiction & Compulsivity, 17*, 31-45.

Timmreck, T. C. (1990). Overcoming the loss of love: Preventing love addiction and promoting positive emotional health. *Psychological Reports, 66*, 515–528.

Walfish, S., Stenmark, D., Shealy, S., & Krone, A. (1992). MMPI Profiles of Women in Codependency Treatment. *Journal of Personality Assessment, 58*(1), 211-214.

Yalom, Irvin D. (1989). *Love's Executioner*. Harper Collins: New York.

Zapf, J., Greiner, J., & Carroll, J. (2008). Attachment Styles and Male Sex Addiction. *Sexual Addiction & Compulsivity, 15*, 158-175

Appendix A: Informed Consent

Dear Participant,

My name is Zehara Levin, I'm in a master's program for social work with Smith College. I am conducting a study on Bay Area clinician's thoughts and opinions on the construct of "love addiction". I am hoping by interviewing clinicians in the Bay Area, I will be able to explore the value of using the construct of "love addiction" when working with individuals who are dealing with issues of maladaptive romantic relational patterns. This data will be used for my MSW thesis that will be read by my research advisor and available to other students at Smith College School for Social Work. In addition, I will present my thesis to my peers at Smith College during the summer of 2012.

If you are a clinician (social worker, marriage and family therapist, psychologist, mental health counselor, or psychiatrist) with at least one year of experience working with adults, then you qualify for this study. If you choose to participate, you will be asked to donate an hour of your time. We will meet in a location of your choosing and I will ask you questions about "love addiction", in the realm of what your beliefs are on the topic and how you work with clients around issues of romantic relational cycles. I will bring a tape-recorder to our interview and do the transcription personally. I will keep all tapes and transcriptions in a secure area, so there will be no risk of anyone other than me hearing the interview. I would like to assure you that confidentiality can be reasonably provided in this research. Your name and identifying information will not be included in any of the written analysis or presentations on this study.

There are limited risks to participation beyond the generous donation of your time without compensation. If you are concerned about the risk of HIPAA violations, I would

like to assure you that I will not be asking about any client identifying information and I will take extra care to remove any identifying information out of the transcriptions. The only other person with access to the transcripts will be my research advisor. In terms of benefits, I am hoping you may find it interesting to discuss and share your personal beliefs around working with issues of romantic relational patterns.

To reiterate, your identifying information will be kept completely confidential and I am eager to exclude any information that you worry would reveal your identity. I will store transcripts and tapes in encrypted files and sealed containers until they are no longer needed and then I will destroy them. According to human subject review's rules, the longest I am allowed to keep these materials would be three years and then I am required to dispose of them.

Participation in this study is completely voluntary and you are free to withdraw from the study at any point before March 31st, 2012, after which point the data analysis will begin. In addition, I hope you feel comfortable refusing to answer any questions for any reason. If you have any concerns about your rights or about any respect of the study, you are encouraged to call me, or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO

Signature of Participant: _____

Signature of Researcher: _____

Date: _____

If you wish to contact me, please email **(personal information deleted by Laura H. Wyman, 11/30/12)**. If you would prefer to speak on the phone, include your phone number and we can arrange a convenient time. I will provide a copy of this signed form for you to keep for your records.

Thank you very much for your participation!

Best,

Zehara Levin

|

Appendix B: Interview Questions

- What is your general view of process addictions?
- What have you heard of love addiction in the past?
- What is your definition of love addiction?
- What do you think are the factors that play into the development of love addiction?
- What are larger cultural factors that may effect love addiction?
- How would you work with an individual with this pattern?
- What are potential benefits of using this construct?
- What are potential drawbacks?

Appendix C: Recruitment Flier

“Love addiction” is the idea that maladaptive romantic relational patterns can fit under the criteria of a process addiction. The construct of love addiction has received a fair amount of attention in popular culture, yet there exists a dearth of academic literature on the topic. I am interested in exploring therapists’ opinions on the benefits and pitfalls of using “love addiction” in their clinical work with individuals caught in maladaptive romantic cycles or relationships.

If you are interested in donating one hour of your time to be interviewed on your opinions about the value of using “love addiction” in clinical work, and you are a therapist (MSW, MFT, Psy.D, or PhD in psychiatry) with at least one year of experience working with adults, you qualify for my study. I will be using this interview as data for my MSW thesis for the Smith School of Social Work.

To participate in my study, please contact me at **(personal information deleted by Laura H. Wyman, 11/30/12)**.

Appendix D: HSR Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950

March 13, 2012

Dear Zehara,

That was fast and well done! Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Best of luck on your project!

Sincerely,

A handwritten signature in black ink that reads "David L. Burton". The signature is written in a cursive style with a long horizontal line extending to the right from the end of the name.

David L. Burton, M.S.W., Ph.D.

Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor

