

SEXUAL ADDICTION AND MFT:
THERAPISTS' PERSPECTIVES ON FACILITATING INDIVIDUAL AND
RELATIONSHIP HEALING

by

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Abstract

In recent decades there has been an increase in literature regarding sexual addiction as well as a growing number of clients presenting in therapy with problems related to their sexual behaviors (including internet sexual addiction). More recently, the impact of sexual addiction on couples has been noted, but little is known regarding how couples can be assisted in the recovery process. In this qualitative study, I explored in depth the critical change processes in couple therapy for sexual addiction from the therapist's perspective, including the therapist's role in that process. The findings suggest that couple recovery from sexual addiction includes (a) individual responsibility in recovery (which includes themes of trauma, family-of-origin, emotional reactivity, depersonalizing, and utilizing other resources), (b) couple recovery (which includes the themes of family-of-origin, communication, empathy, intimacy, trust, and sexual intimacy), (c) balancing individual recovery with couple recovery in the process of healing (which includes the themes of education, accountability, and couple perspective) and (d) distinguishing affairs from sexual addiction. I discuss the implications of study findings, offering a sequential outline of the process of therapy with couples who are struggling to recover from sexual addiction, including therapist interventions that may assist in that process. Limitations to the study and implications for future research in sexual addiction generally and MFT specifically are presented.

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CHAPTER I

Introduction

The publication of the book *Out of the shadows: Understanding sexual addiction* (Carnes, 1992) marked a significant increase in the popularity of the term now called sexual addiction as well as the theoretical and empirical literature surrounding the concept of sexual addiction. The explosion of the internet (with ease of access to all types of information) has provided a new arena for potential sexual addiction because it offers increased access to online sex, pornography, sexual chat rooms, and various other sexual avenues (see Griffiths, 2001 for a more complete list of internet sexual behaviors). Cooper (1998) also points out that the internet offers easy access (24 hours a day, seven days a week), affordability (low-priced or free), and anonymity (people perceive that their communications are unknown, contributing to reduced sexual inhibition). Young, Griffin-Shelley, Cooper, O'Mara, and Buchanan (2000) suggests that the ease of access, low cost, and anonymity provided by the internet may open the door to sexual addiction for individuals who previously did not express vulnerability to sexual addiction or push mild addicts toward more severe addiction. It is estimated that there are between one-half and two million sexual addicts (Delmonico & Carnes, 1999).

Despite the increased awareness of sexual addiction, as well as the increase in avenues by which many can become sexually addicted, many therapists still experience discomfort towards or lack knowledge about sexual addiction. This may cause therapists to miss many important cues and/or completely fail to address sexual addiction in therapy. Because many couples experience intense emotional reactivity, particularly during early stages of recovery, some therapists who are knowledgeable about sexual

addiction prefer to offer treatment for sexual addiction without the spouse. However, many of the conceptual and etiological explanations (see below) suggest that couple therapy might be as effective or more effective than group or individual therapy for facilitating recovery from sexual addiction (for individuals and couples). In this chapter I review the early conceptual evolution of sexual addiction (the struggle for definition) as well as the proposed causes (etiology) of sexual addiction.

Early Conceptual Evolution: Struggling for Definition

Much of the early clinical literature about sexual addiction focuses on whether or not the label of sexual addiction is appropriate. In contrast to those authors who believe that a person can become a sexual addict, some authors argue that it is better termed an obsessive-compulsive disorder (Fischer, 1995; Quadland, 1985; Weissberg & Levay, 1986) or an impulse-control disorder (Barth & Kinder, 1987; Coleman, 1991, 1992; Quadland & Shattls, 1987). Levine and Troiden (1988) argue that the label of sexual addiction or compulsion is not appropriate. Goodman (2001) and Gold and Heffner (1998) offer in-depth synopses of the sides of each argument.

Since its origin, the concept of sexual addiction has received much criticism. Although several authors have expressed concerns about the use of the term sexual addiction (see Goodman, 2001), only a few of the most cogent concerns are mentioned here, along with the improvements in the conceptualization of sexual addiction that have occurred as a result. One major criticism of the term sexual addiction is that it is too vague and allows for overdiagnosis. Much of the confusion with regard to sexual addiction occurs due to the lack of a measurable assessment of the condition. While the *Diagnostic and Statistical Manual (DSM) III-R* (American Psychiatric Association

[APA], 1987) refers to Sexual Addiction Not Otherwise Specified, the term is removed in future revisions due to lack of empirical support. However, as Goodman (2001) points out, no definition of “addiction” or “addictive” is given to allow data to be collected in support of such a condition (including effectiveness research). In fact, in the *DSM IV-TR* (APA, 2000) there is no reference to addiction at all.

Milkman and Sunderwirth (1982) suggest that the term addiction gradually “came to imply psychological dependence in addition to the connotations of physical tolerance and withdrawal symptoms” (p. 177). They note that highly-repetitive nonsubstance behaviors such as gambling and eating are considered as addictions as well. More recently, other investigators of neurobiology (Miller, Dackis, & Gold, 1987; Goldstein, 1989; Jaffe, 1992, in Goodman 2001) suggest that neither tolerance nor withdrawal is necessary for substance dependency. In fact, the *DSM IV-TR* criteria require that just three of seven criteria be met to diagnose dependence, only two of which are tolerance and withdrawal symptoms (APA, 2000). Goodman (2001) suggests that a definition for sexual addiction (that does not require tolerance or dependence) could be constructed using the criteria for substance dependence in the *DSM IV-TR* by replacing the word “substance” with “sexual behavior.” Goodman’s definition may offer new possibilities for research in the area of sexual addiction.

Some also suggest that the term addiction forecloses all treatment approaches besides the 12-step model and that an addiction model allows for abdication of responsibility by the addict (Goodman, 2001). These issues seem to be more of a problem with therapist knowledge or training rather than with the concept of sexual addiction. Indeed, several different approaches other than 12-step models come from an addiction

perspective (Goodman, 2001). In terms of responsibility for change, the Alcoholics Anonymous (AA) model suggests that addicts are responsible for their recovery, although they are not responsible for their tendencies (Goodman, 2001).

Although the term sexual addiction is still somewhat controversial, it is the term most widely used in clinical practice and in recent journal articles (overwhelmingly so in the empirical literature). Therefore, I use the term sexual addiction throughout this paper to refer to the recurrent failure to control sexual behavior despite negative consequences (Goodman, 2001).

Etiology of Sexual Addiction

While the etiology of sexual addiction is different for each individual, several authors identify different factors that may influence the emergence and continuation of sexual addiction. I review several of the factors briefly in this chapter and refer to and expand them in the next chapter's discussion of the patterns and processes of addiction.

Disease model

The biological model of addiction is the disease model which suggests that certain individuals have a genetic predisposition to the disease of addiction. This theory is one major assumption of Alcoholics Anonymous and many of the sexual addiction groups, such as Sexaholics Anonymous (SA). Washton and Boundy (1989) suggest that the addictive personality exists on a continuum and that we are all vulnerable to different degrees of addiction (based on genetics). Other factors influence the way the addiction is expressed (alcohol, drugs, gambling, sex, etc.). Those who follow the disease model suggest that admitting powerlessness over the disease is the first step to recovery. The criticism of the disease model is that, taken to its extreme, it would not allow an

individual to make a *choice* for recovery. In other words, if addicts truly are powerless, they are dependent on their genetic make-up for recovery rather than any ability to choose when and if recovery is to happen.

Family of Origin

Perhaps the most identified environmental factor related to sexual addiction is family of origin (Adams & Robinson, 2001; Carnes, 1992; Laaser, 1996; Martin, 1989). In addition to feeling lonely, lost, and desperate as children, many addicts may have had no one to show them how to take care of themselves or keep from harm (i.e. poor example from parents; Carnes, 1992). Due to poor communication in their family of origin, addicts may experience confusion about family roles, expectations, and boundaries (Martin, 1989). This may result in an inability for addicts to succeed in their families of origin (e.g. meet family expectations). These repetitive failures often bring negative, critical, and punitive responses from the family of origin (Adams & Robinson, 2001), giving the addict a message of worthlessness and a feeling that the wrongs done to him/her, though hurtful, are deserved (Martin, 1989).

Additionally, several authors (Adams & Robinson, 2001; Carnes, 1992; Laaser, 1996) suggest that addicts may not experience healthy bonding with and nurturing from their parents. Thus, they may not receive an appropriate relationship-forming model from their parents (Carnes, 1992) and may experience an inability to develop trust in intimate relationships (Reed, 2000). With few coping skills, poor relationship skills, and/or a sense of distrust of others, many addicts feel a sense of powerlessness, shame (Wilson, 2000), and diminished self-esteem (Reed, 2000; Sprenkle, 1987).

In the “lonely search for something or someone to depend on—which has already excluded parents—a child can start to find those things which always comfort, which always feel good, which always are there, and which always do what they promise” (Carnes, 1992, p. 71). For some, this source of comfort is sex. When these children receive negative messages, rules, or judgments about sex (e.g. being sexual is perverse), their feelings of unworthiness (Carnes, 1992), shame, and powerlessness may increase (Wilson, 2000).

Culture

Culture may also reinforce negative beliefs about relationships, sexuality, and a definition of personal worth, further compounding the problems caused by family of origin. In addition to these factors, culture may provide a more optimal environment for the formation of addictions when it includes the following components: convenience (quick-fix), sophisticated technology (with the assumption that it can resolve all problems), entertainment or escapism, experiences of massive paradigm shifts (i.e. constant improvements in technology lead to many changes in world views), loss of community, high stress, denial of human limits, exploitation of others, and a significant population of other addicts (Carnes, 1991). Many of these conditions are part of our culture today.

Along with these cultural factors that may help create addiction, Carnes suggests that our society slows or prevents the process of recovery from addictions by: 1) perpetuating stereotyping, shame, and secrecy for addicts, and 2) supporting co-addiction (victims get support, thus reinforcing the role of the co-addict in enabling the addict). Finally, Sprenkle (1987) suggests that we live in an age which highly values variety as a

factor in quality of sexual experience. However, if therapists are unaware how these experiences may also negatively impact individuals and relationships, they may not appropriately identify, address, and intervene when sexual addiction is present.

Trauma and Abuse

Childhood traumas may lead to emotional arrest (Laaser, 1996) and a sense of victimization (Earle & Earle, 1995), and several authors suggest that, for some, these childhood traumas are linked to sexually addictive behaviors in the present (Carnes, 1991; Earle & Earle, 1995; Laaser, 1996). Others more specifically suggest that the trauma of abuse is linked highly to sexual addiction (Carnes & Delmonico, 1996; Earle & Earle, 1995). Carnes (1991) believes that all addicts have received some type of abuse (sexual, physical or emotional) and some findings offer that hypothesis tentative support (Carnes & Delmonico, 1996).

Schwartz (1992) suggests that victims of child sexual abuse (CSA) sometimes reenact the trauma of sexual abuse and then become addicted to the “high” associated with the behavior. Carnes (1992) suggests that when a parent is sexual with a child, the child may believe at a fundamental level that s/he has to be sexual in order to have a relationship. This belief may eventually lead to sexual addiction. Links between CSA, promiscuity, and post-traumatic stress disorder (PTSD) are recognized widely in the literature (see Gold & Heffner, 1998); however, links between CSA and sexual addiction are mentioned less frequently (Carnes & Delmonico, 1996; McCarthy 1994; Schwartz, 1992).

Psychological/Emotional

Psychological and emotional factors are integrally linked to the conceptualization of sexual addiction. Therefore, I make only brief mention of this factor here but discuss it in greater detail in the next chapter. Washton and Boundy (1989) suggest that the common factor for all addicts is the “dis-ease” (or lack of ease) within them. This dis-ease (which both genetic and environmental factors may partially influence) leads to faulty beliefs, difficulty coping, and unmet needs, and eventually may lead to sexual addiction.

Summary

No definitive causal links exist between the factors listed above and the occurrence of sexual addiction. Martin (1989) suggests that there are contributions to sexual addiction from a combination of and/or all of these factors, including: physical, cultural, spiritual, emotional, psychological, and social factors. Goodman (1992) offers a summary of sexual addiction that integrates these factors:

In the course of healthy growth, people develop effective, adaptive means of regulating their feelings and their sense of self. When some combination of genetic and environmental factors interferes with development of these self-regulatory processes, people are more vulnerable to being overwhelmed by intense feelings or by loss of self-coherence. (pg. 312)

Some learn to avoid these traumatic emotional states by taking a substance or engaging in a rewarding behavior. In the end, a person becomes sexually addicted when s/he becomes dependent on sex (an external action) to regulate his/her internal state.

CHAPTER II

Literature Review

While individual causes of sexual addiction are idiosyncratic, it is essential to understand how sexual addiction generally plays out in the lives of individuals and couples in order to provide appropriate treatment (Corley & Schneider, 2002; Sprenkle, 1987; Young et al., 2000). Therefore, in this chapter I present (a) a brief summary of the theoretical literature about the sexual addict and treatment options (including marital), (b) a review of the empirical literature on sexual addiction (including addicts, spouses, and couples), and (c) an examination of the possible role marital therapy can play in facilitating healing from sexual addiction (based on the empirical review).

The Sexual Addict: A Theoretical Review

Faulty Core Beliefs

Carnes (1992) suggests that four faulty core beliefs form during childhood that are common to sexual addicts: (a) I am basically a bad, unworthy person, (b) no one will love me as I am, (c) my needs are never going to be met if I have to depend on others, and (d) sex is my most important need. Earle and Crow (1989) added a fifth core belief to Carnes' model: If I have to depend on my social skills to get close to anyone, it will never happen. Core belief one has to do with self-acceptance. Addicts do not perceive themselves as worthwhile persons, and failures of any type create and reinforce deep feelings of inadequacy. As the addiction worsens, the increasing sense of unmanageability confirms this faulty belief. Being imperfect/failing means being unlovable, and addicts believe no one will love them (core belief two, related to intimacy) or meet their needs (core belief three, an issue of dependence) if everything is known

about them. Feeling unloved and unlovable, addicts believe that people will not be there for them and that their needs will not be met. Because they hide their behaviors from others, they know that they are not trustworthy and are convinced that most people (like themselves) cannot be trusted either. Further, if anyone were to find out about the secret life (of sexual addiction), there would be no forgiveness (because addicts judge themselves by society's standards—weird, perverts, unacceptable). Thus, addicts constantly fear (and anticipate) the rejection which may come from being vulnerable or dependent on others. Thus, they appear not to need anything relationally (they give few, if any, cues to others about their need for intimate connection) and attempt to be cared for by others without expressing what they need.

Gradually, sex is seen as the only source of comfort and nurturing (core belief four; Carnes, 1992). The addict assumes that everyone feels and acts the same, which reinforces the idea that to be secure means to be sexual. Thus, addicts seek sexual experiences to meet their needs. The fifth core belief (Earle & Crow, 1989) precludes any effort to establish true intimacy because addicts “know” they will fail if they try. Thus, sexual experience becomes one of only a few options available to try to meet their needs. Because addicts' needs are never truly met through the addiction, they eventually act out sexually (again and again), thus solidifying a place for sexual addiction in their life.

Shame

Several negative emotions result from such faulty beliefs. The first (and most discussed) emotion in the literature is shame. Kaufman (1989) defines shame as the experience of being fundamentally bad as a person. Wilson (2000) suggests that shame comes from a child's sense of helplessness and loss of self-control. To be powerless is to

be shamed. Addicts often confuse doing bad things (guilt) with being a bad person (shame; Adams & Robinson, 2001). Shame comes from the addict's lack of self-acceptance and the feeling that s/he can never measure up (Carnes, 1991). Underneath the shame are feelings of inadequacy, unworthiness, mistrust, loneliness, sadness, and anger (Adams & Robinson, 2001).

Isolation/Loneliness, Relationship Problems

Sprenkle (1987) suggests that attempts to hide the secret of sexual addiction (avoid public shame) can create a painful isolation, and the isolation increases as the secret life grows (Carnes, 1992). Eventually, feeling "normal" for the sexual addict means feeling isolated and lonely since the primary relationship the addict depends upon to meet his/her needs is the relationship with the sexual addiction, not other people. In other words, the sexual addiction is an unhealthy relationship with sexual thoughts or behaviors that has been substituted for a healthy relationship with others (Carnes, 1992; Martin, 1989). Sexual addiction can become such an obstacle to developing significant relationships that Earle and Crow (1989) refer to it as an intimacy disorder.

Ineffective Coping

Each person's belief system includes a repertoire of options (answers, solutions, methods, possibilities, and ways of behaving) that are open to him/her (Carnes, 1992). Because of addicts' faulty beliefs, as well as the limited coping skills learned in their families of origin, addicts often have few options (skills or relationships) that they can use to fill the void inside them or cope effectively with their intense negative emotions such as shame, loneliness, powerlessness, sadness, stress, boredom, anxiety, and anger. Genetic factors also may present some addicts with additional struggles due to an

underlying psychological, emotional, and/or mental disorder (Cooper & Lebo, 2001). Sexual addicts turn to sex to attempt to: “handle,” “remedy,” escape, distract, suspend, or diminish negative emotions (Adams & Robinson, 2001; Cooper & Lebo, 2001; Leiblum, 1997; Magai, 1999; Wolfe, 2000), fill the void (Carnes, 1991; Reed, 2000), self-medicate (Cooper & Lebo, 2001), compensate for diminished self-esteem or low sense of self-worth (Carnes, 1991; Sprenkle, 1987; Wolfe, 2000), or alleviate the pain (Carnes, 1992). Sexual addicts may also use sexual addiction as an attempt to recover from childhood traumas, abuse, or degradations, using a preferred (scripted) sexual scenario as a means of coping with or recovering from the wrongs and degradations done to them (Bergner, 2002; Goodman, 1992).

In addition to the *temporary* reduction of negative emotions, sexual addiction also serves as a means of *temporary* nurturing (Carnes, 1992) and pleasure (Carnes, 1991, 1992; Earle & Crow, 1989; Wolfe, 2000). In the end, though, feeling good does not fill the voids, deal with the emotions, increase addicts’ success at coping with negative emotions, or increase their sense of self-esteem or goodness. Neither does the preferred sexual scenario help the addict to achieve recovery from degradation. In reality, the sexual addiction usually leads to increased emotional distress and feelings of worthlessness (Bergner, 2002; Carnes, 1991, 1992; Earle & Crow, 1989).

The Cycle

Magai (1999) suggests that escaping or diminishing the experience of negative emotions (through acting out) prevents addicts from (a) becoming familiar with the situation precipitating the affective state (thus lowering anxiety), and (b) having success at managing the situations and emotions. Moreover, several authors suggest that sexual

addiction usually leads to increased emotional distress and feelings of worthlessness (Bergner, 2002; Carnes, 1991, 1992; Earle & Crow, 1989). Addicts also begin to become more isolated and/or alienated from healthy relationships as they continue to act out, adding to their negative emotions. Gradually, lack of success, increased anxiety, and lack of intimacy lead the addict to believe that the situation(s) are unmanageable, that they are powerless to handle the negative affect (Carnes, 1991, 1992; Wolfe, 2000).

There is, however, still one simple way for the addict to alleviate the pain *temporarily* and to create a *temporary* sense of intimacy: act out sexually again. As addicts turn to sex over and over again to deal with their problems, they form a belief (usually very quickly) that addicts must rely on things external to the self (in this case, sex) to regulate the self (Adams & Robinson, 2001). The pattern of acting out—the addictive cycle—is self-perpetuating (Carnes, 1992; Earle & Crow, 1989; Martin, 1989) because the completion of each cycle confirms the addict’s faulty belief system and impaired thinking. Denial, rationalization, sincere delusion, paranoia, and blame (towards others) prevent the addict from getting feedback that could correct his/her faulty beliefs (Carnes, 1992). The sense of unmanageability leads the addict to make decisions that sacrifice long-term goals and commitments—including relationships—for short-term relief (Carnes, 1991, 1992; Earle & Crow, 1989) and pleasure (Wolfe, 2000). Martin (1989) suggests that the addiction continues to become a driving force because of its failure to achieve intimacy. Gradually, the pattern or cycle of acting out becomes less conscious and more automatic and habitual (Earle & Crow, 1989).

Treatment Approaches

All these theories conceptualize sexual addiction in a way that can help guide intervention. These theories are by no means exclusive and, in fact, frequently overlap. Cumulatively, these authors tend to agree that sexual addiction stems from a desire to eliminate negative emotions (anxiety, pain, loneliness, worthlessness, powerlessness, shame, etc.) and that there may be a continuum upon which both environment and heredity play a role in the development of sexual addiction (although some models may view one factor as more important than the other). Environmental factors may include a history of sexual abuse (Carnes & Delmonico, 1996), a history of addiction in the family, other relationship harms or degradations (Bergner, 2002), and/or a subjectively high degree of life stressors (which lead to experiences of extreme negative emotions), including relationship difficulties and social isolation.

Therapeutic approaches used for the treatment of sexual addiction include cognitive-behavioral (Cooper & Lebo, 2001), psychodynamic (Turken, 2001), Rational Emotive Behavior Therapy (Wolfe, 2000), and systems approaches (Carnes, 1986; Sprenkle, 1987). Interventions that may be helpful include: medication (Cooper & Lebo, 2001; Kafka & Prentky, 1992), relapse prevention (Reed, 2000), addressing past relationship harms, including family of origin (Bergner, 2002), and addressing abuse issues (Carnes, 1991; McCarthy, 1994). These interventions can occur in individual (Cooper & Lebo, 2001; Schneider, 1989), group (Carnes, 1992; Gold & Heffner, 1998; Goodman, 2001), marital (Corley & Schneider, 2002; Sprenkle, 1987; Young et al., 2000), or family therapy (Corley & Alvarez, 1996). In some cases, inpatient treatment may be better suited to some addicts' situations/needs (Cooper & Lebo, 2001).

Marital Therapy

Despite the obvious links between relationships and sexual addictions, some authors (Cooper & Lebo, 2001; Gold & Heffner, 1998; Goodman, 2001; Wolfe, 2000) make very little or no mention of marital therapy in their discussion of the treatment of sexual addiction. Yet most of the issues addressed above relate directly to past or present relationships. These relationships are factors in creating and/or maintaining the addiction, or are negatively affected by sexual addiction in the present.

The role of marital therapy in helping individuals and couples heal from sexual addiction is sparsely discussed in the literature (Carnes, 1986; Corley & Schneider, 2002; Laaser, 1996; Schneider, 1989; Sprenkle, 1987; Young et al., 2000). Laaser (1996) suggests that marital therapy is necessary only in severe cases, although he gives no definition of severe. Schneider (1989) suggests that marital therapy might be helpful in conjunction with group or individual therapy. However, she views sexual addiction as intrapsychic rather than interpersonal and therefore suggests that marital therapy would be helpful later in treatment but ineffective if it were the only treatment given.

In contrast, Young et al. (2000) suggest that couple therapy should be used in the treatment of sexual addiction unless it is not possible or would likely damage the relationship. Corley and Schneider (2002) focus on the important process of disclosure between partners in therapy and the role of the therapist in facilitating honesty (and avoiding collusion with one partner). Carnes (1986) suggests that having a family member, partner, or significant other participate in therapy with an addict is a significant factor in preventing relapse. Sprenkle (1987) suggests that understanding how couple dynamics might affect the addiction can be an important piece of healing. All of these authors stress that a therapist who chooses to counsel couples where one or both partners

is a sex addict should understand sexual addiction. It appears, then, that marital therapy with sexual addiction requires significant training and familiarity with sexual addictions (including secrecy and other possible couple dynamics).

Several of these authors suggest some common themes of marital therapy (Schneider, 1989, Sprenkle, 1987; Young et al., 2000). These include: restoration of trust, improved awareness of individual issues and emotions, improved communication and assertiveness, forgiveness, dealing with sexual problems, establishing boundaries (not ultimatums), improving intimacy (positive interactions, activities together, etc.), reducing defensiveness, and reducing shame. Despite the increasing recognition of the role of marital therapy in recovery from sexual addiction, most authors only consider marital therapy an adjunct to other preferred treatment modalities (i.e. individual and group).

Empirical Review

Due to the lack of conceptual congruency among authors and the relatively small role marital therapy plays in the current conceptual literature, I conducted a systematic research synthesis to more fully understand the trends and limitations in the empirical literature with relation to (a) the impact of sexual addiction on the addict, the partner, and the relationship, (b) the healing process for the addict, the partner, and the relationship, and (c) the possible role of marital therapy in facilitating healing from sexual addiction.

For the purposes of the critique of empirical literature, I only examined peer-reviewed journal articles. While there is an abundance of books (Carnes, 1983, 1991; Earle & Crow, 1998; Milkman & Sunderwirth, 1987; Schneider & Schneider, 1990a) and non-peer-reviewed projects on this topic, I did not include these in the review. While on-line sexual activities (OSA) have also been addressed in the literature, OSA includes a

wide variety of activities that are not necessarily tied to sex addiction. Also, because the bulk of research draws a distinction between the non-paraphilia and paraphilia sex addictions (Kafka & Hennen, 1999; Kafka & Prentky, 1992), I have eliminated articles addressing both OSA (if not directly linked to sexual addiction) and paraphilia from this review. The articles chosen are a culmination of all empirical articles that have been written since the inception of the concept of sexual addiction.

Method

The articles selected are the results of an extensive literature search in several databases, including ERIC and PsychInfo. The keywords utilized in the search include the following words and their possible combinations: “sexual addiction,” “compulsion/compulsivity,” “impulsive/impulsivity,” “sexual fantasy,” “sexual risk taking,” “study,” “empirical,” “qualitative,” “quantitative,” “comorbidity,” “relapse prevention,” “love addiction,” “dependence,” “marital therapy,” “couple therapy,” “therapy,” “internet addiction,” “pornography,” “cybersex,” and “masturbation.” Additionally, I reviewed the reference lists of all articles collected in the search in an attempt to find any other empirical articles related to the topic that did not appear in the database searches.

The original intent of this research synthesis was to review articles that address issues regarding marital therapy and sexual addiction. Due to the low number of articles, I expanded the parameters to include all empirical articles within the realm of sexual addiction. Once I collected the articles, I sorted them into three categories: (a) studies of addicts, (b) studies of spouses of addicts (also referred to as co-addicts), and (c) studies of couples where one or both partners are sexually addicted. I critique sampling, design, results, and discussion separately within each category, with a particular focus on how

marital therapists might better intervene with couples where at least one partner is a sexual addict. A total of 30 articles are included in the subsequent research synthesis.

Review of Studies

Addicts

Sampling. Twenty-three studies focus on the addict's experience of sexual addiction. Nineteen of the studies are convenience samples. All but two of these authors (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Lundy, 1994) acknowledge the limits of convenience sampling and report different ways that they attempt to verify the representativeness of their groups in an effort to bolster confidence in the generalizability of the findings. Swisher (1995) randomly sampled from two organizations of therapists who work with addictions. Because she used random sampling and there is almost a 50% response rate, the study is generalizable to that population of counselors. Leedes (1999) does not report his sampling method.

Seventeen studies are quantitative, three are qualitative (Chaney & Dew, 2003; Ross, 1996; Schneider, 2000a), two are mixed methods (Reece & Dodge, 2004; Swisher, 1995), and one is not specified (Leedes, 1999). The smallest sample size is 12 (Schwartz & Abramowitz, 2003), and the largest sample size is 9,313 (Eisenman, Dantzker, & Ellis, 2004). See Table 1 for all sample sizes.

Four studies report means and standard deviations for all demographic information (Cooper, Delmonico, & Burg, 2000; Cooper, Scherer, Boies, & Gordon, 1999; Quadland, 1985; Raviv, 1993). The remaining studies report at least some means and ranges (Chaney & Dew, 2003; Dodge, Reece, Cole, Sandfort, 2004; Schneider, 2000a; Wan, Finlayson, & Rowles, 2000), percentages only (Benotsch, Kalichman, &

Kelly, 1999; Black et al., 1997; Kalichman & Cain, 2004; Lundy, 1994; Missildine, Feldstein, Punzalan, & Parsons, 2005; Reece, 2003; Reece & Dodge, 2004; Swisher, 1995; Yoder, Virden, & Amin, 2005), a descriptive account (Ross, 1996; Schwartz & Abramowitz, 2003), gender only (Blankenship & Laaser, 2004; Eisenman et al., 2004; Weiss, 2004), or no demographics (Leedes, 1999). Swisher (1995) reports percentages for the quantitative part of her study but gives no details for the qualitative portion.

Benotsch et al. (1999), Chaney and Dew (2003), Quadland (1985), Reece (2003), and Reece and Dodge (2004) use only gay and/or bisexual men in their samples, and Ross surveys only women (some of whom had comorbid diagnoses), thus limiting generalizability to these specific populations. Less than a third of authors provided information about the addicts' race or ethnicity, and those that did reported samples that were extremely limited in diversity. Thus, most of these studies are not necessarily generalizable across racial/ethnic groups.

Table 1

Overview of Addict (Individual) Studies

Author(s)	Design	Sample
Benotsch et al. (1999)	Descriptive Survey—Sexual Compulsivity Scale (SCS) and researcher-created items.	N=112 (gay/bisexual men with HIV)
Black et al. (1997)	Semi-structured interview based on a combination of several interview protocols, Beck Depression Inventory (BDI), Maudsley Obsessive-Compulsive Inventory, Personality Diagnostic Questionnaire Revised	N=36
Blankenship & Laaser (2004).	Sexual Addiction Screening Test (SAST), Carnes Trauma Reactions Index, AMEN Brain System Checklist	N=70 (men)
Chaney & Dew (2004)	Sexual Addiction Screening Test for Gay Men (G-SAST) Semi-structured researcher-created interviews	N=13 (gay or bisexual men)
Cooper, et al. (2000) and Cooper et al. (1999)	Descriptive Survey—on-line at MSNBC.com website SCS and Sexual Sensation Seeking plus other researcher-created items (59 items total)	N=9265 N=9177 (Different criteria)
Dodge et al. (2004)	SCS and researcher-created sexual behavior questionnaire	N=899 (college students)
Eisenman et al. (2004)	Researcher-created questionnaire	N=9,313 (college students)
Kalichman & Cain (2004)	Demographic questionnaire, SCS, Alcohol Use Disorder Identification Test (AUDIT), and researcher-created drug, alcohol, and sexual behaviors questionnaires,	N=625 (receiving STI health services)
Leedes (1996)	“Guided imageries”—No details reported	N=22
Lundy (1994)	Delphi study	N=93
Missildine et al. (2005)	SCS, Romantic Obsessions scale, and other researcher-created questions (sexual role preference and relationship variables)	N=343 (200 gay men and 143 lesbians)

Quadland (1985)	Pre- and posttest (versus matched control group) Researcher-created test battery, 6-month follow-up sexual behavior assessment	N=29 (gay or bisexual men)
Raviv (1993)	Descriptive-Survey SCL-90-R, Sensation Seeking Scale, Self-Defeating Personality Disorder Scale	N=102 (SA=32, control=35, Path. gamblers=32)
Reece, M. (2003)	Descriptive-Survey Pre-therapy intake and mental health assessment procedures at a clinic, SCS, and researcher-created scales.	N=180 gay/bisexual men
Reece & Dodge (2004)	SCS, researcher created questionnaire, semi-structured interviews	N=26 (MSM cruisers)
Ross (1996)	Structured Interviews Independent raters rated if the audio-taped women displayed Carnes' 10 ten behavior types	N=18 women (inpatient or 12-step groups)
Schneider (2000a)	Descriptive-Survey Researcher-created on-line survey A qualitative inductive method used to develop themes	N=55 45 men 10 women
Schwartz & Abramowitz (2003)	Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), State-Trait Anxiety Inventory (STAI), BDI, and researcher-created sexual obsessions interview	N=12 (6 OCD, 6 NPSA)
Swisher (1995)	Descriptive-Survey <i>and</i> Follow-up structured interviews Researcher-created survey to random sample of therapists. Structured interview questions not reported.	N=248 (survey) N=20 (interviews)
Wan et al. (2000)	Descriptive-Survey—Researcher-created telephone interview	N=59
Weiss (2004)	BDI, SAST	N=418 (220 addicts)
Yoder et al. (2005)	University of California Los Angeles Loneliness Scale, demographics, and internet usage questionnaire	N=400

Design. Four studies used researcher-created surveys in person (Eisenman et al., 2004), via phone (Wan et al., 2000), or on-line at MSNBC.com (Cooper et al., 2000; Cooper et al., 1999). Several authors used valid and reliable psychological measures in conjunction with other unvalidated or researcher-created measures (Benotsch et al., 1999; Blankenship & Laaser, 2004; Dodge et al., 2004; Kalichman & Cain, 2004; Missildine et al., 2005; Weiss, 2004; Yoder et al., 2005) or interviews (Black et al., 1997; Schwartz & Abramowitz, 2003). Reece (2003) used pre-therapy intake/mental health assessment procedures at a clinic and both reliable scales and researcher-created scales to study disclosure of HIV serostatus among gay/bisexual men. In Raviv's (1993) study, he compares three groups (gambling addicts, sexual addicts, and a control group) on psychological and risk-taking variables using a packet of tests (all valid and reliable measures). Quadland (1985) uses pre- and post-tests with a control group, but he does not describe the tests. Lundy (1994) uses a Delphi study to determine what mental health professionals identify as the behavior patterns of sexual addicts, but he does not sample experts (a key element of Delphi studies).

Ross (1996) trained female undergraduate psychology students to independently rate whether audio-taped women displayed the ten behavior types listed by Carnes, Nonemaker, and Skilling (1991). Ross (1996) used independent raters and excluded answers deemed too subjective, suggesting attention to interrater reliability and measurement error. Schneider's (2000a) email survey (except two mailed surveys) includes demographics and open-ended questions asking about the effects of sexual addiction on the addicts and how they dealt with their addiction problems. She reports that the data was analyzed qualitatively using an inductive method to develop themes, but

gives no further details. Chaney and Dew (2003) conducted interviews via instant messenger in men-for-men chat rooms and analyzed the interviews using grounded theory (comparing similarities and differences between two coders for the purpose of inter-rater reliability). While Chaney and Dew give examples of interview questions, neither Ross (1996) nor Schneider (2000a) give details about their questions.

Swisher (1995) used a mail-out survey that was previously piloted. She used appropriate inferential statistics for quantitative analysis and conducted follow-up interviews with 20 counselors who reported frequently encountering sex addicts in therapy. Reece and Dodge (2004) used flyers on campus sites, a website dedicated to cruising, and snowball sampling to recruit their sample. While quantitative measures were used to compare their sample with samples from other studies, the major findings of their study are qualitative, although no specific methodology is described. While Reece and Dodge provide question categories, Swisher (1995) only explains that her qualitative questions explored the client/counselor relationship factors associated with recovery from sexual addiction and probed further about unexpected information that the survey revealed. See Table 1 for a summary of designs and samples for studies on the addict.

Results. Four studies discuss either the experience of female addicts (Ross, 1996; Schneider, 2000a) or gay/bisexual addicts (Chaney & Dew, 2003; Missildine et al., 2005). The majority of women in Schneider's (2000a) study report preferring relationship-oriented on-line sexual behavior, and their on-line experiences led to real-life sexual encounters significantly more than men (80% and 30%, respectively). However, Schneider's and Ross's (1996) findings also indicate that there are some women who prefer behaviors that are typically believed to be male-oriented (e.g. visual stimulation;

Carnes et al., 1991). Several women also report that passive roles, normally perceived as powerless, are actually roles where women experience power through manipulation, seduction, and objectifying of others. Schneider reports that women feel they experience greater shame than men (less socially acceptable) and have fewer 12-step programs than men (that they feel comfortable attending). Group, individual, and couple therapy were helpful to recovery for these women generally, but the women indicated that some therapists lacked knowledge and/or discounted the negative experiences caused by the addiction. In their study of gay men and lesbians, Missildine et al (2005) found that gay men experience both higher sexual addiction and higher romantic obsession scores (although previous gender assumptions were that women would score higher on the latter score). Finally, Chaney and Dew (2003) found that gay/bisexual males are very similar to heterosexual male populations in all aspects of internet compulsive behaviors, although use rates are higher for gay/bisexual men (see also Cooper et al., 2000).

The remaining studies (all quantitative) report their findings mostly through percentages and frequencies, although inferential statistics are also used in a few studies. No studies reported effect sizes. Although many of the authors do not mention couple-related findings, several suggest other relevant factors that are worth brief mention here. Weiss (2004) found that sexual addicts were significantly more depressed than a control group ($p < .01$). Blankenship and Laaser (2004) measured three types of Attention-Deficit Hyperactivity Disorder (ADHD) and found that all three types (anterior cingulate, basal ganglia, and limbic system hyperactivity) were displayed by at least 50% of those studied, suggesting at least a tentative link between untreated ADHD and sexual addiction. Schwartz and Abramowitz (2003) found that their sample of obsessive-

compulsive disorder (OCD) clients differed from their nonparaphilic sexual addict (NPSA) sample. While both groups felt equally driven to do the behaviors, OCD patients experienced greater fear and avoidance related to sexual thoughts and very little pleasure related to the compulsive behavior. Patients with OCD had higher levels of trait anxiety and depression, and all but one had other unrelated obsessions or compulsions as well. Obsessive thinking for OCD patients occurred in an attempt to neutralize the thoughts rather than because the thoughts were arousing. In contrast, NPSA's experienced their sexual obsessions as acceptable or even arousing with a high degree of pleasure related to the compulsive behavior. Sexual addictions were also linked (at least moderately) with other addictions with college students (Eisenman et al., 2004) and a clinical population (Wan et al., 2000). Finally, several studies suggest that sexual addicts are more likely than non-addicts to engage in sexual activities that are high-risk, including samples of gay/bisexual men (Benotsch et al. 1999), clients from a sexually transmitted infection center (Kalichman & Cain, 2004), and college students (Dodge et al, 2004).

Although many of the studies did not mention couple-related findings, several did suggest general relational links. Quadland (1985) and Reece (2003) reported on gay/bisexual men. Reece found that HIV-positive sexual addicts had significantly lower perceived responsibility for disclosure ($p= 0.034$) and lower disclosure rates ($p= 0.04$) than HIV-positive non-addicts (more willing to risk infecting/harming others). The addictive group in Quadland's (1985) study reported a history of fewer long-term relationships than the other groups. Interestingly, although treatment did not focus on increasing relationship stability, the percentage of individuals that were involved in a primary relationship increased from 20% at pretreatment to 40% at post-treatment for the

sexual addiction group, a finding that approached significance when compared to the control group ($p < .06$). Thus, recovery from sexual addiction may be somewhat linked to involvement in a primary relationship, although the association may be weak.

Yoder et al. (2005) report that loneliness and pornography usage have a significant association (their regression model accounted for 45.9% of the variance in loneliness). Raviv (1993) reports that sex addicts have significantly higher interpersonal sensitivity and are more anxious, depressed, and obsessive-compulsive than a control group. Leedes' (1999) study indicates that addicts have significantly more discomfort with closeness than nonidentified sexual addicts, with 95% of the sexual addicts in his study displaying insecure attachment styles. Leedes also found that guided imagery intended to access and reduce this sense of discomfort is successful in decreasing the negative power of fantasies, suggesting that positive relationships may reduce sexually addictive behaviors. While these studies do not directly suggest that couple relationships are affected, they do suggest a link between sexual addiction and relationship factors.

Several authors found that sexual addiction had a direct impact on relationships. Findings from several quantitative studies directly suggest that marital or family relationships are negatively affected or jeopardized as a result of sexual addiction. The therapists in Lundy's (1994) study list endangering one's family life as one of the top ten characteristics of sexual addicts. For OCD patients in Schwartz and Abramowitz's study (2003), sexual thoughts and compulsive behaviors were more of a concern for the patient, but for the NPSA group they were a greater concern for those closest to them (i.e. spouse). In Black et al.'s (1997) study, 42% of the sample reported that their sexual addiction has affected their marriage or other important relationships. Twelve percent of

the sample in Cooper et al.'s (2000) and Cooper et al.'s (1999) study reported that online sexual pursuits negatively affected their personal lives, and 13% reported that their online sexual pursuits jeopardized their relationships. As time spent in online sexual pursuits increased, higher degrees of interference and jeopardizing were reported. While it is uncertain whether increased time in online sexual pursuits is a cause or result of relationship difficulties, it is evident that addicts recognize that sexual acting out is potentially jeopardizing to their relationships.

Wan et al. (2000) suggest that marital status is not a factor in preventing relapse; however, they do indicate that divorce and separation are factors that lead to increased relapse. The authors do not take any measures to confirm or reject whether the level of satisfaction or adjustment in a marriage was a contributing factor in preventing relapse.

Finally, in Swisher's (1995) survey of therapists, the most common forms of treatment for sexual addiction are individual and group therapy. Surprisingly, 14% of the counselors surveyed do not endorse 12-step groups. Sixty-five percent reported that they would use couple/marital counseling and 63% would use family therapy in treating sexual addiction. Those using marital therapy reported using family systems therapy (described very broadly as brief, intensive therapy, classic Bowenian, or a combination of both). Interventions that are common include defining behavioral boundaries and recognizing and avoiding high-risk situations. Those who treat sexual addiction frequently listed anger management, cognitive restructuring, confrontation, contracting, defining sexual sobriety, defining behavioral boundaries, empathy, and grief counseling as types of treatment for sexual addiction. They also suggest treating the addiction(s) first followed by the other presenting problems, whereas those not working with addictions

frequently report that they would treat the problem that the client wants to address. While Swisher's study names interventions, little detail is given regarding how those interventions are done and in what circumstances they might be appropriately applied.

Discussion. In the discussions, the majority of the authors suggest that many therapists have a general lack of awareness of what may be signs of sexual addiction. Thus, the majority of the discussions focus on the signs to look for that would increase and improve appropriate assessment of sexual addiction in therapy, including not relying solely on client self-reports (Cooper et al., 2000); comorbidity with other addictions (Eisenman et al., 2004; Kalichman & Cain, 2004; Wan et al., 2000); comorbidity with other DSM diagnoses such as depression (Weiss, 2004), ADHD (Blankenship and Laaser, 2004), and OCD (Schwartz & Abramowitz, 2003); time spent in the activities (Cooper et al., 1999; Cooper et al., 2000); subjective degree of discomfort caused by addiction (Black et al., 1997; Raviv, 1993); degree of risk-taking involved (Benotsch et al. 1999; Dodge et al., 2004; Kalichman & Cain, 2004); isolation, loneliness, or difficulties establishing long-term relationships (Cooper et al., 1999; Quadland, 1985); and the impact of the addiction on work, family, marital, and other aspects of life (Chaney & Dew, 2003; Cooper et al., 1999; Cooper et al., 2000; Schneider, 2000a; Schwartz & Abramowitz, 2003). Cooper et al. (1999) stress that ongoing relationship struggles should not be confused with addictions; however, together with other factors it serves as an indicator that further probing is necessary to assess if addiction is present.

The few authors who make treatment recommendations beyond assessment support both group and individual therapy as viable and useful options for treating sexual addiction. Wan et al's. (2000) findings suggest that some addicts feel uncomfortable in a

group setting, and those who abstained (no relapse) reported attending *no* groups. Despite their findings, Wan et al. still argue that self-help groups should be emphasized to maintain change (indicating a possible researcher bias toward group treatment). At least, their findings suggest that therapists should be careful to assess which type of treatment best suits each client's needs.

Only a few authors address the inclusion of families or couples in some type of treatment. Swisher (1995) suggests that changing family dynamics is essential to long-term recovery, a process she recommends facilitating in inpatient programs. Raviv (1993) proposes that including the addict's family members in treatment or encouraging them to participate in S-Anon will increase the family's understanding of addiction as well as their ability to support the addict in change. Cooper et al. (1999) suggests that couple therapy could be a forum for assessing why addicts' relationships are lacking or why they are withdrawing from them. Schneider (2000a) suggests involving the partner in therapy and combating isolation through increased time with the partner/family.

In terms of specific interventions, Ross (1996) proposes that helping women to let go of a view of sexuality that incorporates an aggressor and victim allows women and men to build intimacy based on equal power. Leedes (1999) suggests that sexual addicts need to realize that their fantasies are surrogates for interpersonal relationships which offer responsiveness and affirmation, and he recommends using guided imagery to help reduce discomfort in relationships and decrease the negative power of sexual fantasies. He suggests that increasing interpersonal relationship comfort in reality is more useful than interventions that work only to eliminate the virtual world (e.g. fantasy stopping, victim empathy, etc.). Benotsch et al. (1999) suggest enhancing sexual behavior self-

management skills, and Reece (2003) promotes addressing sexual decision-making skills. Cooper et al. (2000) recommend targeting the concepts of anonymity, accessibility, and affordability through public education (in work, schools, etc.). Schneider (2000a) recommends reading, making the computer safe (cleaning off images, using blocking services, changing the location to a highly visible place), and increased time with friends, fun activities, and sports/exercise as general interventions for combating sexual addiction.

Spouses (Co-addicts)

Sampling. All four studies about the spouse's experience of his/her partner's sexual addiction are qualitative and use convenience sampling. King (2003) surveyed wives of clergy on-line and reported only marital status and age of participants. Milrad (1999) recruited 35 recovering women co-addicts from a hospital's sexual disorder unit, outpatient, and 12-step programs. All but one were Caucasian, all but 3 were upper- or middle-class, and all participated in groups or some type of therapy. Schneider's (2000b) sample consists of partners of cybersex addicts (91 women and 3 men) who were negatively impacted by their partner's sexual addiction. Demographics include means and ranges for age and time in cybersex addiction as well as whether or not they were still in a relationship with the addicted partner. Bergner and Bridges' (2002) review of 100 letters posted by women on the internet includes no demographic information other than gender.

Design. Schneider (2000b) used an open-ended survey to determine the adverse effects of addiction on the partner (the questionnaire is included in the article). All except three respondents (who chose to do so by mail to assure anonymity) returned the survey via email. King (2003) used an open-ended, on-line, anonymous survey to assess the experience of spouses of sexually addicted clergy. Bergner and Bridges (2002) chose

letters (posted on internet sites) by women who discussed their personal experiences with male partners whose only reported problem was pornography addiction. Because female perceptions and reactions are the foci of the study, the authors argue that the female's reports of partner addiction are not a weakness of the study. For analysis, two investigators independently identified major recurring themes, met to identify common themes and discuss differences, and arrived at a consensus. No details were given about the investigators' biases or steps taken to control such biases. Milrad (1999) does not report how she conducted the interviews, which limits the generalizability of her findings.

Results. Before I review the results, it is noteworthy that several wives in Milrad's study, 22.3% of the spouses in Schneider's (2000b) study, and 8% of clergy wives in King's (2003) study had divorced their partner. This tentatively implies that recovering from sexual addiction and maintaining the relationship may be a difficult process.

Milrad (1999) outlines four stages of recovery. In the prerecovery stage, women deny their intuition that something is wrong, although some insist on couple therapy to improve the relationship. All but one partner began detective behaviors and eventually confronted their husbands (many of whom denied any problems). Schneider (2000b) notes these "snooping" behaviors in her sample as well. Both Schneider and Milrad report that wives also attempted to reduce the likelihood of acting out through bargaining, increased sex (and sexual repertoire), lingerie, and makeovers. Spouses transition to the crisis stage as women realize they are in crisis and need help.

The crisis stage (Milrad, 1999) includes feeling sad, depressed, overwhelmed, hopeless, helpless, betrayed, isolated, angry, bitter, traumatized, shamed, a low sense of self-esteem, and confusion about whether to stay in the relationship (Bergner & Bridges,

2002; King, 2003; Milrad, 1999; Schneider, 2000b). In Schneider's (2000b) study, partners who experienced both on-line affairs and live affairs reported that they felt the same degree of hurt for both types of affairs. Clergy wives (King, 2003) experienced feelings of guilt about not being a better wife even though they knew it was their partner's responsibility/choices. Bergner and Bridges (2002) suggest that, while wives recognize that the addiction is not about them, they struggle to believe it is true. They feel undesirable and weak/stupid for not leaving their partners. Wives also struggle with how they view their husbands, seeing them as sick, perverts, selfish, and inadequate (as fathers and/or husbands). However, wives see repentant addicts more favorably and are more willing to stay in the relationship. This fits with the crisis stage of Milrad's study, where 28 of 35 husbands sought at least some type of therapy. Schneider (2000b) adds that the marriage is often additionally stressed because of the impact of the addiction on the children. Interestingly, all but two of the respondents in Milrad's study sought therapy during the crisis stage, yet 38% of clergy wives in King's (2003) study didn't seek any form of help during this stage. King suggests that this may be due to an attitude of silence that often surrounds the pastorate. As this stage ends, women gradually let go of detective behaviors toward their husbands and begin focusing on themselves.

The shock stage (Milrad, 1999) brings numbness, yet also a cautious optimism about the future. As the addict displays commitment to recovery, detective behaviors further decrease. As this phase ends, "thawing" occurs as the wives begin to be more aware of their emotions and take risks. Many report attending marital therapy or Couples Anonymous. The last stage (grief) leads to growth through exploration of losses and a focus on gaining insight from the past (e.g. traumas, family of origin, relationships, etc.).

Discussion. Schneider (2000b) focuses on the importance of assessment in her discussion. She suggests that a spouse's complaints about cybersex may simply be a reflection of her own discomfort, although it may be a sign that cybersex is a problem. In many cases, therapists' attempts to be nonjudgmental often cause them not to address addiction. Schneider suggests that a thorough sex history (including beliefs about sex, pornography, and masturbation) should be taken when concerns are expressed. Some therapists had never heard of sexual addiction and recommended ineffective problem-solving behaviors (e.g. have more sex with your partner).

Milrad (1999) suggests that the discovery of sexual addiction is similar to posttraumatic stress disorder (PTSD). She suggests that the PTSD symptoms should be addressed first because the spouse is in trauma, helping the spouse to focus on regaining control of herself. This initial focus on resolving trauma may be particularly crucial given the process of discoveries of acting out, promises to do better, broken promises, rediscovery (Schneider, 2000b), and broken boundaries (King, 2003) that often occur before and during treatment. Milrad suggests that, marital therapy should help the spouse to differentiate from the addict, and Schneider (2000b) and Milrad both suggest empowering the partner to focus on her needs and recovery. King (2003) suggests that this may require challenging the magical thinking (e.g. pray harder and I can fix it) that many clergy wives reported. Commitment to her own recovery, however, is tied to hope of rebuilding the relationship (Milrad, 1999). Milrad suggests that the addict should be learning new coping skills for their addiction during this early stage of couple therapy. Clergy wives (King, 2003) reported the use of prayer and scripture study as specific coping strategies. In terms of helping the addict, Schneider (2000b) suggests that it is not

generally useful for the spouse to be the “keeper” of the computer; this is better left to the addict’s therapist or sponsor. Schneider also suggests that such negative-oriented methods for preventing addiction (filters, limiting computer use, etc.) are not generally successful in the long-term if they are not accompanied by positive recovery-oriented activities; however, she does not delineate clearly what those activities might be.

Couple therapy can also help partners be aware of each other’s thoughts, perspectives, issues, and struggles (Milrad, 1999). Couple therapy could be a forum for addicts to learn to identify and share feelings and create a communication bridge. Bergner and Bridges (2002) suggest that addicts are trying to repair their self esteem by creating scenarios that, if they were to happen in reality, would lift them from a degraded status to a new position of triumph (or so they believe). Unsuccessful attempts lead to further degradation, which lead to additional attempts, and so on. This view of the addict, they suggest, will help the spouse to see that the addiction is not about them. As spouses experience the addict in this new light, they are able to abandon the view of their partner as a pervert and begin to see him as a man who is decent in many ways but who is in a pathological state. Understanding her partner’s problem helps her to deal more effectively with it, be more objective and less emotionally reactive, and feel less devastated.

Bergner and Bridges (2002) suggest that therapy can then focus on helping partners change previously ineffective problem-solving behaviors. Therapy can help the spouse focus on defining her own personal limits, communicating those to her partner (not as an ultimatum but as preserving her own dignity), and taking actions up to and including separation to maintain boundaries. Milrad (1999) suggests that as PTSD symptoms subside, a shift toward insight-oriented therapy may be more appropriate.

Couples

Sampling. All three studies addressing couple issues related to sexual addiction were convenience samples. Two were quantitative (Schneider, Corley, & Irons, 1998; Schneider & Schneider, 1996) and one was mixed methods (Schneider & Schneider, 1990b). Schneider and Schneider (1996) use a sample of 54 couples where both partners reported individually on their shared marriage and an additional 34 respondents who reported individually on their marriages. Schneider et al. (1998) sample 48 couples where both answered the questionnaire, 34 with partner-only respondents, and 34 with addict-only responses. Schneider and Schneider (1990b) sample 22 marriages (18 couples represented by both partners and 4 by only one partner). Because all of the men in this study are committed to maintaining a monogamous heterosexual marriage, the findings are limited to this population. All reports in these articles are based on the entire sample, but only those surveys where both partners respond are useful for couple-comparisons and verification of information. All authors list demographics (as percentages mostly), but no means or standard deviations were reported. Race/ethnicity was also not reported.

Design. All three studies used mail surveys with open-ended and forced five-point Likert scale questions, and each listed examples of each type of question in their reports. Response rates are given for two studies: 35.5% (Schneider & Schneider, 1996) and 16% (Schneider et al., 1998). However, the authors in these studies are uncertain if all the surveys that were distributed to therapists were given to clients for completion. In addition to their survey, Schneider and Schneider (1990b) also interviewed three couples by telephone. No details about the interviews are given, thus restricting the inferences one can make from the interview findings.

Results. Schneider and Schneider (1996) report that trust increases with time and consistency in the addict's behavior. Setting limits and boundaries was a consistent problem, but 82% of respondents reported having a plan to deal with boundary violations. When asked if they agreed on what sexual limits were, 1/3 of couples (where both partners responded) disagreed about whether or not they had an agreement. Many partners required over a year to forgive their addicted spouse. Interestingly, reports showed that more forgiveness was given by partners than the addicts predicted. While some spouses reported no change or worsening their sexual relationship, the majority (74% for men and 66% for women) reported improvement. Most couples reported resolving their sexual problems through improved communication, individual and/or marital counseling, and 12-step programs.

Schneider et al. (1998) report that, over time, disclosure was seen by both partners as the right thing to do, but at the time of disclosure addicts were significantly less convinced that disclosure was ($p < .001$). The authors suggest that disclosure is a process which usually included several disclosure events, but also said that staggered disclosure is damaging to trust. Partners felt that honesty was crucial, yet addicts that are further in recovery had a greater chance of relapse and reported being less honest than those in early recovery. While partners initially felt they should be the ones to decide how much was told, partners further in recovery recognized that gaining more knowledge about the addict's behavior did not give them power to control the addict or the situation. Spouses reported wanting more support from peers and counselors at the time of disclosure. Finally, addicts and spouses reported several common factors which were helpful in recovery, including (percentages for addicts are listed first): therapy/counseling (49%,

58%), 12-step meetings/groups (40%, 50%), spirituality/religion (38%, 47%), the 12-step program or “the program” (33%, 30%), relationship with partner (31%, 28%), and friends/recovery friends (28%, 41%). In terms of statistical analyses, both articles reported only percentages (except the statistically significant finding already cited).

Schneider and Schneider’s (1990b) found that bisexual men and their wives experience very similar emotions compared to what is reported for most sex addicts regardless of sexual orientation, with the addition of the risks of HIV. In addition, almost all wives sought out 12-step programs to help deal with the extreme isolation they felt due to the bisexual nature of their husband’s addiction. Finally, success in adjusting to monogamy depends on the strength of the husband’s sexual identity as well as his commitment to the marriage. No statistical analysis was reported for the quantitative data.

Discussion. Schneider et al. (1998) suggest that disclosure, while initially painful to the spouse and scary to the addict, is seen as helpful in improving both the relationship and the addiction. Several disclosures might occur because of addicts’ fears of what will happen if they tell everything initially, but multiple disclosures may also occur because addicts often don’t remember everything or don’t deem certain facts or events important initially. Also, the reports of less honesty for addicts that are further in recovery suggests that relapses are often hidden and will require additional disclosure at some point.

Schneider et al. (1998) indicated that most spouses react with threats, but threats do not prevent relapse. In fact, threats are usually counterproductive because addicts often withhold important details due to fears of losing the relationship. The authors suggest that helping the spouse to set boundaries with appropriate consequences may

allow the addict to feel more open to disclosing/being honest. Finally, they found that an addict's willingness to be open and honest was crucial for healing from sexual addiction.

Schneider and Schneider (1990b) mentioned no interventions in their discussion; however, both Schneider et al. (1998) and Schneider and Schneider (1996) suggested that individual and/or group therapy might be more effective than marital therapy initially. These findings may be biased due to the fact that the sample was taken from 12-step groups which focus on healing the individual.

Conclusions

Based on the reports in many of these studies that therapists often lack understanding of sexual addiction, I offer a brief overview of the process of couple recovery based on the findings and recommendations of the authors in the articles I reviewed. As pointed out previously, because of the convenience sampling and significant methodological flaws in many of these studies, these recommendations should be considered tentative until further research is available (including outcome studies).

Discovery and Trauma

Although there are differences in the experience of sexual addiction across gender and sexual orientation, in general the addictive experience appears to be far more similar than different. Regardless of etiology, all addicts continue to participate in sexual behaviors despite negative consequences to their personal life and relationships. Generally, addicts experienced shame and isolation as a result of their behaviors but could not stop them.

Despite these negative consequences (and perhaps because they wanted to avoid further negative consequences), addicts continued to hide their behavior from their

spouses. Thus, many spouses are unaware that the sexual addiction occurs. Partners sense that something is wrong generally and feel a distance in their relationship with their addicted partner, but they are unable to identify what was causing those feelings. Gradually, they engage in detective behaviors until they discover their partner's addictive behaviors. None of the studies relate an experience where the addict revealed the behavior prior to being caught by their partner.

When the sexual addiction is discovered, women report feeling sad, hopeless, overwhelmed, betrayed, isolated/alone, angry, traumatized, and confused about whether to stay in the relationship. Spouses who experience both on-line and live affairs report that they feel the same degree of hurt for both types (Schneider, 2000b). They engage in behaviors that they hope will reduce the likelihood of acting out, including more intense detective work, bargaining, increased sex (and sexual repertoire), lingerie, makeovers, and so forth. Most women enter therapy when these efforts are unable to change the partner's addictive behavior.

Role of the Therapist in the Process of Healing

Whether in individual or couple therapy, therapists should pay attention to symptoms which may suggest that sexual behaviors are negatively impacting the individual, partner, or couple. When these cues arise, therapists can probe further. This is particularly important when a spouse discloses a concern about his/her partner's sexual behavior. If therapists discount the partner's concerns in an attempt to be nonjudgmental about the sexual behaviors, the partner may feel further isolated. The finding that addicts' partners wish they had more assistance from therapists (Schneider et al., 1998) suggests that therapists are not validating the experience of spouses in therapy. If probing discloses

further behaviors, a complete sexual history can identify if a sexual addiction is present. For more detailed assessment information, see the “discussion” heading in the “Addicts” section of this article.

Therapists who are not experienced with sexual addiction tend to suggest that they are willing to work on whatever the clients want to discuss; however, therapists who are experienced in working with sexual addiction work on the addiction first (Swisher, 1995). Working on the relationship or other issues without resolving the problems related to the addiction may undermine progress in therapy.

While addicts and spouses may show some hesitance due to the possibility of negative experiences (trauma to the partner and loss of relationship for the addict), spouses’ reports suggest that disclosure was necessary and helpful (long-term) in improving the relationship and recovering from the addiction. Partners who are further in recovery suggest that gaining more knowledge about the addict’s behavior does not give them power to control the addict or the situation, and often times too much detail can be more traumatic than helpful. Because disclosure of certain details may create/exacerbate PTSD symptoms, the therapist should help the spouse carefully consider potentially negative consequences of collecting too much information. After careful consideration, the therapist should promote appropriate disclosure and especially avoid colluding with the addict in being secretive or dishonest with the partner. Therapists can warn the addict that future disclosure of things they choose to hide now can destroy progress in therapy and potentially permanently end the relationship. While this will not prevent addicts from hiding information, it may facilitate more openness. As necessary, individual sessions

may be appropriate for deescalating negative emotions. As therapists are sensitive, they can facilitate a process of disclosure that helps maintain and improve the relationship.

If disclosure occurs prior to therapy, most spouses have already reacted with threats to leave and other ineffective (and often detrimental) problem-solving behaviors. These findings suggest that threats do not prevent relapse and, in fact, are usually counterproductive because addicts often withhold important details due to fears of losing the relationship. Instead, therapists can help partners to set appropriate boundaries with consequences (up to and including separation) that will perhaps allow the addict to feel more open to disclosing/being honest. Schneider and Schneider (1996) suggest that trust increases with time and consistency in the addict's behavior for these couples, a process that can be facilitated, as Milrad (1999) suggests, by helping the couple become more aware of their own feelings and learn to share these feelings with each other. Therapists can continue to help the couple increase trust by facilitating boundaries and managing future disclosures. While relapses are mentioned in these articles, there is very little discussion of how to handle relapses (other than those related to disclosure).

In terms of general treatment approaches, therapists recommend contracting, anger management, cognitive restructuring, confrontation, defining sexual sobriety, defining behavioral boundaries, empathy, and grief counseling as treatments (Swisher, 1995). Schneider (2000a) recommends reading, making the computer safe (cleaning off images, using blocking services, changing the location to a highly visible place in the home), and combating isolation through increased time with partner/family, friends, fun activities, sports, exercise, etc. Prayer and scripture study were also useful (King, 2003).

Marital Therapy

Many authors either directly or indirectly suggest that there are couple and/or relationship (e.g. interpersonal sensitivity) factors related to sexual addiction. Despite the connection of sexual addiction to relationships, most authors fail to discuss marital therapy as even an option. A relatively small number of authors suggest that marital therapy could be helpful, and even fewer authors offer ideas for marital interventions (Milrad, 1999; Schneider, 2000a). Most authors tend to work from the perspective expressed by Schneider and Schneider (1996) that individual recovery is the basis of building healthy relationships. Some even suggested that beginning with marital therapy could be detrimental (Schneider et al., 1998; Schneider & Schneider, 1996). This stance is understandable given the tendency of many therapists to ignore cues to sexual addiction and focus, instead, on the relationship.

From a systems perspective, however, an equally cogent argument is that both relationship and individual well-being influence each other. The fact that relationships are one factor in creating and/or maintaining sexual addiction suggests that healing the relationship may assist in the process of recovery. Milrad (1999) suggests that couple therapy should include both individual recovery (for the addict and spouse/co-addict) and couple issues (stabilization) simultaneously. Indeed, a more stabilized marriage (with improved trust and openness) may aid in a more rapid recovery, based on the findings that suggest that relationship fears often prevent the addict from being honest (an essential element in healing from sexual addiction).

Additionally, couple therapy allows both partners to be a part of each other's healing process, sharing feelings with each other, and learning to be more open, factors which may facilitate a more rapid growth in trust. The number of divorces reported in

some studies (Milrad, 1999; Schneider, 2000a) appears to be an indicator of how much sexual addiction can impact marriages. Marital therapy, provided by competently trained therapists, gives couples another resource in their efforts to maintain their relationship as they recover from sexual addiction.

Finally, when group therapy is not a good fit for clients (Wan et al., 2000), couple therapy may be an effective avenue for normalizing each partner's experiences. Couples may prefer to deal with the problem privately through marital therapy before going to a more public forum. Schneider (2000b) suggests that the addict's partner not be responsible for monitoring the computer or the addict's behaviors. She suggests that the therapist and/or group can do this. Eventually, the previously detrimental detective behaviors can be transformed to help spouses support the addict in his/her recovery.

CHAPTER III

Methodology

Despite the obvious link between relationships and sexual addiction (including the trauma the partner experiences and the potential for divorce after disclosure), the role of MFT's in helping couples through the recovery process is sparsely discussed in the articles included in this review. While the literature provides some guidelines to therapists, no empirical studies focus directly on how couple therapy can help couples in the process of recovery. Therefore, this qualitative study will explore in depth the critical change processes in couple therapy for sexual addiction from the therapist's perspective, including the therapist's role in that process.

Design

Due to the limited empirical exploration of couple therapy and therapist behaviors which facilitate recovery from sexual addiction, I used a qualitative approach for this study. I used structured interviews with open-ended questions and analyzed the interview data using a qualitative, group hermeneutic or interpretive approach. Qualitative research, and in particular the group hermeneutic/interpretive approach to qualitative data analysis, is an effective methodology used to collect, analyze, and interpret data concerning marital, family, and other interpersonal relationships (Benner, 1994; Chesla, 1995; Gale, Chenail, Watson, Wright, Bell, 1996; Odman, 1988; Packer & Addison, 1991; Wright, Watson & Bell, 1996). Additionally, qualitative methods are also well-suited for developing a holistic and processual view of complex phenomena (Gale et al., 1996), such as the process of recovery from a sexual addiction and therapy process. Finally, qualitative methodology "allows extensive probing in areas that have not been well

studied ...” (Rosenblatt & Fischer, 1993, p. 173) and can help to uncover what lies behind a phenomenon “about which little is yet known and can give the intricate details of phenomena that are difficult to convey with quantitative methods” (Strauss & Corbin, 1990, p. 19).

Thus, qualitative methods are uniquely suited to the study of the process of recovery from sexual addiction, including therapist behaviors. Holistic and processual qualitative investigations provide clinically relevant and applicable data, are theoretically fruitful, and are potentially useful for guiding future quantitative investigations. In addition to these advantages, a qualitative design avoids prematurely foreclosing any possible perspective and details relating to the dynamic being investigated (Ezzy, 2002).

Participants

Participants were 15 therapists who self-identified as therapists who work with clients who struggle with sexual addiction and who, at some time, have seen couples as part of their work with sexual addiction. I made contact initially with therapists who I know (or who are referred to me through contacts) as well as through the membership list of The Society for the Advancement of Sexual Health (SASH). I then used a snowball sampling procedure to obtain the remaining participants. Participants were informed that the purpose of the study was to investigate how therapists can better help couples who have been negatively impacted by one or more partners’ struggle with a sexual addiction. After the initial contact, I sent a letter (or email) to the participants to review the material covered in initial contact. The letter also invited them to choose a specific couple they have worked with whom they consider to have had success in recovery from sexual addiction and to be prepared to discuss that case in the interview (see Appendix A). I

asked therapists to choose one specific case so that they could focus in-depth on one specific successful process of change, and I invited them in later interview questions to consider the process of change more generally so as to not exclude other important aspects of change not related to the specific couples. I also enclosed a copy of the interview questions in an effort to give therapists the necessary time to consider the questions with regard to their case and their experiences, thus providing opportunity for more in-depth responses and reduced interview lengths, and also allowing therapists who had less time available for the interview to decide which questions they wanted to give more attention.

Procedures

At the beginning of the interview, I read each therapist a statement (see Appendix A) which provided them with an explanation of the research project (that it specifically investigated therapists' perspectives about therapy with couples who have been negatively impacted by one or more partners' struggle with a sexual addiction) and explained the procedures I would follow throughout the interview. Each participant also completed an informed consent form (see Appendix B).

I conducted one in-depth interview with each therapist, lasting between 50 minutes and 2 hours. The interview focused on what constitutes successful recovery, significant change events or turning points in the couple process of recovery from a sexual addiction, the role the therapist plays in facilitating that process, and any other factors that may have contributed to their success. I conducted interviews with therapists either in person or by phone, taped, and later transcribe the interviews. Interview proceedings, tapes, transcripts, and all handling of the data were kept strictly confidential.

Each therapist was asked to complete a brief demographic questionnaire after the interview (see Appendix B), of which 12 responded. Based on the interviews, 12 therapists were female (of which 9 responded on the demographic sheets) and three were male. Based on the demographic questionnaire, the average age of the therapists was 53 and the ages ranged between 31 and 64. Eleven therapists were Caucasian and one was Asian. Nine therapists were Christian, and the remainder reported having “all religions,” nature as a religion, and being Unitarian/Universalist. On a scale of 1-5, therapist reported an average religiosity of 3.6 (ranging from 2-5) and a spirituality of 4.6 (ranging between 4 and 5). Therapists had practiced between one and 20 years (average of 13.5 years) and practiced therapy with sex addiction for an average of 8.8 years (ranging from one to 17 years). They carried a 65% case load of sex addiction cases average (ranging from 10 % to 90%), of which the average of 55% were couple cases (ranging from 2% to 90%). Nine therapists had master’s degrees and three had doctorates. Four were trained in marriage and family therapy, two in psychology, five in social work, and one as an addictions counselor. Therapists reported having the following theoretical orientations (various therapists reported using several of these theories): narrative, Bowenian, family-of-origin, solution-focused, Gottman, attachment theory, systems, addiction, humanistic, cognitive behavioral, structural/strategic, and Gestalt/experiential. Therapists were located throughout the United States, including Texas, Minnesota, Arizona, Colorado, California, and Utah.

Measures

The structured interview consisted of open-ended questions which I formulated so as not to direct participant’s thinking in any way, unless it is necessary for question

clarity. I began the interview by asking how the therapist measures success in therapy for sexual addiction. I then asked questions about critical change events with the specific couple, how the therapist facilitated these events, what other factors impact success in therapy, and how couple therapy is different/same from other approaches. Finally, questions addressed critical change processes generally. In order to ensure thoroughness and a more complete understanding of the process of recovery, I closed the structured interview by asking about any other therapist behaviors which seemed helpful as well as any other important information that might have been missed during the interview. The central research questions are the following: (a) How do you measure success in couple therapy for sexual addiction? (b) What are critical change events in couple therapy for sexual addiction? (c) How does a therapist facilitate these critical events in therapy? (d) What other factors impact success in therapy for these couples? (e) How is couple therapy with sexual addiction the same/different from other approaches? See Appendix B for a complete copy of the interview questions and Table 2 for an overview of the central research questions and associated interview questions.

I have participated in qualitative interviewing previously (Butler, Gardner, & Bird, 1999; Bird, Butler, Fife, 2007) and conducted the interview in such a manner as to avoid creating demand effects, insofar as possible. Where restating questions was necessary, I made every effort to not adjust the context or tone of the question. While this does not preclude the possibility for subtle effects which can occur as a result of the interviewing process, it does constitute a reasonable attempt to protect against the same.

Table 2

Central Research Questions and Related Interview Questions

Central Question	Question Number (and Sub-concepts)
How do you measure success in couple therapy for sexual addiction?	1 (overall success) 2 (initial progress)
What are critical change events in couple therapy for sexual addiction?	Couple specific: 2, 5 (main challenges), 10 General: 11
How does a therapist facilitate these critical events in therapy?	2, 3, 5, 6 (balancing individual and couple recovery), 7
What other factors impact success in therapy for these couples?	4 (client factors) 9 (experiences outside therapy)
How is couple therapy with sexual addiction the same/different from other approaches?	5 (couple vs. individual) 8 (sexual addiction vs. affairs)

Analysis

I used a group hermeneutic/interpretive approach to the interview data, conforming to guiding principles described by Gale et al. (1996) and specific procedures outlined by Wright et al. (1996). Hermeneutics was initially used solely for interpretation of biblical texts, but the term is used more widely now to refer to the art of interpretation generally (Ezzy, 2002). While hermeneutics seeks for individual meaning-making/interpretation, in a group hermeneutic approach individuals discuss their individual findings and struggle together in a combined meaning-making experience (Gale et al., 1996). Four analysts examined the interviews. The inclusion of multiple analysts in the hermeneutic process provides triangulation and a more holistic picture arising from the contributions of multiple perspectives. Additionally, I seek to control against premature foreclosure of interpretive possibilities arising from individual forestructures and world views (Ezzy, 2002) by the inclusion of other analysts, three of which were previously unassociated with the project in any way. I also attempted to choose analysts with different backgrounds.

The forestructures of the analysts were as follows: (a) a 32-year-old Christian male licensed marriage and family therapist with 7 years experience working with sex addiction, (b) a 53-year-old Christian male licensed clinical social worker with five years experience treating sex addiction and one year of post-graduate training in structural family therapy at the Philadelphia Child and Family Therapy Institute, (c) a 25-year-old Christian female graduate student in marriage and family therapy, with two years experience in working with sexual addiction and clinical training in solution-focused therapy, (d) a 25-year-old female graduate student in marriage and family therapy, with

nine months experience in working with sexual addiction and clinical training in solution-focused therapy. See Table 3 for an outline of the methods of improving the credibility, trustworthiness, and transferability of this study's findings.

Phase 1

Analysis began by distributing transcripts to each analyst as well as both written and verbal instruction to familiarize them with the different phases of the analysis (see Appendix A). Each analyst read the transcripts completely through one time independently in order to obtain an overall picture of how the participants responded to the interview questions. Each analyst then did a second independent reading of the transcripts, extracting and highlighting highly recurring themes. Following the second pass, each analyst prepared an individual summary of the major themes s/he extracted from the transcripts. I then distribute individual summaries to all other members of the team. No discussion of the data among the analysts occurred prior to this time.

Phase 2

The analysts then met together to share their individual summaries and, using a group hermeneutic/interpretive process, reached a consensus regarding the major themes represented in the spouse interviews. In an order established by random lot, each analyst represented to the group the themes that s/he feels are most prominent. Once the analyst described an observed theme, s/he defended it by reference to supportive material in the interview transcripts (transcript data supportive of observed themes were "coded" or highlighted carefully by each analyst). Cross-sectional support was emphasized in order to establish a theme. Other analysts interjected for clarification or to detract. Whenever a consensus developed regarding a particular theme and its articulation, it was put to a vote.

To be considered a major theme, result, or “finding,” all four researchers had to concur; otherwise it was discarded and no longer considered.

Phase 3

Once the analysts attained consensus regarding the major themes, phase three began. Each analyst conducted a third analysis of the transcripts, individually searching for further information and clarification of consensus themes. Each analyst recorded elaborations, refinements, and clarifications of these themes in individual summaries, as well as possible exceptions to the themes. Additionally, each analyst returned to the interview data to “code” or highlight transcripts in terms of the themes. Following completion of the entire data analysis, I “coded” or highlight both transcripts in terms of the consensus findings.

Phase 4

During the final phase, each analyst shared his/her individual summaries from phase three, and the group hermeneutic/interpretive process was repeated. Again, analysts substantiated and defended their clarifications and refinements by reference to the interview data, emphasizing cross-sectional support. Where applicable, possible exceptions to the themes were discussed and alterations or amendments were made to the associated themes. The analysts also outlined how each theme interacted (processually) with other themes. In this manner, we identified, elaborated, refined, and clarified the major themes from the therapist interview transcripts. This process of repeated triangulation helps to enhance consistency of the findings. I tape record both the Phase 2 and Phase 4 group hermeneutic discussions.

Table 3

Methods of Improving Credibility, Trustworthiness, and Transferability

Credibility: How readers know if the results are consistent with the data.	Trustworthiness: How readers know that the researcher's findings can be trusted.	Transferability: How readers know if the study's findings might relate to the circumstances of others.
Triangulation of data Therapist interview data Disclosure of analysts' forestructures	Triangulation of data Therapist interview data Investigator triangulation Multiple analysts Analysts not previously associated with the study Disclosure of analysts' forestructures	Triangulation of data Therapist interview data Extant literature (multiple theories) Thick description

CHAPTER IV

Findings

Findings of this study consist of consensus themes and elaborative sub-themes extracted from the interview transcripts by the researcher-analysts. All themes and sub-themes represent a consensus of all four analysts. Significantly, the individual findings presented by each of the four analysts at the beginning of the first group hermeneutic meeting were highly consistent with one another. The bulk of the consensus-building work centered on the elaboration and refinement of the major themes, and on the best articulation of themes and sub-themes.

The findings consist of three major sections: (a) individual responsibility in recovery (which includes the sub-themes of trauma, family-of-origin, emotional reactivity, depersonalizing, and utilizing other resources), (b) couple recovery (which includes the sub-themes of family-of-origin, communication, empathy, intimacy, trust, and sexual intimacy), and (c) balancing individual recovery with couple recovery in the process of healing (which includes the sub-themes of education, accountability, and couple perspective). One additional theme, affairs versus sexual addiction, was deemed to be important but not contained within the broader three categories; therefore it is addressed at the end of the findings section. See Table 4 (Sections and related themes) for an overall summary of the findings. I organize these findings linearly in order to more clearly illuminate the different themes and their interactions; however, analysts indicated that these themes did not necessarily occur sequentially. While the analysts agreed that some component of individual recovery occurred first, components of couple recovery

Table 4

Sections and Related Themes

Section	Themes
Individual Responsibility in Recovery	Trauma Family-of-origin Emotional Reactivity Depersonalizing Utilizing Other Resources
Couple Recovery	Family-of-origin Communication Empathy Intimacy Trust Sexual Intimacy
Balancing Individual Recovery with Couple Recovery in the Process of Healing	Balancing Individual and Couple Recovery Process Education Accountability Couple perspective
Affairs Versus Addiction	Affairs Versus Addiction

began to unfold almost simultaneously, with each affecting the other throughout the process, thus requiring continual attention to balancing the process of healing.

Individual Responsibility in Recovery

Analysts indicated that the process begins as each partner works to recognize and take responsibility for his/her individual issues, thus taking individual responsibility in recovery. I highlight the process that therapists described their clients' going through in order to take individual responsibility as well as the therapeutic interventions that facilitated that process. The analysts indicated that this section begin by addressing trauma, because the therapists in this study regularly referred back to trauma (past and present) in their discussion of many other themes. I then review the impact of family-of-origin (a portion of this theme is also connected to couple recovery later). The next theme I discuss is the role of emotional reactivity, followed by the process of depersonalization. I then address the importance of outside resources on individual recovery, and conclude this section by outlining the role of boundaries.

Trauma

Nearly every therapist in the study mentioned some form of trauma that their clients encountered. I first address traumas outside the family and then discuss traumas and issues related to family-of-origin. One therapist noted that the extreme level of trauma encountered with couples that struggle with sexual addiction issues:

And the level of trauma with these clients is significantly greater than any of the other people we've seen. A lot of our referrals are from therapists who say, "I don't know what to do with them. I think they're a hopeless case." And they'll come in and [we'll] turn around and look at each other like, "This is who we see all the time."

One therapist noted that “the attachment people talk about “big T” and “little t” trauma...” “Big T” traumas that therapists in this study mentioned included physical abuse (by a partner), sexual abuse, and neglect/abandonment. “Little t” traumas included a traumatic first sexual experience, peer ridicule, and traumatic “repercussions” around being truthful (historically).

Additionally, the trauma due to the sexual addiction was a “little t” trauma for both spouse and addict. One therapist suggested that exposure to pornography (whether initiated by the addict or others) at a young age is traumatic for addicts:

There’s a... really intense [exposure] to pornography or sexual stimulation, prior to puberty where they locked on like a moth to light... I call it blowing the circuits. Sort of the brain isn’t ready for it. The person hasn’t had their own sexual experience yet in the full blown form, so they don’t know what to do with it.... it wasn’t fair that they were overwhelmed by the stimulation at a time when they couldn’t process it cognitively... So in a way it’s like a one shot trauma that never leaves them. They might have even been introduced to this by a brother or a neighbor. But that that [sic] wasn’t their choice. Had they chosen it, they would not have wanted something so overwhelming that they didn’t understand and that they couldn’t control... From a very young age our arousal templates are shaped and influenced, and sometimes we’re not even aware consciously what goes into them. And I really fear for men that have had their arousal templates distorted and twisted and deeply impacted by pornography, especially pre-puberty pornography exposure.

Thus, early exposure to pornography can be so traumatic as to cause unmanageability and/or affect addict’s arousal templates negatively. For spouses, their experience of the sexual addiction was traumatic for several reasons. Spouses often felt like their lives were “spinning out of control” as a result of the discovery of the addiction, including the uncertainty caused by constant lying/covering up both before and after the initial disclosure. Spouses felt “fearful of being ostracized” and very isolated. When some reached out for help, they were further traumatized.

The minimization of the problem, the being told to, “Well, just pray about it.” And she also was told to have sex with her husband more often, which was very traumatizing to her. When an authority figure tells you, “If you just had sex with your husband more often this wouldn’t be a problem,” she left there feeling blamed. She felt very traumatized. She did not feel safe to be with her husband sexually. So she had some challenges from outside sources that made that harder.

Thus, both the process of disclosure as well as some experiences encountered while trying to reach out for help were experienced as traumatic for spouses.

One therapist noted the consequences of trauma for the addicts and spouses she worked with: “...these people come out of pretty highly traumatized backgrounds so typically with the men you have guys that are dissociative and narcissistic and the women who are hyper-vigilant and they have some borderline traits...” Thus, a history of trauma was linked to sexual addiction and was linked with negative long-term outcomes.

Interventions. Several therapists suggested interventions for trauma that helped facilitate individual recovery. In some cases, just going back and discussing the trauma was all that was needed for resolution. Another intervention for processing trauma was the use of Eye Movement Desensitization and Reprocessing (EMDR) therapy.

And he tried some EMDR...to kind of help with some of the trauma typing that had occurred when he was a child that made him feel so incapable of making an impact, because he wanted to do some sales and he wasn’t able really to get the confidence to do that. And so he was willing to take some chances that he had never done before.

Thus, EMDR had a positive impact for this addict in increasing his willingness to take risks he had not taken previously due to feelings linked to past traumas.

Other therapists suggested having clients write a life story or time-line. One therapist shared how he facilitated that process.

...the guy will actually do the 4th step of the 12 steps. I have the guys write out their sexual history... And say, “I want you to write out all your behaviors that you can remember: all the traumatic, all the positive, all the good things in your

life. Just write a brutal history of who you are... what always seems to happen is that as they start to unload all this sewage all of a sudden some key pieces start to fall into place and they go, "Oh yeah, I was molested by this babysitter," or "Oh yeah, my dad took me to this strip club," or "Yeah, I started drinking when I was a lot younger than I thought." So, a big piece of the whole thing is whether or not they can work through this brutal assessment of their whole life.

This therapist considered the life story (linked with the fourth step) as a critical component of individual recovery. In a similar vein, one therapist suggested using a "trauma egg" or "life egg":

Pat Carnes... calls it a "trauma egg". I call it a "life egg." And just have people do this huge sheet of paper with this oval shape that they draw little things from their childhood and their adulthood that were significant to them both positively and negatively. And then put the family rules and the family roles onto that sheet of paper. And what always develops from that is that you can see the themes. Like for this woman, throughout her life, there were themes of having to be perfect, being criticized in all areas of her life. And so usually a couple of themes emerge for each person...

Thus, completing a life story, timeline, or trauma/life egg helped both addicts and spouses access past traumas in a helpful, healing way.

One therapist found it helpful to use three hula hoops on the floor to represent each individual recovery and the couple recovery. She would have each individual stand in their own hula hoop to discuss things related to their own recovery.

It's a very concrete thing of putting them into their own hula hoop and really asking them to stand there and talk about some of the things from their childhood, some of the wounds, even if you didn't come from a dysfunctional family, some of the things that they bring from that process... So I think the visual thing is really helpful... And so usually a couple of themes emerge for each person, and that's usually the theme that they have in their hula hoop that the other person... is triggering.

Thus, using the hula hoop concept helped set visual boundaries that allowed individuals to stay focused on their own issues in recovery rather than blaming it on the partner.

Family-of-origin

Varied levels of trauma also occurred within the context of the family-of-origin. Therapist reported that traumas in the family-of-origin included: alcoholic parents, multiple marriages/divorces, suicide in the family, sexual abuse, religious shame (abuse), and being adopted. Additionally, therapist reported that clients had high expectations with low support in their family-of-origin as well as poor modeling of appropriate coping behaviors. One therapist shared how these trauma-based backgrounds set the context for the coupleship.

...her mother was a diagnosed bipolar and had actually had a psychotic break when she was in high school. So she had to grow up very rapidly and had to start taking on the parentified role.... his father left his mother when he was like 8 or 9, and his mother had to go to work and couldn't afford a sitter. So he was left at home to his own devices, and that's actually when he kind of got into using masturbation as a way of soothing, self-soothing. He would sit in front of the TV and masturbate for hours... to try to self soothe as a child.... both of them had had... a feeling of being left..."

Thus, family-of-origin had a significant impact on both spouse and addict, leading to both the addictive and codependent behaviors.

Interventions. Specific interventions related to understanding family-of-origin issues were suggested by several therapists. One form of intervention was simply talking about the family and exploring how that impacted the client:

We also talked about how his mother and Dad showed affection... what was done at his household. His grandparents didn't live very far away, and how did they show affection, and what did they think? Did he have a religious idea of what was good and acceptable and what wasn't? And once we started going through that, yeah, he had come from a [religious] family, and it [sex] was considered shameful...

Several therapists also mentioned the use of genograms in accessing and processing family-of-origin issues. "I have them do a genogram... and list out all the addictions within their family and where they have essentially picked up a lot of their core

beliefs...” Another therapist shared how a genogram brought awareness that the client was carrying her mother’s sadness. The client was able to then decide, “I’m not going to do that any longer. Because it doesn’t belong to me. It belongs to my parents, and I’ve carried it around long enough, and I don’t need to carry it around any more.” Thus, therapists can use genograms to help clients identify addictive patterns, core beliefs, and other issues that help addicts or spouses prevent old patterns or roles from occurring in the present.

Letter writing and empty-chair work was also suggested to be a helpful process for one client as he worked to resolve issues with his father and step-father.

And he did more healing around his step father. He never really liked him but at least he doesn’t feel so much animosity toward him... I had him do letter writing. He talked to his, put his stepfather in the chair and told him how angry he was and humiliated he was by his behavior and how much it hurt. And also his biological father he had to do some letter writing and grief work around that also.

The interventions of letter writing and empty-chair work successfully helped work through the addict’s feelings of anger, humiliation, and grief in his family-of-origin.

A few therapists suggested helping clients to access their feelings in the present and related them to the past. One described the process this way: “... just the whole thing of when he’s in that place, ‘How old do you feel? And what’s that connected to in your family-of-origin...?’” Thus, this therapist accessed the emotional state in the present, relating it to how old the client feels in the present, and connecting that to the family-of-origin. Behaviors of others in the present may also help clients access feelings that can help them to process family-of-origin traumas. One therapist noted that that affair of a wife (reacting to her own pain about his infidelity) was an unintentional intervention that helped the husband heal.

...the bottom line fear that was underlying his addiction... was his fear of abandonment: that he had been abandoned as a child by his father, and he had always feared that. And when he was being abandoned by his wife it, it just totally opened him up to the pain that he had been feeling not only from his wife's infidelity... but he was also was able to get in touch with the child part of him, the wounded child. So the healing began.

Thus, feelings of abandonment in the present related to the wife's affair opened up a process of healing related to his fathers' abandonment in the past. Another therapist helped feelings in the present connect with family-of-origin issues in this way:

Really going, "O.K., was there ever a time when you felt like this as a kid?" Satir, has what she calls the "iceberg model" and we use that a lot. Taking the iceberg, the tip of the iceberg is above the surface, and that's the problem. But that's really not the problem. And so really working them through with any issue I immediately bring out the iceberg model and say, "Well, it's really not the issue."

When issues arose in the present, this therapist helped clients relate it back to their childhood, noting that present behaviors are linked to larger, underlying issues from the past via the use of the iceberg model.

Emotional Reactivity

Due to unresolved past/present traumas and family-of-origin issues, many therapists reported that both the addict and spouse had such high levels of emotional reactivity that they struggled to take responsibility for their individual recoveries. One therapist noted how individuals struggled to contain their emotional reactivity, wanting instead "to just move [their] emotional distress to how much the partner's emotional distress is." One therapist described the emotional reactivity in this way:

... they're just like so uncomfortable with their own emotional state and the other person's emotional state... they're both like just so distressed that they're having an amygdale hijacking... that's a Daniel Goldman description about what happens to you when your old brain takes over from your new brain, and that there's no way to make your high functioning part of your brain go, "OK, what's really happening here, and how can I be an adult person?" You're just like all over the place emotional. And you have no control over it.

Also of note here are several references that therapists made to their client's experience of either themselves or their partner as a "little girl" or "little boy." Although most of those therapists referred to those in the context of intervention (see below), one therapist described the relation between emotional reactivity and a younger ego state in this way:

First thing that comes to mind is obviously the anger and fear because of the betrayal and lack of trust. And again, that speaks to the intensity of the emotion, becoming overwhelmed with the anger and fear, which is—they're reacting to that in themselves and to each other. What they'll do is have difficulty in maintaining their boundaries. It starts with them finger pointing, where they go into their 2 or 3 year old ego state... naturally the challenge is to help them get to a place where they cannot be overwhelmed with their own emotions.

Thus, emotions may lead to difficulty staying in an "adult" or "controlled" state (emotional reactivity). In this study, every therapist referred in some way to client's difficulty in managing their emotions, particularly in the early stages of therapy. The emotions that these therapists suggested were difficult to manage included shame, anger (at spouse, God, parents, etc.), grief, sadness, loneliness/disconnectedness, betrayal, boredom, fear/anxiety, powerless, and inadequacy.

Intervention. Therapists suggested that if couples are "too reactive to sit in the same room, then there's no point in doing it [couple therapy]. Then we try to get them into some one-on-one or maybe into their own respective groups where they feel like they've got some footing and some support, and then bring them together." Thus, some couples may need to do some individual work as a pretreatment for couple therapy. One therapist shared what typically happens when these couples attempt couple therapy.

If they are together, usually their relationship is continuing to be chaotic, crisis management. Usually there's still a lot of reactivity. They really go into blaming and shaming. It's very difficult for them to maintain their boundaries... So typically there is at least some period of time where they're doing individual work to a point where they're not so emotionally reactive..."

Thus, negative outcomes were associated with trying to do couple therapy with couples where emotional reactivity is too high. In some cases, it may take just a few sessions to lower the reactivity, but it can require longer-term individual work. A few therapists also recommended that couple therapy may be necessary prior to individual work to provide crisis stabilization. Finally, many therapists recommended a team approach.

So unless there's really a team of people working together to help these people heal it makes it very, very difficult because there's a high level of reactivity—and then somebody sitting in my seat really just needs a whistle. There's not a whole lot of work that can get done. So I am pretty sure that... couples that get into recovery together are the ones who have a much greater chance of staying together.

Thus, these therapists suggest that emotional reactivity has an impact on how therapists might consider engaging their couples in therapy.

Regardless of the initial arrangement for therapy, the long-term goal in each case is to work through the individual recovery issues in a way that reduces emotional reactivity, leading toward couple work. Several therapists suggested helping both partners commit to the relationship for a period of time to help establish individual recovery.

And with most couples I work with I really in the very beginning try to get them a commitment from each of them that they are going to stay in this marriage for “X” amount of time. It might be 3 months, it might be 6 months, it might be a year. But that during that time that they agree not to pull the “leaving card”... for “X” amount of time they're going to really work on it and then they're going to evaluate whether they want to stay in the marriage or not... I think the purpose is so that abandonment issues don't get stirred up... I think when you pull those threats of leaving out of the bag it really throws up people's abandonment issues. And I think it just takes it for a period of time, whatever they are willing to commit to, it just takes that issue out of the mix.

Thus, it was important to get an initial commitment to the relationship for a period of time so each partner could focus on individual work rather than fears of abandonment.

Regardless of the level of separation, therapists discussed the need for treatment to focus on the individual.

“You both need to be willing to stay out of each other’s stuff for awhile, basically stop working each other’s program and taking each other’s inventory.” Because early on in recovery, the first six months to the first year, it is really critical that they have a sense of separation because they’ve been so enmeshed and they’ve been so dysfunctional in this dance. Even if they’ve been avoidant, they’re still doing the dance together. And so for that first six to twelve months it’s really critical... that they get to a place early on where they’ve got a pretty firm foundation.

As that foundation is established, couples begin to “shift from the “If only you did or didn’t do this, then I would feel better” to an understanding about how I influence the dysfunctional problems in the marriage and work them out, and what I can do to alter that.” This process may be particularly difficult for spouses. In such cases, therapists recommended confirming the reality of the addict’s responsibility while redirecting the spouse to her thoughts, feelings, and behaviors and figuring out what she can change.

De-escalation often occurred and individual recovery was supported by helping clients to become more aware of their own feelings. Initially, it may be a struggle because couples “don’t seem to understand that this is more than them just white knuckling it. They don’t understand that there are emotional aspects...” Nevertheless, several therapists commented on the need to do “a lot of work with identifying how you’re feeling” as well as “raising their consciousness, raising his consciousness about himself, about his emotions, what was going on in his life...” Therapists can also reflect and validate each partner’s feelings. Another therapist shared how she supported spouses in their emotional experience and helped to educate them about the process.

And it’s just critical to support the partner having just a wild variety of feelings. That they’re going to be ambivalent about their relationship. They’re going to be scared. They’re going to be angry. They’re going to think it’s about them. It’s

helping educate them about “This is the process. And all that is normal. It’s OK. It’s important to have a journaling process so you can write out what your anger is about.”

Thus, clients can receive support in experiencing their emotions via tracking, empathy, validation, and education.

Other therapists shared that triggers and/or relapses could also help clients to access feelings. One therapist shared how she helped facilitate the connection with feelings and learning process when triggers and/or relapses.

But the thing that he was capable of doing that I think was particularly successful for him was identifying and learning from every single relapse. As he went through the process, he began to see “Oh. I was feeling this” or “All of that was going on.” And he was able to move the relapse process and his analysis of the relapse process away from what was going on immediately when he relapsed to what was going on days before or hours before or you know whatever the situation was. And I think going through that relapse pattern and becoming more self-aware has contributed to his ability to stay sober...

Thus, therapists used triggers and/or relapses to help heighten awareness and access emotions.

As emotional awareness was heightened through these various methods, therapists also shared that clients needed to develop ways to tolerate, soothe, or cope with the new feelings instead of becoming emotionally reactive. One therapist shared her belief that “part of what they have to do to get into recovery is to tolerate unpleasant emotions without having to do anything to change them.” For the addict, this means being willing to “go through the pain” instead of avoiding it. For spouses, this means avoiding obsessive questioning about the addict’s past behavior. One therapist suggested that after the initial questions have been answered, that she has spouses write down their questions, but them in a box, and revisit them after 30 days. She noted that “a lot of times none of them are important to them anymore.”

While simply tolerating the emotions is one important component, therapists suggested that it was important for clients to develop ways to soothe themselves.

Every moment they're just like so uncomfortable with their own emotional state and the other person's emotional state that... the work that you do for a long time is helping them tolerate emotional distress and stop emotionally flooding, and learn to self soothe. And I do this in session with both of them or singly, even when they're both like just so distressed that they're having an amygdale hijacking [highly emotionally reactive]... And then I have to become the brain.

Thus, this therapist noted that there was a shift from tolerating very uncomfortable feelings toward stopping flooding and self-soothing. She also noted that in some cases the therapist might have to become the source of soothing when the client has become too emotionally reactive. Therapists can also help clients access both self-talk aspect and behavioral aspects of soothing:

You've got to let go of that and learn to soothe yourself... just to say to yourself, "Nothing bad's happening right now. I'm just having a rough time, but nothing bad's happening. The house isn't burning. The children haven't exploded. Nothing terrible is going on."... people individually can do that kind of work, through reading, through journaling, through exercise, through calling somebody who's in their program... to keep things from getting hot.

Thus, helping clients develop soothing self-talk and behaviors can help them to avoid become emotionally reactive.

Several therapists suggested that one set of interventions that can help clients to better recognize, tolerate, soothe, and cope with emotions was related to developing a sense of self. One therapist said that "the challenge is for them to be able to develop a self, sooth themselves down, and not be so reliant on the other for validation." One therapist shared how they helped the individual to figure out "Who's the person you want to be? How do you want to live life?" Another noted "encouraging them from time to time to stay in their authentic adult self, or their strong adult man or strong adult woman

in recovery. I use that language a lot... I've worked with them on visualizing what that is, what the characteristics are..." It is about "getting beyond fear and getting into faith or strength, coming from a place of strength instead of fear. And doing their own individual work of just growing themselves up and being the kind of people they wanted to be, strove to be..." Another therapist shared how she would "help them make conscious choices" guided by values instead of reacting:

I think it is so important for both people in recovery that when you're active in an addiction you are letting your feelings and your desires guide your decision making, and the shift is: when you jury your decisions through values, you really stop doing that. There just aren't that many people to whom it's OK to hurt others. Their values just aren't structured like that... I guess it raises mindfulness about that.

Instead of making decisions from a reactive place, then, this therapist helped clients develop a better ability to channel decisions through their own values. Thus, therapists helped develop a sense of self by directly looking at values, who clients want to be, how clients want to live, or working on characterizing the sense of a strong man or woman in recovery. They then helped clients make decisions from this sense of self/personal values.

Several therapists also suggested that faith could be a resource in helping religious clients to access their sense of self and reduce emotionally reactivity:

... we work with the spouses about what's the vision of the woman you want to be in God's eyes... oftentimes, their behaviors within the marriage do not set that vision. And once they've established that vision, it becomes really easy to go back to say, "It really doesn't matter what you did. Is this the woman in your vision that you want to see in God's eyes?" And usually the answer is no. "And so then what he did is not important really. It's about how you're reacting to it."

Thus, religious clients develop a sense of self through their faith/relationship with God.

Several therapists also suggested that, when clients become emotionally reactive, one way to access their sense of self and use it to move through those feelings was by checking in with clients to see how old they felt in that moment. One therapist shared:

... when they get into places where there is blaming and their own shame comes up... then they say, "I'm not enough of a person to handle this." They go on the attack instead. So one of the ways to decrease that... is to check out with the individual in terms of how does he assess himself? How is his self-esteem doing? Are they doing things to take care of themselves so that they're not continually going into places of shame... I always ask, "How old are you feeling? How old are you feeling today? How old are you feeling right now? How old do you feel when you're in a fight? How old do you feel when she says that? How old do you feel when you go home for Christmas?"... Are they better able to stay in sort of an adult ego stage? Not that any of us stay in an adult ego stage 24-7, but if they are able to tie either crisis, or discomfort, or conflict, or basically when life happens, can they move through that in an adult way... so that they're not falling back into that little angry, ashamed, scared place.

Thus, as an individual begins to become reactive, this therapist suggests that asking clients how old they feel can help them to shift to an adult ego state that can move through difficult feelings in a more healthy way. Another therapist shared how she helped her clients to connect the age they feel to past family-of-origin experiences:

Well, just the whole thing of when he's in that place, "How old do you feel? And what's that connected to in your family-of-origin that you're wanting her to replace that you can't get from her. That was a piece that you didn't get, that you have to give that to yourself internally by your own authentic self saying to your little boy, 'Here let me hug you.'" And going in and doing visual imagery to do that kind of thing. And that'd been work that I'd done with him around some other things, so I was pretty aware of when his body stance got like it did, that he was into that little kid shame, hurting, needing place... And how could they then soothe that [hurt] themselves, but be in their grown-up authentic self.

This therapist helped the client by noticing the stance associated with the "little boy" place, asking the client how old he felt, helping him access what needs he had (related to family-of-origin), and helping the client do the necessary soothing of that child via visual imagery. Thus, there were a few therapists who used ego-state/age to help clients connect

with the adult ego state and intervene in ways that helped clients move through their negative emotions successfully rather than becoming emotionally reactive.

In addition to developing a greater sense of self, one therapist suggested that, much like God did for religious clients, individuals could also develop an internal picture of someone that could help them to manage their emotions without becoming reactive.

I've used the technique of identifying a resource that can be an internal resource for them, like a wise grandmother, or my sponsor, or Jesus, or this character in this book. And so if Larry was the character in the book I might say to the person, "How can Larry help you through this?" And I would then work with them in individual session around that...

Thus, developing an internal picture of someone that can provide assistance in difficult times was another resource for reducing emotional reactivity.

Finally, therapists shared that supporting clients in doing appropriate self-care helped in managing emotions (either preventing negative emotions or dealing better with them). Several therapists commented on this idea: "I'm in the business of helping each individual gain... abilities or options for a healthier lifestyle..." "I also do a lot with self care. How are both of them managing themselves and stress and lifestyle and nutrition and exercise...?" One therapist shared how important it is for the client to know that they can/will take care of themselves: "She needs to know that she can take care of herself and will take care of herself emotionally."

In addition to helping clients see that "from a perspective of taking care of yourself and loving yourself, this [the addiction] isn't good for you," another therapist shared the metaphor she used to help her clients focus on self-care:

When we do things like my fortress analogy... the idea that they have to build a fortress around them... How do I build a fortress around myself so that when temptation comes, I have something to fight it off with? ... [also] the idea that we have to fill ourselves up with good things... The tank is the idea that there are

many areas of our lives where we need to have strengths and activities and places to go and good things that eliminate the need for the escape.”

Thus, this therapist suggested that self-care includes creating ways to protect yourself from repeating the addictive behaviors as well as developing ways to fill their tank/lives with good things. If clients don't develop the skills, one therapist suggested that boredom could lead to relapse, particularly for intelligent clients.

As soon as they start dealing with their sexual addiction and they start to shut down those behaviors in terms of medications and their world started to dismantle and they've got all this free time and all this mental energy where they're going “What do I do with this” and they... start getting bored, it's really a problem. So... I tell them, “Why don't you go back to school, pick up a degree? Why don't you take a class with your wife and try to focus on your relationship or building your relationship with your bride because you've neglected it or poisoned it so much?” But the boredom part is very difficult.

Another therapist warned that cross-addiction might occur if clients don't find healthy ways to fill their lives:

...as you lower one compulsive activity that another one would take its place unless he really learned to do some stuff: soothing, a new activity—whether its exercise, Tai Chi, I don't care, something that... didn't involve a new bad behavior. And so that was stressed, and he did do that.

Thus, developing appropriate ways to fill their lives individually was one important aspect of recovery.

Part of the focus of filling the tank/life was also on building connectedness with others. As shared earlier, one woman was able to fill her life with positives by going back to work and having positive interactions with students, coworkers, and parents. Another therapist helped the couple to focus “on the positive aspects of the relationship that were relatively undisturbed by the addiction, so within 6 months people can begin to have fun together again.” Another therapist discussed ““What activity could you do with your wife and what activity can you do with your children?” so that he could get past some of that

loneliness.” Finally, another therapist shared her belief that building intimate relationships with other men was important as well:

Most of the men that I work with don’t have very healthy intimate relationships with other men. And so if they can start doing that, not hanging out with the guys watching football and porn, but hanging out with the guys and doing healthy things. That seems to really help them to bond.

Overall, then, as addicts become aware of how the addiction does not provide self-care, these therapists recommended that efforts on keeping out the addictive behaviors need to be supported by a focus on developing appropriate ways fill their lives individually and relationally. By doing so, therapists suggested that clients are more able to appropriately managing feelings of boredom, loneliness, etc.

Depersonalizing

One important piece to lowering emotional reactivity was the theme of depersonalizing, which is described by therapists as being “able to detach a little bit from it and not take it so personally, an affront to who they are” as well as understanding “that his acting out wasn’t about her...” As that awareness occurs, another therapist noted that the spouse is no longer

... devastated, that this isn’t about her and her body. So it has a little less, or a lot less reactivity. And that they understand because you’ve done such an educational piece, that they really understand that this is a disease. And diabetics can have a relapse and it’s not the end of the world. So as they get healthier, I believe that it fits into a context, whereas when they first come in everyone is so intense, so emotional.

As the emotional reactivity goes down, one therapist noted that one particular spouse, “...doesn’t go into a shame spiral and go into taking it personally.” Thus, depersonalization leads to a decrease in emotional reactivity. While most cases of

depersonalization relate to spouses, we also note in the intervention section below when instances of depersonalization for the addict occurred.

Intervention. Several therapists noted that helping depersonalization occur can be very difficult. One issue was that the spouse might temporarily disregard her own feelings because the addict expresses neediness.

...without saying it, they're saying, "I really can't do this alone. I need your help. I need you to be here with me. I need you to understand. I need you to forgive me. I need you to tell me I'm not a horrible person." Whatever that is, but then what happens with the spouse is the spouse is left with the idea that they're supposed to protect the addict from their own truth. So it takes a while... for the spouse to be able to reveal and to grieve their own sense of betrayal and their own feeling that they weren't enough to keep this spouse from acting out.

Another issue was that the addict blamed the spouse for his behaviors, thus perpetuating her faulty belief that his acting out is about her. When this occurred, one therapist told the addict, "It's not about your wife. I don't care how many times she rejects you in bed or puts you down in front of somebody else. You can address that, but that's not a reason or an excuse for whatever you do after that." Thus, a few issues such as disregarding their own needs or addict's blaming may act as road blocks in the process of depersonalizing. Finally, one therapist stated how difficult it can be to help depersonalization occur beyond the level of intellectual understanding:

And it's still a personal betrayal even if they intellectually understand that, "Oh yeah. This is about an addiction, and that person is just an object to them or that behavior just fulfills this addicts needs." Because it's sexual, it's personal... even more so because with sex addicts lots of times they have acted out in so many different ways for so many years before it gets to the place before somebody comes for couples' work. And so there's lots of betrayal pain.... Still, you like somebody else better than me.

Thus, the process of depersonalizing is something that the therapists in this study considered important, yet it was reported to be a difficult task that takes some time.

Because it can be so difficult to get clients to depersonalize the other's behaviors, a wide variety of interventions were suggested. One initial intervention that may help facilitate depersonalization is meeting with the addict first.

I will invite her to the session as an honored guest. I cannot treat her like the patient... I just can't afford to add to that sense of shame. And so the message from me by not including her is that, 'It's not your problem, but I would certainly like your help at some point down the road.'

Thus, working with the addict first (prior to couple work) was one way to help the spouse not take his acting out personally (as her fault).

Therapists strongly suggested that education about addiction was very important for depersonalization. Therapists suggested reviewing the definition/characteristics of addiction, looking at Carnes' four core beliefs. One therapist shared that educating,

...really helps the wife to be able to understand that it's not something that she's done by default or done something wrong but rather it's a result of unresolved issues in a guy's life that he hasn't resolved... I try to get the wife to understand that it's not about the sex it's about him medicating...

Thus, better understanding the addiction process can help both partners to depersonalize the behaviors, not reacting to it as a personal assault. Another therapist suggested looking beyond the idea of addiction recovery as "willing" the behavior to stop and looking more at the causes of the addiction.

A lot of times the education: this isn't about a moral issue, this isn't about whole will, this isn't about "just say no." This is about looking at family-of-origin issues, this is about looking at the shame issues, this is about looking at the chemicals. So when you can educate them about addiction and about sex addiction and about brain chemistry, and what it means to be an addict and to act out, it helps to move it away from just a lack of character. So that's huge. That really helps a lot.

Thus, both the addict and spouse are able to depersonalize the addiction, seeing it instead as a response to previous issues, shame, and brain chemistry rather than a lack of

character, thus taking it less personally. Another therapist explained the brain chemistry aspects of addiction more specifically:

....what we know about addicts is when they're under stress they regress... I think what happens in brain terms is that the neocortical functions are no longer operational and any kind of implicit memories that are stuck in the limbic system just start firing off and it becomes a fight or flight mode and they go to what they know... the partner can start to see this and it not be personal.

Finally, one therapist suggested that referencing how our culture views addiction may make it easier for spouses to depersonalize.

...the addiction model is more familiar to people. The whole model of treatment... it's easier to get people to believe that it's not about them. The culture has an understanding of addiction and... that addiction is growing by leaps and bounds on college campuses because of availability. I mean most people get that it's not personal. See, you can put it in a sociological perspective that they can grasp.

Thus, educating about addiction and addictive processes (including brain chemistry) in a sociological perspective may help more easily depersonalize the addictive behavior.

Several other interventions outside of education were also used to facilitate depersonalization. One therapist suggested having the addict share the personal history of acting out with the partner during a session (when appropriate) may have a positive impact in helping the spouse to not react to the acting-out as personally. One therapist took it a step further and helped the addict to verbally say to his wife: "Honey, I want you to know that this isn't about you. None of my acting out has to do with you. You are of worth. You are of value. It's nothing you did. It's all my stuff." Thus, depersonalization might occur as the addict shares his history of addiction, including helping the addict to depersonalize it verbally.

Helping partners to understand the underlying patterns related to the coupleship may also lead to depersonalization.

I try to take a very non-blaming approach, and I think working systemically and focusing on patterns versus people is one way that I do that therapeutically. And so drawing on the board, or white board, what is the pattern? He acts out, withdraws. The more he withdraws, the more anxious she gets. The more anxious she gets, the more he withdraws and puts him at high risk for acting out again. Really identifying what is that vicious cycle that they're in. And... for them to be able to visualize it, to give a name to it, to realize, "Hey, we're both in this together. This isn't you trying to do this to me. This is both of our best efforts to deal with a very icky problem." That was a real turning point where they could start turning together versus against one another.

Thus, each partner was able to see the destructive behaviors as not "doing this to me" but as an attempt to deal with a difficult problem, which allowed the couple to shift from an emotionally reactive stance toward working together against the problem. In looking at couple patterns, another therapist suggested "helping couples to pull back and realize that their issues with their spouse are really not usually issues with their spouse, they're usually issues from their childhood. And if they can do that, then it kind of takes some of the heat off the coupleship." Thus, connecting behaviors in the relationship to past relationships may also help partners to take their interactions less personally.

The process of depersonalizing allows a shift toward individual recovery work and further depersonalization. "Okay the focus is he acted out. Let's understand, and then how are you doing and how are you handling this addiction?" Thus, this therapist shifted the focus from the acting-out behaviors to the pain the spouse was experiencing. Another therapist also pushed the spouse to look at "how did your beliefs and responses contribute to aggravating that or taking that personally...?" Often responses were based in the shame spouses experienced around the addiction. One therapist processed through shame related to body image with a spouse: "...what are they comparing themselves to? Let's talk about this rationally. Who are these women? What do we know about the industry?" Thus, processing several aspects of shame to "the point where she can see that this isn't a

reflection on her sense of self worth” can lead to greater depersonalization. Thus, depersonalization can lead to a focus on individual recovery which can lead to further depersonalization.

Other Resources

Another theme related to individual recovery was utilizing outside resources, a theme mentioned by every therapist in this study. Several different supports were mentioned in addition to individual therapy: 12-step meetings (Sex Addicts Anonymous (SA), Sex and Love Addicts Anonymous (SLAA), COSA (for Codependents or spouses of sex addicts), Co-Dependents Anonymous (CODA), S-Anon (for family members of sex addicts), etc.), sponsors (including step-work), spiritual/religious supports (12-step groups, church, church groups, church leaders, confessor, etc.), family (parents, kids, etc.), healthy relationships/friendships (same-gender friends, friends in the 12-step community, etc.), couples’ groups such as Recovering Couples Anonymous (RCA), intensive workshops, and special intensive programs. The majority of therapists suggested using a team approach, noting how a variety of outside resources can help couples change negative patterns more easily.

I would say that most people are not able to be successful, just because the systems that they are in are very powerful. And it takes a lot of support and pull from the other side. I frame it as: we’re coming in a tug of war here, and if it’s you by yourself pulling against the system, you’ll never win that war. It’s really about having more people on your side, encouraging you, helping you, helping you figure out how to finesse what you’re doing. It’s going to take a lot more people on your side than the power of a 20 year old system. And so the more people you can have over there, that you can surround yourself with, that can encourage you and help you and give you more feedback about this, then the more successful you’re going to be.

Thus, outside support is essential to helping clients resist the pull of old patterns. In general, outside resources can help reduce emotional reactivity, reduce shame, provide healthy relationships, and provide perspective and hope.

With regard to emotional reactivity, one therapist remembered a client that would often call “a sponsor first and get some of their feelings out on the table so that they can come back to their spouse less reactive.” Another couple “made good use of talking to other people and not hurting each other with every little thing that comes up for them.” Another therapist shared the importance of having outside resources when crises happen.

...when the slips happen, or when there’s crisis or when there’s conflict, it’s really important so that the relationship doesn’t just explode... that they have a support system. And that support system is going to be responsive. It’s going to be their 12-step [program]. It’s going to be the individuals with whom they’re connecting and they’re building intimacy and they’re doing things with. Because certainly over time, it would be much better for them to have that support system than having to pick up the phone and call a therapist every week.”

Thus, outside resources can provide both spouse and addict a place to process through emotional events in a way that prepares them to engage less reactively in the relationship. Additionally, therapists discussed how outside resources can help reduce emotional reactivity by providing opportunities to manage difficult processes (i.e. preparing appropriate and full disclosures) and practice new skills (i.e. anger management, assertiveness). Thus, outside resources can reduce emotional reactivity in various ways.

Outside resources can also help reduce shame (although it may be difficult initially for spouse and addict to access outside supports due to their shame). One therapist shared how shame reduction could occur for both spouse and addict.

I’m very much of a 12-step advocate for addicts and coaddicts, simply because they need to get out of the shame that thinking that they’re the only ones that this is happening to. That they need to be able to talk about it to other people because that begins to diminish the shame that they’re carrying. It gets them out of

isolation. It gets them to feel that they're not alone. It gets them to call other people and not just their therapist when they're upset. So I think that that's probably the biggest asset is to be able to use 12-step programs as an adjunct along with therapy in order to do the shame reduction.

Additionally, four therapists mentioned the specific benefits of Recovering Couples Anonymous (RCA) in relation to shame reduction:

The RCA works really well. It reduces the shame. It gives them an opportunity to be in a community of individuals, other couples, who are in similar predicaments, and also helps them to look at their coupleship as an entity in and of itself—sort of the coupleship is bigger than the both of them and also it has a life of its own. And so it helps to really reduce not only the shame, but it also holds each accountable in the coupleship so that they're not just pointing fingers at each other and blaming each other....

Thus, RCA is another form of support that can help shame reduction to occur.

Outside resources may also provide opportunities to form healthy relationships.

One therapist noted:

Most of the men that I work with don't have very healthy intimate relationships with other men. And so if they can start doing that—not hanging out with the guys watching football and porn, but hanging out with the guys and doing healthy things—that seems to really help them to bond. There's some co-mentoring going on. There's accountability going on.

Thus, appropriately intimate same-gender relationships can provide healthy activities, mentoring, and accountability. Healthy relationships assisted clients in “stepping out of that isolation and into trying to create some relationships with like-minded people and people that were interested in trying to improve themselves rather than just staying in the sickness.” Thus seeking out others that were focused on improvement was important. Additionally, therapists can help both partners form a healthy relationship with a higher power/God.

I think the main thing for my world view is that they can't do it alone, and they have to have a relationship with God. You call it a higher power. I would say a

relationship with Jesus Christ... because they've tried so hard on their own going to groups and stuff. God's the one who changes hearts, that's the bottom line.

Thus, a relationship with a higher power may be an important piece in addition to groups and other resources. These relationships can continue to provide continued support even after therapy is completed.

Another benefit of additional support is the development of a positive perspective and hope.

I think they can see other people who have been in similar circumstances and seem to be working some of it through. And that gives them hope, too. It's like, "OK, I can't see how we're going to get through it, but you seem to have gotten through it. And I don't know how, but maybe I can too."

One therapist noted that her work with couples seemed to fall short of helping couples find hope, noting how groups could accomplish more:

It never works for me to just tell them. They need to kind of see it from a peer... saying, "Yeah, we went through the same thing and I can tell you how things are different now. It was tough in the beginning, but we stayed with it. We really trusted the process." And so I think having that support from other people who had actually been through the process was really helpful.

Spiritual supports also provided a more hopeful perspective:

...their involvement with the church, their religious involvement, their spiritual connection, was pretty strong... I think just having some faith that maybe there's a bigger picture here, and even what I'm seeing right in front of me, I think maybe this isn't all going to be catastrophe.

Thus, outside resources provided hope/faith that gave them commitment to the process of change from a bigger perspective.

In general, therapists noted that the bringing in outside resources is essential to the process of healing. While one therapist suggested that in some rare cases it may be possible to not use outside resources in the recovery process, she did suggest that using outside resources will speed up the process of healing. Additionally, individuals and

couples seem to move more quickly through handling slips or relapses when they are active in engaging in outside supports.

While outside resources were recommended by every therapist, several therapists suggested that “everybody’s different. Everybody recovers differently.” Several therapists noted that individuals may struggle with different support options.

I ask people to go to meetings two or three times, see if they can get into it. And addicts, of course, we say, “Go to meetings all the time.” And lots of sex addicts especially, because the meetings are young and there’s not a lot of health, complain about a lot of war stories going on. “It’s uncomfortable for me.” And if they’ve given it a good shot I might ask them, “Alright then what you’ve got to do is find the three healthiest guys in that meeting and you’ve got to start a breakfast club, or a lunch club, or whatever it is”... I’ll say [to wives], “Go to meetings, and if you don’t like COSA, go to Al-Anon, and if you can’t find somebody there that you can relate to then you’ve got to find three girlfriends that you can go and you can actually talk openly about what’s going on and get some support.”

Thus, this therapist helped both addict and spouse to explore all their options in order to find support that works for them. Another therapist shared,

I’m not adamant that it has to be one type of support. I like to assess where they’re at, what kinds of supports they’ve had in the past, what’s their preference, what’s been most helpful before... It really depends on the learning and the skill set that the client brings, too.

Thus, therapists can pay particular attention to clients’ histories in determining what will work best for that individual at that time in their process of recovery.

Intervention. While some clients reach out on their own to other resources, therapists may need to facilitate the process.

I say, “You know what? I want you go to out to lunch with these guys. I want you to build relationships talk with them. So these guys are out, they go to lunch together. They walk their dogs. They go to movies... The guys will get together and go play cards, poker, or chess or whatever over there. They need to build relationships; they need to build healthy relationships.

This same process may be useful with other relationships as well (i.e. God). Therapists also encouraged couples to reach out in service to others. One therapist offered a couple the opportunity to participate in a documentary on pornography addiction (recovery-focused). Their therapist discussed the impact it had on them:

It audienced it for them. It authenticated what they had done that had been good, and so I feel that was very powerful for them... It doesn't mean that he has not had relapse since, but I just thought that cementing, and, I mean when you're put in a position where you have to teach or you have, you're expected to be an authority in something, it's helpful.

This therapist also shared: "I encourage them to write anonymous letters to other women, and I collect a binder of these letters that I photocopy and give out as handouts." Thus, therapists can have a positive impact on helping clients search through and use their outside resources more effectively.

Finally, the level of reliance on outside resources may shift over time. Couples may rely more heavily on outside resources as they terminate therapy. One therapist suggested that while there are some people whose lives are "centered around 12-step kind of thought and activities, and that's their social life", she noted that "most everybody gets back to 'here's my life'." Thus, therapists can be aware of client's need, noting that shifts in outside support may be appropriate.

Boundaries

The last theme that the analysts identified as pertinent to the individual recovery process was boundaries. One therapist noted that couples' "boundaries are so screwed up when they come in, their distress, their fear of being ganged up on..." Past traumas and family-of-origin was highly linked to difficulty setting boundaries. For example, because one client's abusive past "it was impossible for her to say 'no' to people and I think this

was... because she was molested... by somebody in the community and a family member, so her boundaries have been zero.” Also, the family-of-origin may impact the ability to set boundaries:

...he’s so enmeshed with his family; she’s so enmeshed with her family. And both of their parents tended to jerk on their chain or be very controlling. Being able to draw healthy boundaries is still an issue that they struggle with because they want to be loved by their parents...

Thus, past trauma and family-of-origin may impact client’s abilities to set boundaries.

Boundaries were directly linked to a sense of identity: “Identity diffusion... is part of the problem... That is what the whole issue of boundaries really goes to... The capacity to attune where I end and somebody else begins is not as clear to some people as it is in non-codependent people.” Thus, having a sense of identity (differentiating between myself and others) was linked to setting boundaries. Boundaries are discussed last in this section because they require that individuals be addressing and practicing the other aspects previously discussed in order to successfully set and keep boundaries.

Interventions. Several therapists suggested that one boundary that is important to discuss early in treatment is the decision to stay in the relationship. One therapist informs her clients “that with many different types of crisis, many people will later state that it was good for them to wait a few months, kind of a cooling off period, to then make a major life decision.” Another therapist noted how powerful it was to the spouse to know she didn’t have to make a decision immediately:

She didn't have to draw any lines right then, that she could take as much time she needed... And she said that that was helpful to her because she didn't feel like she was under any big pressure then... she had said that he gave her back in a sense of control to her life... When they first came in as a couple, she felt like everything was out-of-control—that everything that she thought was true with him was a lie. So it was getting some sense of control... that she had choices.

Not feeling pressured, this spouse felt a sense of control and ability to make choices.

While a few therapists asked the spouse to wait for specific time frames (“Could you give me a couple of months?”), the majority of therapists suggested helping the spouse to make the decision rather than push for a specific resolution.

“I’m not here to say you have to get in. You certainly can choose to walk at any time. However, if you walk now and you don’t do your own recovery stuff, the chances that you will find yourself in another unhealthy relationship or probably even a less healthy relationship are pretty significant.” That kind of scares them. And so usually she’ll say, “I don’t ever want to do this again.” “Well, OK, if you don’t ever want to do this again, why don’t you do the best that you can to heal this relationship and heal yourself, and then if you choose to walk in 6 months or a year, or whatever, do it. But do it for the right reasons.”

Thus, therapists can educate the client about potential risks, helping the spouse to consider her decision more carefully. One therapist also suggested that taking time would give closure if the relationship ended: “my work is focused on her building her sense of self. And then she can choose... whether she stays, if that behavior’s tolerable for her or if it's not... she can leave... with the feeling that she's done... all that she can do...” Thus, time can help the spouse develop a better foundation for making the decision non-reactively, thus providing better closure if the decision is made. In some cases, the spouse may perceive that these attempts to educate and process may be the therapist’s attempt to persuade her to make a specific decision. In these cases, one therapist suggested acknowledging it: “My fear in sharing this with you is that you may perceive this as my attempt to convince you one way or the other... How are you hearing this? What do you think my purpose in sharing this is with you?” Thus, open discussion about the spouse’s perceptions can help her to re-focus on what is best for her individually.

If couples decide to give the process time before making a decision, one therapist required that neither partner threaten to leave during that time period.

...during that time... they agree not to pull the “leaving card”: “I’m not going to stay, I’m leaving, I’m out of here.”... I think the purpose is so that abandonment issues don’t get stirred up because they think lots of times when life gets tough—like around disclosure or relapse... she will either say, “I’m out of here. I’m not going to live like this.” Or he’ll say, “I’m just such a loser. You’re better off without with me. I’m leaving.” And I think when you pull those threats of leaving out of the bag it really throws up people’s abandonment issues...

Thus, preventing partners from threatening to leave during the period of decision making can help avoid abandonment fears which can disrupt the individual recovery process.

Another boundary situation with sexual addiction relates to the handling of disclosures. Therapists suggested supporting addicts in preparing full disclosure. One therapist reported that spouses also wanted full disclosure: “straight across the board I find women telling me ‘We want to know. Almost always we know anyway. So it just reduces the crazy-making, and can help us trust our instincts, and get us in touch with reality, and let us know that we’re reading the situation accurately.’” Another therapist suggested that the “disclosure piece is important early on to get it out on the table. It’s really important that the co-addict be given an opportunity to also work through the feelings of anger, betrayal, and the shame that is associated with that...” Thus, early and full disclosure can allow the spouse to deal more quickly with her feelings.

Whenever possible, therapists suggested preparing addicts for a full, formal disclosure in order to prevent destructive future disclosures. Prior to formal disclosure, the addict may also need to be prepared for the spouse’s reaction and to find support after disclosure occurs.

I might say to the guy... “Just know that I’m going to support her in whatever she says, and you’re kind of going to have to take it on the chin, because this is your unmanageability. You’re going to have to be able to call somebody after our meeting.” He’s going to have to be able to deal with himself the best he can because in truth he has broken his marriage vows, he has lied, he has created all sorts of problems in the relationship and this is part of recovery. It’s hard.

Thus, in addition to preparing for full disclosure, therapists can provide support as addicts prepare for the spouse's response.

It is also important to support the spouse during and after the disclosure process. One therapist recommended supporting the client in controlling the amount and type of disclosure that occurs (including preparing with their therapist).

And so the partner gets to put the brakes on. They're in control of the brakes and the gas peddle, if you will, during that process: "I've heard enough. I don't want to hear any more" or "I want to know how many people. I want to know when and where." So they feel like they're getting the whole picture.

Thus, the spouse is helped to maintain boundaries that are appropriate for her during the disclosure process. Another therapist shared, "I tell them, we really don't want to go into the gory details because... what ends up happening to her is she starts obsessing about it, then she starts into her own stuff. So really, disclosure is very general."

After disclosure, therapists need "to find support for this partner, because a lot of partners are suicidal... And so you really do have to check that out as well... Are you staying safe... where you can have some respite?" The partner "is encouraged to speak to their therapist, go to their own group, do whatever they need to take care of themselves... I'm typically very supportive of the partner's feelings of betrayal, loss of trust. People are typically really, really angry when they hear that list..." After hearing the list, many spouses may obsess. One therapist shared that she had spouses create a list of questions and putting questions on hold for a time (after the initial disclosure and questions). Doing so, she suggests, may provide time to sort through individual recovery issues.

Other disclosures may be necessary. First, the initial full disclosure will most likely not be complete because "when the addict is acting out, that it's fogged. So it may

be that he is disclosing everything to the best of his ability...” This therapist recommends sharing that idea prior to the formal amends. Additionally, relapses may also need to be disclosed if they occur during the process of recovery. One therapist noted: “I think it’s hard with this [sex addiction]. It’s not as cut and dried as alcohol.” Confusion about these boundaries seems to hinder the process of recovery (individual and couple). Thus, both addict and spouse may need help sorting through their boundaries for acting-out behaviors.

Below, I review the process (for addicts and spouses) of developing boundaries for acting-out behaviors and then discuss the process of bringing those boundaries together to form a plan to interact around those boundaries if and when acting-out occurs. Several therapists specifically discussed the work to help addicts recognize their own boundaries related to their acting-out behaviors. There were three basic levels of severity therapists mentioned. While therapists used different words to represent the levels, I choose one labels to represent each concept. The first level is a lapse. Lapses “aren’t going to be going back to the old [relapse] behaviors,” but they do involve thoughts (“fantasy without actually acting out” or “think about going to the porn site”) or behaviors that are precursors (or triggers) that come before the acting-out behaviors (“linger too long in looking at a woman. They’ll linger too long looking at a site that’s a little too sexually explicit”). One therapist helped clients to increase awareness of these lapses (triggers), noting that it acted as a boundary that protects clients from returning to destructive behaviors.

I hope that by the time I’ve left them, as in this case, we’ve identified as many triggers as possible. I’ve gone up to two hundred and fifty. I’m really a bug about that, because I think to the degree that people don’t get their triggers—internal,

external, smells, sights, emotional, experiences, being dissed by their boss—whatever the triggers are, if they don't know them, they're left unprotected.

Thus, increased awareness of what things indicate lapse can empower clients to respond to possible threats to their recovery, preventing them from moving to more severe levels.

The next level in severity is a slip/relapse, which occurs when

...somebody does something and they're 60, 90 days into recovery and let's say they get online and they click on a porn site and they're not on it for very long—let's say they're on it for about an hour. But afterwards they immediately make a program call. They call their therapist. They talk about it. They deal with it and start to look at what the triggers were—the actions were—that had them doing that. I consider that a slip because the person kind of fell [off] the horse and got back on and kept going.

Another therapist also added that clients might assess: “What happened? What do we need to do different? Sort of do an autopsy on it.” Thus, slips/relapses seem to refer to isolated incidents of acting-out behaviors that are followed by an effort to understand what happened and actively work their recovery in a relatively quick fashion.

Finally, “a collapse is just somebody fell off the shelf, just is going on a binge, and really has no intention of stopping.” Another therapist suggested that collapse is when “the person starts lying and they start keeping a secret and they're actively acting out while they're actively lying and going to meetings and acting like everything's fine when it really isn't and I think that requires a higher level of care at that point, or could.” Thus, collapse is a full entry into acting out without any focus on recovery. These levels can help clients gain a greater awareness of their sexuality and when they have crossed their own boundaries in behaviors.

Almost all therapists noted that it is a struggle for spouses to sort through their own boundaries around the addict's sexual acting-out behaviors. One therapist shared:

I'm surprised sometimes how naïve the women are around this issue, especially women of faith... So I would explore where... does that desire "never again" come from? It's understandable—none of us want an icky thing to continue— but is that appropriate or the most helpful way of looking at this?

It may be difficult for partners "to understand that slips are going to be part of recovery because they hear that as the therapist giving them their partner's permission to slip."

In an effort to stop the addictive behaviors, spouses may initially demand that the behaviors never occur again, fearing that other approaches might give the addict permission to continue acting out.

One therapist noted the result of setting "black and white" boundaries:

... it's good to have some boundaries and some bottom lines, but it's also good not to dash yourself into a corner. Because you don't know what you may do, and relapse is going to happen. So it may be a boundary that I understand that relapse is going to occur, but it may be that, if a relapse happens—say that it's another affair... if that happens, I'm going to have to reevaluate my commitment to staying in this marriage. It doesn't mean that I will leave, but I know that it's going to be tough for me... I really work with the wives to try not to back themselves into black and white corners. Because often times it will happen and they won't do what they said they were going to do, which is more damaging than if they had not done that in the first place.

Thus, when spouses set "black and white" boundaries they may not be willing to follow through, which may be more damaging than if they had not set boundaries at all. One therapist shared how her mediation experience helped her in this process.

Well, we went through what she felt was acceptable behavior, and what she could and couldn't tolerate. And we went through several weeks of going over... "If you're not willing to accept it, don't say that you are, because it won't work."... the one thing I learned [from] years of doing mediation [is] that if you agree to something that you really don't want to do, you won't follow through with it, not for very long. And that works very well with couples too... It's like a threat to a kid. If you don't intend to follow through with it, don't make it.

Thus, boundaries must be sorted through so that spouses will be able to follow through if/when relapses occur. Another therapist noted the same dilemma and discussed what she called “non-negotiable” boundaries in more detail.

...if he does do whatever it [is] that basically she said is a non-negotiable for her, then she needs to be able follow through with that. Now what I say to them is non-negotiable—you really need to be very careful about non-negotiables—because if you say a non-negotiable, and it happens, because it may, you have to follow through with it. So... my preference is to say, “If you have another affair, then here is what the consequence is, and this is what we need to do.” So it might look like—instead of I’m leaving—it might be better to say, “If you have another affair, you move out of the house. You won’t see the kids. You’ll be in counseling more intensely. You’ll go to inpatient treatment”—whatever it is.

One therapist suggested that a wife can then “feel like she had a little more power, because one of her issues was a feeling of powerlessness.” Additionally, the spouse begins to feel “like she’s taking care of herself... She needs to know that she can take care of herself and will take care of herself emotionally. And have some boundaries and not avoid it. Come back to it and say, ‘OK, this is what I need’ and proceed accordingly.” Thus, the overall process with spouses helps them to do “some anticipation and problem solving beforehand” so they can set boundaries that they can more successfully follow through with as the addict goes through the process of change.

Overall, individual responsibility in recovery involves working through individual issues (often a result of trauma and family-of-origin issues and patterns). Therapists help couples to focus on managing their own emotional reactivity (versus blaming). Therapists can assist couples in reducing emotional reactivity by helping partners to depersonalize the other person’s behavior that they have taken personally. Outside resources can also play an important role in reducing emotional reactivity via shame reduction and by providing additional support/connection and modeling for each partner. As partners are

able to deescalate and create a better sense of self, therapists can then support them in developing appropriate boundaries.

Couple Recovery

As individuals take responsibility for their own recovery, they can begin to engage in the process of couple recovery. Thus, individual recovery work (which can occur in a couple settings as well as individual or group therapy) is a precursor to couple recovery. I now outline the process of couple recovery, which includes better understanding the role of family-of-origin in couple issues, improved communication, and increased empathy, intimacy, and trust. The last theme is the improvement of physical intimacy.

Family-of-Origin

Analysts suggested that the theme of family-of-origin (which was connected to individual recovery previously) was linked to couple recovery as well. Several therapists shared the idea that clients “come into the marriage with all this luggage from the families and breaking away from the families is very difficult as a couple... it’s two people bringing their luggage to a marriage and start intermingling it, it just makes it more complicated.” One noted how important it is “to stay out of their own individual family-of-origin crud.... to move themselves into this relationship instead....” In essence, the work of marital therapy allows the couples to “actually starting to deal with each other for the first time.”

Old patterns seem to “get flared up when stress and anxiety gets high...” This results in partners “staying in a very dysfunctional, very angry, very victimy, very blaming, very resentful, very entitled place.” Often both have high defenses due to past

issues in their families-of-origin, and they have the expectation that their partner will make up for their past woundedness, looking for the parental from their partner and feeling anger when the other is unable to do so. Additionally, patterns in the family-of-origin can be recreated in the couple relationship, recreating similar pain. One therapist shared an example.

There was no abuse, but she had a pretty powerful mom and she really was never allowed to have her own thoughts or ideas or to have a voice about something. He grew up in a family where things were very rigid. Where, again, a pretty strong mom who was prone to fits of rage and volatile behavior. So then they marry and of course, he's someone who is very rigid and needs things very perfectly, needs her to be a certain way, needs her to have this certain image, much like she was in her role in her family. And she, because of her anger, really suppresses it for a while and then just really goes into these fits of rages, so that they're triggering each other all the time about old family stuff.... So he could say the least little thing, maybe from him didn't even feel like a criticism. But she would take it as a criticism because of her mom and she would immediately go back to being a little girl in that situation. And at that moment her husband encompassed all the people in her life who had been critical of her, and she would react to him in that way.

Thus, partners can feed off each other in creating an emotional reactivity based on the patterns and pain from their childhood. As couples stay in this pattern of being “triggered so much by each other” into their own family-of-origin issues, one therapist noted that this can lead to relapses for both partners: “They’re going to struggle, struggle, struggle because they’re going to feel so awful, and they don’t know what to do with that feeling. So they go back to what they did in their family-of-origin to alter mood and to get something they want...”

Intervention. Because these patterns can escalate and may lead to relapse, therapists suggested that family-of-origin impact needs to be addressed as part of couple therapy. One therapist noted how just being there as part of therapy to listen to the addict’s struggles opened up awareness for the spouse:

... he started to come to grips with the lies that he had believed as he was growing up. And as his wife sat through quite a bit of this and she was listening to it she started picking up on a lot of the information that she had had as she was growing up so she started working on her issues as well and she also was going to this healing hearts group for the women which deals with a lot of codependency and codependent issues—she was codependent to the wall—helped her work through her issues with her parents...

Thus, being in therapy together while one person is processing their family-of-origin issues can help the partner to look at the impact of their own family-of-origin.

Therapists also helped couples to look at how family-of-origin issues were linked to current couple patterns. One therapist urged the patients to ask the question, “What in their family history has contributed to how they contribute to the couple patterns now?” Another therapist helped the couple “to identify how they both fall into family-of-origin kind of black holes that would move them back into a dysfunctional pattern with each other.” Another therapist suggested

...using a lot of Virginia Satir stuff—about helping them figure out if there is a blamer, a placator, or an irrelevant person, or a super-reasonable person. And again, where did that come from? Where did that style of interaction in the coupleship, where was that originally started? And usually they can go back to their families and see that.”

Thus, while negative communication patterns will be discussed in greater detail later, these few examples indicate how family-of-origin work was done in the context of discussing communication patterns.

Finally, therapists addressed how family-of-origin impacted the couple. Noting how one addict became reactive, one therapist asked, “How old do you feel? And what’s that connected to in your family-of-origin that you’re wanting her to replace that you can’t get from her?” Another therapist would share directly with her clients that “You marry someone to work through your own issues.” In some cases this was very direct.

One thing that I do say from the get-go is that most spouses—gee, I really hate this point—“If you hadn’t have chosen him to be your spouse, you would have chosen somebody else in some kind of a dysfunction, because healthy people don’t choose unhealthy people or stay with unhealthy people.” So when they hear that, they’re usually automatically angry and resentful. And it takes awhile to get them through that. Then as we start to explore the spouse’s family-of-origin issues, it’s very similar to the addict’s family-of-origin issues.

Thus, confrontational methods could be helpful, but they were mentioned tentatively.

Communication

The theme of communication was the foundation from which the couple work was accomplished. As one therapist noted, in many ways “the issues they can work on in sex addiction couples’ therapy are not unique to [sexual addiction] couples... If you listen to audio tapes or video tapes of 50 sessions, and compared the 50 sort of generic marital therapy sessions, its 95 percent overlap.” Because much of the work is similar to couple work in general, I review couple interventions only briefly and focus on those findings that are specifically related to sex addiction couple work.

Interventions. Overall, the tools to tolerate one’s own and the other’s emotions, self-soothing, and boundary work (including time-outs) allowed clients to “stand in the direct face of their partner’s rage and just hear it, and not defend themselves, and not explain, and just find that strength to be there.” Thus, couple therapy takes “that individual knowledge that I have and understanding that when you do X, that’s why I come unglued instead of just looking at it and shirking my shoulders.” Thus, individual recovery tools provided groundwork for appropriate communication.

In addition to readings, conferences, and other media that can help couples learn about healthy communication, therapists suggested coaching couples to utilize speaker and listener roles. Therapists helped individuals identify feelings and needs and express

them appropriately (using “I-messages”). One therapist uses an “iceberg model” to help clients get past the fighting to the real issues (moving from the “tip” to the real issues underneath). She shared,

...with any issue I immediately bring out the iceberg model and say, well, it’s really not the issue. Let’s work it out and figure out what the real issue is. ... helping couples realize that what they’re fighting about is not the real issue. And if they can get through the iceberg model and talk about what the real issue is, then usually it’s not a fight. It’s usually more about understanding why... that has been such an important issue for them.

Thus, as couples can focus on the underlying issues, they may be able to avoid fighting and develop greater understanding of the real issues. Several therapists also suggested that focusing more on the communication patterns than content had a similar impact.

As vulnerability increases and emotional reactivity decreases, several therapists suggested helping the couple shift to more face-to-face interactions in therapy.

It’s really getting them face to face and allowing them to express their thoughts and feelings, their needs and wants, their perception about what went on; letting them share that. “When you went out and had an affair with Suzie, what that meant to me was that I wasn’t worthy of your love, affection, attention, money; that I wasn’t enough because she was able to offer you something that I wasn’t. So I started to experience some insecurity. I’m not good enough then. Then I started to be afraid, and when I get afraid, then I start to withdraw. So when I start withdrawing, then that’s a way for me to protect myself.” Then the guy goes, “Oh, well honey, when you withdraw, then I feel like I’m not worthy, and you don’t love me, and you don’t like me, and I’m not sexy, and I’m not important enough, and blah, blah, blah.” And so it’s kind of a way of taking the pieces apart to see how they’ve reacted to each other out of their own perception.

Via face-to-face interaction, couples increase their ability to communicate their feelings; they develop an understanding of their pattern from both partners’ perspectives.

In addition to general couple therapy interventions, several specific interventions were suggested for working with couples that are struggling with sex addiction.

Therapists suggested two initial ways to help couples. First, therapists can help couples

shift from having an “identified patient” in the sex addict to a focus on the relationship. “Even though he may be the identified patient in both of their minds, I tell them at the beginning that there is no identified patient there: the relationship is.” Thus, verbally establishing the relationship as the focus may be an important element early in the process of beginning couple communication work with sex addiction. Second, therapists indicated that commitment to the relationship impacted the ability to communicate effectively. One therapist noted, “I don't think either one of them truly were wholehearted in. They each had one arm and one leg into that relationship. They wanted it, but everybody felt too nervous about doing it. And I think they didn't realize that ‘Yeah,’ they really did want it.” As reviewed earlier, helping couples establish a time frame of commitment to the process prior to making a decision, together with the commitment to work their individual recovery, was the only process mentioned related to commitment. However, several therapists did note the role of faith in increased commitment. One shared the couple was

... very, very committed to their faith, committed to God. If I had to pick one thing that probably sealed this whole thing and kept them together, I would say it was that. They go to church together... The people who have a faith commitment or a value system that said “I'm married for life”—they certainly have more tools to work with than people who don't.

Thus, commitment to the marriage via faith or values provided some additional tools and “gave them a level of commitment to change and commitment to each other.”

Therapists encouraged couples to dedicate time to the marriage outside of therapy to provide opportunities to communicate. One therapist shared how the couple set aside time regularly. “They got these rituals of talking to each other every week about highs

and lows and having scheduled intimacy times...They carve out time for each other.”

Another therapist indicated

...we want them to have couple meetings where they just sit down and get current. There isn't a bunch of time elapsing. Just teach them how to do that. And if there is something going on, OK. Chances are they caught it relatively quickly. I think just continuing to do their individual recovery work and then staying current as a couple. I think that's really helpful.

Thus, time together to share the events of the week as well as to get current around what is happening with the addiction provide time together to communicate outside of therapy.

Therapists suggested providing rules to help these experiences be more positive. One therapist outlined rules around dating.

We made rules about the dates. They could not go to a movie they could not go to a play. They could not go to anything where there could not be direct interaction between the two of them. And that was, that was a helpful thing, because they actually had to interact, they had to talk about things.

Another set up regular times to practice speaker/listener roles. “I built the homework assignments... where it was an instruction thing twice a week and three times a weekend where one talks for only 15 minutes and the other only listened and can only ask questions for clarification.” Finally, another therapist recommended working together “to build a healthy relationship with God.” He suggested that they read the Bible and share it together, which gave “them an opportunity to build their relationship with God and have a common thing that they can talk about.” Thus, various forms of interaction were planned with specific rules to help couples experience success in communicating.

Finally, one measure of success shared by a therapist was when couples are “able to develop an open communication around disclosure and what the triggers are and how the wife can be recruited in to support, or to not get involved and to have good boundaries.” Therapist helped spouses to understand their feelings around relapse,

processed what she needed, and coached her to ask for those needs. One therapist shared how that might happen.

I might coach her language-wise to put it in a language about herself instead of pointing the finger at him... she'd say ... "I saw you looking at that woman while we were at lunch and you were ogling her and objectifying her and that's like you always used to do it." And then I would say, "OK. One, did you guys talk about was he triggered or were you scared he was triggered? And in what way did you let him know that you were thinking that? And she said, "No, I just sucked it up." And then, "Alright, so what could you do differently? And so what do you need to tell him about that now?" And have her kind of go back and see how she could do it differently.

Thus, helping the spouse to own her feelings and share them in an appropriate way may be helpful to handling the emotions around relapse/disclosure. Addicts need support to manage their feelings when the spouse is upset about disclosures, staying present and listening instead of becoming emotionally reactive.

Empathy

Analysts suggested that the themes of empathy, intimacy, and trust are interrelated. Because empathy has the most direct links to communication and is referred to several times as a precursor to intimacy, it will be discussed first, followed by intimacy and trust. Initially, clients are so wounded that they struggle to have empathy for their partner. One therapist noted how her client was "caught in a developmental stage where it's all about that narcissistic child—that it's all about me. I'm the center of the universe." Early on, one addict made an attempt to receive empathy via a letter to his wife.

... it was not helpful because it had to do with him and didn't acknowledge her. I think the letter would have been better had it been written way later. Or that he could've written it and just held it back until she was ready... she didn't have much empathy and compassion for him at all... She was still trying to lick her own wounds... there wasn't anything left right then for him.

Thus, early efforts to elicit empathy may be counterproductive for these couples.

Empathy gradually began to occur as individuals became aware of and addressed their own woundedness. One therapist shared how her client's individual healing opened him up to having empathy for his wife.

I think he felt his own grief really for the first time. Instead of the bravado, the arrogance, the façade, he felt the grief of his life, and it hit him like a brick... I think the connection was after... I think he got it that that's what he's bring into the marriage, but I also think it helped him have some compassion for the likelihood that his wife was bringing that same level of being traumatized.

Thus, being able to connect with their own woundedness lessens partners' feelings of betrayal in the marriage and allows empathy to occur.

Open, vulnerable communication also helped empathy to occur. One therapist shared how a spouse's willingness to vulnerably share her feelings affected her husband.

She allowed herself to connect with her feelings in front of him, which she was really reluctant to do for a very long time. She was stuck in her anger. But a lot of her anger was toward herself. And he of course was able to become more empathic toward her when she was honest with him about how she felt about herself.

Thus, her vulnerability allowed the addict to experience empathy towards her. As they shared their feelings, "they have great amounts of empathy for each other and compassion. Because usually when they're sharing it, I'm afraid that it is pretty difficult... to be angry with someone who is sharing at their vulnerable level that they're afraid of losing you." Thus, when partners share feelings vulnerably, it is more likely to create empathy than anger, creating "a softening... you can see their facial expressions change... all of a sudden their faces look gentler, their voices sound more relaxed."

One therapist also suggested that empathy reflects acknowledgement of the other, finding value in giving as well as receiving.

I think ultimately the way to healing... is when the addict begins to understand that they are not alone, that there is another person there that needs to be

acknowledged, that they begin to have empathy. They begin to see the value in that other person, not just as what she can give to me, but also what can I give to you. They seem to understand that they have a value in the giving not just in the receiving.

Thus, over time empathy is created as clients shift from valuing only what they can get from others to also valuing what they can give/share with others.

It may be a struggle for addicts to develop empathy around the impact of their acting out “because they’ve been so desensitized by the pornography, and have rationalized this and compartmentalized it for so long, and disconnected from reality, it takes them a lot of work to be able to connect with their partner’s pain.” Additionally, addicts may struggle not to become “very defensive and very reactive to her bringing it up or showing that [his acting out] caused her pain.” As depersonalization occurs—being “able to detach a little bit from it and not take it so personally, an affront to who they are”—therapists noted a shift. One therapist noted the addict’s

... ability to have compassion and empathy for her triggers, instead of being reactive to them... if something would trigger [her], whatever that might be, and he would respond to her instead of defensively with, “I know that must've been hurtful.” And not that she's trying to beat him over the head with it but for him to understand that... she still was going through pain of that. And yes, he was the original source of that pain, but that he could still be compassionate with her.

Ultimately then, an addict gains the ability to have “compassion for his spouse, and hearing the emotional consequences for her... just his listening to her being pissed off at him and hurt.” One therapist noted how critical it is when addicts “can really empathize in a genuine way with why this is so devastating to their wives. I think that’s... a critical moment in therapy for the women.” That empathy is “a pretty important part of the wife feeling safe.”

Finally, in addition to empathy regarding the impact of acting out, addicts can also begin to express empathy in other ways. One therapist noted how her client was

...embarrassing her left and right with behavior... at public events. And he would lose his temper and jump on the roof of the car and yell. He thought it was just him you know, "It's just who I am" and sort of had to work with him around how, how that would feel to the person sitting in the car if he were to get back in.

Thus, awareness about nonaddictive behaviors is another component to empathy.

Interventions. While some couples "love each other, and then they generally care, and so can through that lens both have empathy for the other's suffering," therapists can facilitate opportunities for that to be experienced and expressed more frequently. Several therapists noted the importance of writing an amends, apology, or atonement letter as part of the initial empathy work. The therapist's role in that includes "coaching the men into what does a good apology look like? What comprises that?" One therapist connected developing and sharing an amends letter to 5th step work (from 12-step programs).

...usually this kind of amends piece is much more respectful, full of insight about the impact it's had on the partner, and speaks to the emotional betrayal... he did the specific amends, on his knee, with the goal of being fully accountable to you, having you understand that I have some awareness of how hard it was for you, and that I am sorry for what I did and for every time it brings you pain. And that was critical because she was ready to be done with sort of that piece of it.

As the addict is able to express empathy, the wife and the relationship experience a shift.

...when this woman was able to hear from him that he actually got how it isolated her from her friends and family, how it made her feel terrible about her own sexuality and body image... because she's... put a lot of stock into what he said in the past, so really hearing him say, "It took me away from being a good husband, a good father. I spent all of this money. I stole from our future. It isolated you. It left you feeling bad about yourself." That is a big turn around for people... that they're finally heard and they're finally understood at how much pain they've been caused by these behaviors.

While the amends letter is an important tool, one therapist warns that "you will find that somebody wants [the other person] to pay restitution... no matter how many amends you

make... I'll just put it out on the table, what would be restitution for you? What do you need to demonstrate that he's paid the price, he's atoned?" Thus, some spouses may need assistance in sorting through what they need to be able to experience empathy.

Additionally, therapists can use the communication tools clients are learning to help the addict stay present and develop empathy as part of the disclosure process. One therapist shared how to coach the addict in that process:

...he got very good after some coaching of repeating back what he heard her say and then making amends for what he did that even gave her that memory. And saying...that it makes him sad...instead of getting in a blaming place... I would coach him a little bit. "Honor her. Honor what she's in. You're her best friend. Act like her best friend. Honor what she's in. How would you do that?" He said..."she would know that I'm hearing what she's saying." So I'd say, "And how would you do that?" And so he would, he'd say, "I'll tell her what I'm hearing." And so he would do that. And when he... would just automatically get into having so much compassion with where she was at, feeling sadness—sometimes he would cry, and he would say, "I feel sad about what I have put you through and what you have to go through as a result of my addiction..." I would coach them. "What can he do today to help you with how you're feeling? And sometimes she would say "He's just done it, he's listened" or "Nothing" or "I don't know yet" or "I don't know." And I would say, "Think about it and come back next week with what he can do when you're in one of these places to help you with it." And sometimes she would say something specific like, "I want you to give me some demonstration of your love." And he would. He'd love to be creative and so he would write her a poem and so he would do something like that. But ... he soon got into the place, just to the rhythm of saying what he felt, expressing his feeling about what she was in, making amends and then asking her what he could do today, bringing her into the here and now. And that's really important to bring her into the here and now, because partners can stay stuck in the past. What can I do today to help you be ok with where you're at?

Thus, therapists can help addicts communicate effectively by helping the addict identify healthy ways to be present for his wife and providing coaching to help him listen appropriately, make amends, and inviting the spouse to share what he can do for her.

Several important interventions are related to individual work. Genogram and sexual histories were seen as helpful for opening empathy (for the impact of their

behaviors on the self and others). Also, several therapists noted that having the spouse in the room while the partner is doing individual work.

I think even a lot of my couple therapy in the beginning about doing individual work is doing it together because I think it is helpful. Like with this couple, it's really helpful for him to understand how damaged she had been by the criticism to be perfect... And so I think that by doing that worked for the other person to see... there can be some level of empathy.

For both husbands and wives, doing individual work as a couple brought insights, understanding, and empathy.

Several therapists suggested specific interventions in couple therapy for creating empathy. One therapist discussed how Imago therapy helped couples.

One of the therapist's [I work with] is an IMAGO therapist. And so when she starts bringing in each person's family history and tying it to not only well this makes sense about why you married so-and-so, but this also explains a lot about why you guys are struggling with what you are struggling with. That's really helpful in terms of them starting to get some empathy. They understand and they've got a bigger picture and they can detach a little bit.

Thus, seeing how they came together and formed their relationship based on their family-or-origins can create greater perspective and empathy. Discussing goals for therapy on a regular basis can be one way to create empathy.

It gave them something that together again that they were choosing... it caused an opening of conversation... "Well, what do you think we need to work on? Well, I really kind of wanted to work on this... Well how do you feel about that? Is that important? Is that a topic that you want to work on this week or next week? How do you see that as a problem within the marriage?"... it really opened up some communication, where it might be she was oblivious that that was a problem for him. And all at once it's like, "Oh, gosh. I didn't know that. I didn't know you were under stress at work... And how can I help with that?" And that was the healing.

Discussing goals seemed, for this couple, to open up insight into the other's struggles in a positive way. Finally, therapists also suggested ways to facilitate vulnerable sharing. One therapist noted that the addict "was so vulnerable to fall back into that little kid stuff" and

that it was very important for the wife to develop “more of a gentle start up” so that he was less likely to react. Another therapist suggested highlighting the process in therapy after a partner shared something vulnerable.

Frequently a partner will say, “Gosh, I never knew that about you or you never told me about that.” “Well, I was too scared of how you might reject me, if you knew that about me.”...What’s it like for you now that you’ve heard that about your partner? Well, gosh, you find out about what kind of empathy is available and, yeah. I think we did a lot of knee to knee, and some hand holding exercises.

Helping the couple to process the experience of vulnerability in session was helpful in generating empathy. Thus, facilitating communication in healthy, vulnerable ways is one important therapy tool for creating empathy.

Intimacy

Therapists noted how appropriate communication linked to growth in intimacy. One therapist shared that the addict in one couple she worked with said,

“When you did this, what that brought up for me was, I started to think that I wasn’t good enough. Then when I thought I wasn’t good enough, I got angry, and I felt guilty, and I felt ashamed, and I felt ugly... And then I had fear, and the fear was basically that I was going to lose you.” “Oh, well that makes sense.” And so when they start to really get into sharing their realities from a place of vulnerability—not to say that it’s easy—that builds intimacy.

Thus, communicating in a vulnerable way can lead to intimacy. Another therapist noted the strong link between intimacy and sharing feelings and needs.

Usually what ends up happening here is they haven’t been sharing intimately so they haven’t been sharing their thoughts and feelings and needs and wants with each other. They’ve been keeping them secret. So one thing that they need to start doing is to share. Here’s what I’m thinking. Here’s what I’m feeling. Here are my needs, and here are my wants.

Thus, intimacy was highly related to the communication of feelings and needs.

Empathy was also a precursor to intimacy. One spouse “broke down into tears and acknowledged... the pain she has around her body image, and he didn’t know prior to

that experience how much pain she was in. And it certainly brought them closer together.” Thus, her vulnerability, followed by his willingness to be present for the sharing of her pain (empathy) brought the couple closer together (intimacy).

Thus, being able to stay present in the moment and have empathy allowed the couple to see that they could be intimate with each other.

Several therapists suggested that sexual addiction is an intimacy disorder. One therapist noted,

I actually don't like the term “sex addicts”... I really think this is about intimacy disorders. And I think the sex addiction, the sexual behavior, is really just the coping response to the intimacy disorder... using sexuality in some way to avoid intimacy in their marriage... when it's really said and done its much more... a fear about intimacy. And so for these people they use sex as a way to feel that pseudo-intimacy but not real intimacy. They tend to marry people who have as much of a fear of intimacy as they do, and so in many ways the system will work for awhile because everybody is avoiding intimacy.

Therapists suggested that many of these couples are not even aware that they struggle to be intimate: “...sex addiction is really an intimacy disorder, an inability to attach and an inability to connect and be truthful... I think it's true of the sex addict from the day they walk down the aisle. They think they're connected but they're not.” While many sex addicts can be “very charming, very capable in social kinds of situations,” they typically have “a very difficult time connecting with people on a genuine level.” As one addict

...explored relationships that he had in his family and friendship relationships, his relationship with his wife and he became pretty aware that most of his relationships were pretty superficial... that's often just a major underlying issue for people who have sexual addictions. They just don't really do intimacy very much.

Thus, while it may appear that they have better abilities to be intimate, sex addicts and their spouses may struggle to know how to “do intimacy.”

Without an understanding of what intimacy is (or that it is lacking in their marriage), many couples focus their attention on other areas (like trying to stop the behavior) without really addressing the intimacy issues.

They often don't seem to understand that this is more than them just white knuckling it. They don't understand that there are emotional aspects, spiritual aspects, intellectual aspects, physical aspects. They don't understand that this is a lot about intimacy and closeness and how they do that.

One therapist noted that lack of intimacy was one of the signs of a lapse (or emotional slip). Not being aware, couples may not intervene effectively when such lapses occur.

Several couples' patterns of interactions prevented them from connecting intimately. One therapist noted that the addict was "feeling disempowered, and if their wife has been beating on them about it she's feeling empowered in a way that takes away from her everything she really wants, which is intimacy." Another therapist shared that her couple was "very practiced at avoiding one another." Thus, couples not only had a lack of awareness, they also had patterns of interaction/communication that needed to be changed in order for intimacy to occur.

Many of these couples only "start to find out how far apart they've been" as they attempt to come together. Therapists shared ways that clients attempted to create intimacy. One couple started "to get their home in order in a different way so that they have more privacy from their children, and they're both actively starting to make moves towards one another as opposed to the sort of built in avoidance tendency they had." Thus, setting boundaries for privacy and actively focusing on getting closer was part of the process. Another therapist shared that her couple began by

focusing on the positive aspects of the relationship that were relatively undisturbed by the addiction... begin to have fun together again... early on the

addiction is so much the center of the universe that it kind of gets right-sized again. And parenting, fun, spirituality, whatever else is there comes back in.

Other therapists mentioned several ways to improve intimacy: “going to movies “together, having more family interactions,” as well as “time together traveling, engaging in mutually satisfying activities, and keeping conflict at a very low level...” Another couple “would have a time where they would hold each other and just hold each other until they felt really comforted and calm... a lot of the times they’d just stop having time to be close to each other.”

One therapist said that doing some of the activities, together with “improved communication [and] the ability to express feelings to each other” made it so that “this couple has become emotionally intimate.” For one therapist, success in treatment was when clients can “handle that their level of intimacy would increase.” Another shared that overall success in therapy with sexual addiction was related more to intimacy than sobriety: “that intimacy has been reconnected. I think that that is as important—probably more important than—whether the behavior is completely under control because I think it’s really a life-long struggle.” Another therapist suggested a similar belief around couple therapy with sexual addiction.

It wasn’t that his desire went away or that he was able to stay sober that they would have defined as success, but rather the connection that they had developed in between the two of them that they never had before... I’m observing that in almost every couple that has been able to stay together, is that I think the emotional intimacy that develops during the therapy.

Thus, developing intimacy was seen by several of these therapists as a very important measure of success for recovery from sexual addiction.

Interventions. Therapists spoke of how they would “tend to the... reconnection, development of intimacy, true intimacy...” One therapist intervened in this process by helping couples to develop lists of things they could enjoy doing together.

I had each of them make a list about things they enjoyed... and that really helped because they shared those interests with each other. And sometimes they would actually incorporate those things into their dates... I had them reading spiritual things or intellectual things, and talking about ideas a little bit more and that helped them. Those kinds of conversations tend to deepen the different levels of intimacy, the different types of intimacy. I don't think either of them when they first came in had a clue that intimacy included more than physical intimacy. So then there's a little education piece there that I think lots of couples need. But they particularly needed that, “Are you guys talking about ideas? Are you sharing thoughts? Are you sharing goals? Are you sharing feelings or are you sharing spiritual experiences with each other? And as they realized that they weren't, we tried to increase the frequency of those kinds of interactions, and that seemed to help them quite a bit too.

Thus, this therapist helped her clients develop an understanding of what intimacy is and how to create it in their marriage.

Having the partner present while individual processing occurred also had a significant impact on intimacy.

...what I have found extremely effective is when the other party is silent and watches the other person either become aware of something, or have a feeling, or be able to face something in the eye, or talk about a childhood experience. They talk about how close they are when they leave. I say to them it's because you have a piece of information about this person that you wouldn't have had without them sharing it. And that's what intimacy is.

Thus, intimacy may be created in the processing of personal information or feelings.

Finally, therapists can help facilitate in-session communication that leads to intimacy by supporting individuals in staying in an adult place.

...he would then physically kind of move out of this like little kid stance into kind of grown up man stance, and I would cheerlead that. And then she would start responding more to him, and she'd even spontaneously reach over and you know squeeze his hand or touch him on the leg. And so she reached out to him...

Thus, supporting the individual in staying in an adult stance may help provide opportunities for intimate connection.

Trust

The next theme is “working through trust issues.” Several therapists suggested that both addicts and spouses often come from backgrounds that make it difficult to trust. One therapist noted, “I think from an emotional standpoint, neither one of them had ever trusted anybody more than just a tad.” Thus, it may be very difficult for these couples to trust one another even without the distrust related to the sexual addiction. Additionally, because sex addiction is often linked to so much deception, spouses often have an

...exquisitely torturing experience... because they are confronted with their intuition... which is telling them that something’s going on. And then... on the other fork they’re blind. They’re hearing their partner say, “Oh, that’s not true”—the person who they love and trust most in the world. And typically as they initially trust the partner... it is a terrible thing to fight with somebody else’s reality. Because if you mess with somebody’s relationship with reality, that’s fundamental stuff. And that, frankly, I think, is the deeper wound than the sexual wound.

It is even more difficult for the spouse to trust when she discovers the addiction versus the addict disclosing (which is almost always the case, according to these therapists).

Even after full disclosure occurs the spouse will struggle to trust: “Now that I know that—now I know I can’t trust you.” Another therapist shared that the spouse she worked with “still does not trust him. She feels her security is in danger every time he makes a move where she finds out he’s lying.” Even when “there’s more of a real sort of honesty between the two of them that they’ve not experienced before... she still doesn’t completely trust him, nor should she actually, based on his use.” And if relapses occur and the addict is not honest, it reinforces this lack of trust.

“It’s the lying I can’t stand, it’s not the things itself, and assuming the thing itself is not with another person—that’s usually harder to take with a prostitute or an online affair but if its looking at pornography a lot of women don’t think it’s that big of a deal. But they can’t stand that they’re being lied to and manipulated and that creates another breach in the trust which means that they have to start all over again. With the couple that we’re talking about right now he has had a slip and he has lied about it and kept it a secret because he has a history of being terrified to be truthful about who he is without there being great repercussions and, really, trauma... he’s getting better in being able to tell her in real time as opposed to her discovering it a week or two later which then sets her back and has her feeling like she can never trust him.

Thus, withholding disclosure creates another breach in trust, while the ability to have effective ongoing disclosure can be one factor in restoring trust.

Because trust is “the product of experience with behavior over time,” therapists need to help couples develop a way to get “time and continued exposure to, and maybe seeing his shift” in order for trust to begin to increase. This is more easily accomplished

...if both are participating in some kind of recovery process, then the trust level is going up. He’s being consistent... when what he says and what he does are lining up. She’s doing her own recovery work and so she’s better able to trust herself, to take care of herself. And the more she’ll trust herself, then the better foundation she’s got to trust her husband.

Eventually, “they start getting an experience of many resolutions, like, ‘Oh, we got through that.’ And they start building up a history.” It may be particularly difficult for a spouse to “open her heart to him and be loving when she’s always got radar out for is he going to hurt me again, and that goes back to our conversations about forgiving but not forgetting what happened.” Thus, positive behaviors over time, in conjunction with the wife’s efforts to forgive but not forget, may help establish a foundation of trust.

Intervention. In terms of interventions for trust, one therapist suggested that trust-building may need to occur first with the therapist’s relationship with the couple, “being patient with them and just trying to create enough safety in the office where they—you

know a lot of times this is the first time they've ever trusted anybody." A relationship of trust with the therapist may provide a foundation for couples to begin establishing trust.

Some spouses do not try to rush through the process too quickly, short-cutting forgiveness and preventing true restoration of trust.

I find especially ... women of faith tend to want to say too quickly, I forgive you. And yet... toxicity is still there. And to kind of slow down that process because they're sure in a hurry to hurry it up in this erroneous thinking that if I hurry up and say that I forgive him maybe it will be so and we can get back to normal. And I just find they create more heartache in the end because they haven't been genuine. There's a real heart and soul of what forgiveness transformations look like. And so slowing that down, discussing forgiveness.

Thus, therapists can slow down the process, when necessary, to ensure that couples do not encounter more pain as a result of missing steps in the process.

Facilitating full disclosure and ongoing honest disclosure around any relapses for the addict as well as effective individual work for the spouse around how to handle relapses if they occur in the future are critical elements to establishing trust (see accountability section for more information, including facilitating a couple contract for ongoing disclosure). One therapist suggested facilitating the process of ongoing disclosure by "coaching the addict on... being accountable for all your moments, your actions, going back to the things that she said she needed early on to rebuild trust, doing those again." If couples follow their contract and "they are able to achieve and maintain the original transparency," a therapist shared what success might look like.

I think the wife is at a place where if it happened again in you know X amount of time she wouldn't be fatalistic about it... She wouldn't discount the successes of the last year and a half or whatever the time may be.... disclosure as soon after the relapse occurred as possible, the shortness of the relapse, if it only lasted for you know a small length of time-if it only lasted for hours instead of days or weeks. That would be much easier to handle, much more a sign of handling things and being successful than if it had gone on for a while. The nature of the relapse of course would be helpful as well. If it was only masturbation or only

pornography and short. Both of them together—which is more likely—then that’s more of a challenge.

Thus, ongoing transparency through continued disclosure is an important element of rebuilding trust.

While a majority of the therapists focused specifically on disclosure of relapses to rebuild trust, one therapist broadened the idea of making a contract to include ways to build trust generally (for both partners).

It’s a mediated contract. It’s an action oriented list. Both of them come up with a list of action-oriented things that they need to see, hear, or experience in order to feel more trusting of their partner. So for example, one item on hers may be that we get rid of internet for the next six months. One on his may be that we decide mutually who will know about this problem. I’ve had even husbands say, “I’m concerned with the amount of time my wife watches soap operas, because I feel that’s an emotional fantasy outlet for her. And if we’re going to purge our family and marriage of infidelity, I want that to be on the list as well.” For wives too, some of them have been as small as related to the computer, to as big as we need to move cities. “I want you to change career paths and jobs.” That’s a pretty extreme example, but my point is they both come up with action-oriented items... and as a mediator my job is to ensure that both are respectful, that the lists are realistic, that it’s not punishing... and we prioritize them. And so the first round of the contract may have two really big items on it, and then the next time we have a follow-up, we may add one more or adjust it. It’s a living document. It’s not written in stone. It’s intended to change and adapt as the couple increase their trust of one another, because it’s based on the premise and the dilemma that the couple can’t really move forward if he doesn’t feel trusted in the relationship. And she can’t move forward if she doesn’t trust her husband. So how do you get out of that mire? ... And so the “Living Above Suspicion” contract was designed to help couples get out of that deadlock of not trusting one another.

Thus, this “Living Above Suspicion” contract can help couples to outline specifically those things that will help rebuild trust. Because it is a “living document,” it can also adjust over time as the couple’s level of trust increases.

Physical Intimacy

The last theme related to couple work in recovery is the theme of physical intimacy. While therapists suggested that physical intimacy needs to be addressed later in

the recovery process, therapists felt “very strongly that sex therapy needs to happen at the end. I don’t think the work is done until that happens.” Another therapist’s opinion was:

I don’t think our field has done a good job of helping prepare for that later phase of helping couples deal with the sexual stuff. And so a lot of people don’t bring it up or it happens after they get through with their basic couples work and so they just kind of get into the maintenance phase. They have maintenance sex, which can be a trigger for an addict acting out again because like I’m feeling the same crummy feelings that I was feeling before when I wasn’t being honest about what’s going on with me.

Thus, importance was placed on not forgetting to address the sexual relationship prior to ending therapy or it may leave unresolved issues that trigger relapse.

Some of the couples discussed in this study were not engaging in physical intimacy for various reasons. One therapist reported that a spouse had withdrawn from “physical intimacy... it’s been difficult for her to re-engage in that... I can’t say they don’t ever have any physical intimacy but it’s not frequent... He’s much better with handling it—doesn’t see it as a punishment as much as he did when it first started...” One addict “wasn’t engaging in sex with his wife. So he was taking away from that relationship, and he didn’t see it is as that.” Thus, for various reasons either the spouse or the addict engaged in no physical intimacy or limited physical intimacy.

Even when couples were engaging sexually, therapists suggested that the display “an immaturity or a difference about their sexual relationships right from the get-go.” Addicts may struggle to be intimate because they can’t switch from acting out sexually “to trying to be actually intimate with her.” Another therapist noted that her couple “never really had sex as sober people, so there’s a lot of issues and fear around that.” One therapist noted that even if spouses are being sexual, “they’re not being sexual because they’re feeling amorous towards their partner. They’re doing it because they’re fearful

that if they don't he'll go act out. Sex early is about fear, not love." Thus, early fears led to sexuality rather than being motivated by love/desire for intimacy. Thus, immaturity around sexuality negatively impacted these couples' interactions even when they were able/willing to engage sexually.

Interventions. Because couples were often very immature around physical intimacy, one intervention that helped was education around physical intimacy. Generally, therapists suggested talking with clients about physical intimacy even if it is difficult. One therapist shared how she talked with couples about healthy sexuality as it relates to sex addiction.

I'm real clear that in the beginning of their recovery and for the rest of their lives, that the goal isn't to make him a eunuch, or to make him non-human or non-male. It's very natural. It's harder in recovering sex addiction to recovering a sense of healthy sexuality, not going to the extreme. And so it's important that they both understand that for each of them it's normal to be viscerally excited by in heterosexual couples, members of the opposite gender... it's not reasonable to expect that he is never going to look at another woman and be excited or that he is never going to have fleeting fantasies or recall. It is not a reasonable expectation for him as a male, as an adult, as a human being. So that's difficult to really get to a point where they're both understanding that there is a happy medium between the compulsive acting out, and then way to the left, asking him to being anorexic and then moving back to sort of happy, healthy, normal medium.

Another therapist referred her clients to other sources to explore other ways to educate themselves around sexuality. She shared that she "did what I could to make recommendations and to explore those resources, certainly referred them to reading a variety of books, and some films." A few therapists also educated around "God-ordained and worldly views of sex." One therapist shared, "I say 'You know, God's not against sex. He made sex and he made it as a wedding present—as long as you're both happy and you're both in agreement and enjoy it. Try to have healthy sex.'" Thus, education about healthy sexuality was as an important intervention.

In addition to education, therapists also helped clients to explore their beliefs around physical intimacy. One therapist spoke of the struggle one wife had to separate the addictive sexuality from true physical intimacy.

Well I think for her it's condoning. If she is intimate then that means that she condones this other activity [sexual acting-out]... Plus she's wondering "What is he thinking about?"... and so it disrupts the intimacy... I think part of it is just kind of a cognitive restructuring, letting go of some issues like control. "You know what? You can't control what he's thinking about. All you can know is what he's telling you and sharing with you." And having her restructure some of the meaning of some of the intimacy and more of what she gives to it than letting him define what that is. "What is it you want to say by being physically intimate?"

This therapist helped her client by processing her fears and helping her to focus on what physical intimacy means to both partners. Beliefs can be discussed together as a couple as well. One therapist shared this: "I think recognizing that it doesn't mean the same to him and to her, they both have some different meanings about that, and recognizing that hers is just as valid as his." These conversations around the meaning of sexuality provide opportunities to see each partner's point of view and experience it as different but valid.

One therapist noted that couples might also work together to re-establish a safe environment in the house or bedroom for physical intimacy to occur. One therapist shared how she worked with her couple:

How could you make the house, then, special again? And they came up with some things. Like they had somebody come in and do a Native American ritual around making their bedroom sacred again... And then we talked a lot about how to bring sort of their spiritual strength to that, and could they do something in the beginning by bringing their spiritual guide with them. So I would use the information that they gave me at some other time to add to the things that they were talking about creating... just things that they hadn't thought about, and so I might bring that up. And I usually bring that up with everybody. Especially talk about becoming sexual with each other again... Every couple's different about... how the addiction has played a role in their sexual relationship... her fears around it and rebuilding trust and so... I might bring that up... to rebuild trust. What's

happened in your bedroom as a result of this sex addiction? And what do you need to do to make this a sacred place again for you.

Thus, couples may benefit from doing some things to establish a safer environment for physical intimacy to occur.

Many of the therapists also suggested working on establishing physical intimacy gradually, beginning with “developing touching and holding hands, and taking time out, and going away for the weekend, and kind of going through the process of courting again.” Therapists also helped couples understand “the concept of there’s a lot of other things you can do besides intercourse that... means intimacy.” As part of exploring physical intimacy, several therapists helped clients to schedule time to be intimate in different ways.

Then they’d have to make an appointment with each other to have an intimacy time that was beyond this time. And that’s not to say that sometimes they didn’t have spontaneous sex or spontaneous loving feelings towards each other, but they scheduled it because they were so busy... A lot of the times they’d just stop having time to be close to each other. And this couple worked very hard to keep that in their relationship.

Thus, clients were urged to scheduling time for intimacy and were helped to develop skills to talk about and manage their feelings as part of that process. Another therapist shared how her clients were able to successfully be present emotionally when being physically intimate.

...early on when they began to get sexual they would talk about what they were feeling, and they would let that happen instead of feeling this pressure to have sex. He reported one evening coming to her and putting his arms around her, and she stayed present with her discomfort and her stress and whatever was going on and he laid down next to her and just really listened to her. And it wasn’t a sexual moment at all but as a result of the intimacy and the closeness, the arousal came out of that which was really a new experience for him because he’s used to just objectifying things and that’s how he gets aroused. He had an experience of really having his heart open being connected emotionally and that the arousal came out of that more loving state.

Thus, supporting clients in learning to share feelings when being physically intimate can help the couple increase their ability to improve their physical intimacy.

The final intervention was the use of Sensate Focus. Therapists suggested that Sensate Focus needed to be timed appropriately, “after they had kind of laid the weapons down. There was an openness and vulnerability between the two of them...” Another therapist noted the importance of the gradual shift toward increased physical intimacy.

One of the things that we did with them when we finally got through to that point was the Sensate touching. For weeks all they did four nights a week were just touch one another, no sexual anything. To just not have that even in their thoughts until, and we worked through them for four weeks, and that the intimate four weeks, actually, the idea was then to have them have sexual relations then. And that worked. It worked. Actually that was real successful for them. They didn't actually wait until the fourth week... She saw him where he was in touch with not just trying to rush through, but he actually took the time. And she saw and felt him as being present.

Thus, the partner's ability to stay present and not push too quickly toward increased intimacy helped this couple to move forward more quickly. One therapist used these various interventions and noted their outcome for the couple she worked with: “Not simply that this couple was having sex again, but that the quality of the sexual relationship has experienced great healing, and that they can feel safe with one another.”

Overall, then, the process of couple recovery has a foundation in individual recovery. Therapists help couples to understand how their family-of-origin experience plays into their couple dynamic. By coaching effective communication of emotions and thoughts, therapists can help facilitate increased empathy, trust, and intimacy. With that foundation, the couple can then work through issues regarding physical intimacy.

While I have outlined the process of recovery in a linear fashion, analysts noted that the process quickly becomes interactive and sometimes even occurs in a different

order. For example, in the couple recovery section we outlined the process linearly from empathy, to intimacy, to trust. However, another therapist highlighted how trust could lead to intimacy. “I think as people come to trust each other, and as they come to heal the wounds, that they become more accessible.” Another therapist suggested

...helping them to understand that they can say “I was scared” or “I was hurting” or “this is what I was feeling” and getting that there will be people that actually hear that and see them and don’t hurt them as a result of them making themselves vulnerable and that starts to build intimacy between two people.

In several instances, then, trust was a precursor to intimacy rather than coming after it in a linear fashion. Thus, while I have presented these themes sequentially, the analysts indicated that the process was more systemic and less linear.

Balancing Individual Recovery with Couple Recovery in the Process of Healing

Because individual recovery and couple recovery can occur simultaneously, therapists must be sensitive to balance that process over time. Below I review the themes related to that process, including: (a) balancing individual and couple recovery processes, (b) addiction as a process that occurs over time, (c) education, (d) accountability, and (e) taking the couple perspective.

While individual recovery is a precursor to couple recovery, therapists differed in how they balanced the process of individual and couple recovery. Several therapists suggested doing couple therapy only after individual recovery has been worked on for a period of time. One therapist said, “I think there are things that the addict needs to talk about in terms of getting into recovery that the partner doesn’t need to be in the room for, and then vice versa. And then once things are fairly stabilized, then the couples’ work can begin.” Thus, some therapists preferred doing individual therapy first followed by couple work.

Several other therapists suggested that couple recovery can occur at the beginning of treatment and may open up insight that allows individual recovery to occur where it otherwise might not have. One therapist shared that the addict

...started to come to grips with the lies that he had believed as he was growing up. And as his wife sat through quite a bit of this and she was listening to it she started picking up on a lot of the information that she had had as she was growing up, so she started working on her issues as well.

Thus, individual work with the spouse present helped her to begin working her own recovery. One therapist also suggested that couple patterns may need to be addressed for the individual recovery to move forward.

... as long as they're engaged in this dance, they're going to stay in their 2, 4, 6 year old state and they're going to continue reacting to each other, rather than owning their own sense of self. And as long as they're reacting to each other they're going to experience the sense of being victimized, obviously, because they're not empowered.

Thus, unchanged couple patterns prevented the individual recovery from occurring successfully. Another therapist noted how changes in couple intimacy could impact the addict's ability to change individually: "Intimacy between the couple helps the addict to move into feeling, changing some of those core hurts, changing some of the loneliness and the inadequacy and things like that because there is that person who is loving them..." Thus, couple therapy work helps clients to look at their individual recovery, stop negative couple patterns that prevent individual progress, and builds intimacy that helps create an environment for individual recovery.

Several therapists indicated that it can be difficult (if not impossible) to separate individual and couple recovery processes. One noted,

I don't see them as separate at all. If I'm [with] individuals, I'm recovering the couple and if I'm recovering the couple, then I'm recovering the individual. I just don't think you can separate them... Whether I'm seeing them together or separate

doesn't, in my mind, limit whether I'm working on individual issues even with her not present. If I'm coaching him on... individuation... When you're building that, you're making the passion in the relationship healthy and vice versa. So I'm not really feeling like because I'm seeing him individually, I'm not doing systems work. It's more actually getting them unmeshed.

Thus, this therapist viewed individual recovery work as being inseparable from couple recovery work, and vice versa. Another therapist suggested that individual and couple recovery work may be different in some ways but may have some areas that overlap.

... from my perspective they're not always distinct and different... If you had a continuum there would be this little area in the middle where it's kind of both, which I think should amount to be true of a marriage: there's some areas that you can't really separate out as being individual versus couple.

Because individual therapy can build up couple recovery and couple therapy can bring insight into individual recovery issues, several therapists suggested that either type of therapy may be useful early on.

The second aspect of balancing individual and couple recovery involves the decision therapists make to act only as the individual therapist, only as the couple therapist, or to act as individual therapist to both as well as couple therapist. The majority of the therapists divided the individual therapy and the couple therapy between therapists in some way. One therapist noted how dividing the couple was counterintuitive to her training in systems theory. "I break it up... that's one of the rules that you're taught not to do... I tell them ahead of that that is a model that I'm going to use in this, that I wouldn't use in other things, other problems between couples..." Thus, even against her initial training, one therapist felt it was important to separate the couple.

Another therapist commented that if the client is "looking for an advocate or somebody to understand them as an individual, they need an individual therapist, not

somebody working with the person they're trying to figure out whether they want to stay with them or not." One therapist who supported splitting the load between therapists said:

I won't see the couple if I'm seeing the addict. [The other therapist in my office] won't see the couple if she's seeing her addict. We might see them together. But their boundaries are so screwed up when they come in, their distress, their fear of being ganged up on, that I haven't seen it work very well at all. They'll try to suggest, "Well why don't you see us?" But usually that's when I start talking about boundary 101 and why that probably wouldn't be a good idea, at least in my way of thinking.

Thus, several therapists suggested set clear boundaries around they would work with.

Dividing therapeutic responsibilities (individual and couple) between therapists also sends an important message.

I think by breaking them up its also saying, "You both have issues in this." I think it's helpful for him because often times he comes in as the identified patient. And so I think it's helpful for him to say, "We really do have some serious issues here." We also realize that she, not that she caused your serious issues, but that she's a part of the system... But I think it's symbolic of saying, "We want to see you bring to this system, and help you figure that out."

Thus, breaking up the work with different therapists may help send a clear message of each partner's own individual responsibility in recovery.

Therapists divided the therapy in several different ways. Some therapists would do individual therapy with one partner while another person in the same office would do the other partner's individual work. Therapists would then combine to do couple therapy. Others would work with various therapists in the community. While one therapist did not coordinate treatment with therapists, others suggested danger in not being collaborative.

Well, I'm very clear that this needs a team approach, and I don't trick myself in thinking I'm going to manage all those pieces on my own. And so I really, I've always been a very collaborative type professional, with psychiatrists, physicians, other therapists, [religious] leaders... So I think making sure that all the pieces are attended to... I'm aware that they all need to be attended to and so I will make sure and inquire, "Who's doing what? How can we consult with one another to see how all these pieces are being managed?"

Thus, collaborating with professionals around treatment provides continuity and ensures that all the components of treatment are addressed. One benefit of collaboration is “they can’t split us. It’s a lot harder for them to go into the victimization and the self-righteousness as long as they know we’re all talking.” Another benefit of consulting with the other therapist(s) was that it “established a common language.” A therapist explained the risk when a common approach is not used.

I do have some couples I work with who have other individual therapists that maybe have a different approach. And I do think it’s slower... I think the more important thing is not the approach, but that everyone is talking the same so that that gets reinforced from every angle—from your individual therapy, from your couples’ therapy, from your group, so that you’re always getting immersed in it. And its similarly problematic I think for couples who see someone else individually who I think are very good therapists, who have very good approaches, but we’re just not all talking the same language, so the couple doesn’t get as immersed in it.

Thus, finding a common language provides consistent reinforcement that helps improve the client’s ability to clearly understand their process of recovery and avoids confusion.

In contrast to those who divided therapy, a few therapists reported doing both individual therapies and couple therapy. One therapist shared,

I see them individually. I see them as a couple... I never filter them out. I think that’s ridiculous. And I say to them... once we make it clear, well this is your abandonment issue... “Would you like to work on this individually?” So then we meet a couple of times, work through that, keep the couple still coming maybe every other week or every third week. And then I kind of just use this as a process of we’re going to plough through this... We’re not talking about months or years or anything like that... But they usually will say, “I want to come in and talk about this.” And I just say to the other person, “Is that OK?” And they go “Yep.”... If you have an individual that needs more individual time, then you just give it to them more.

Thus, this therapist let couples decide which issues were important to talk about and which forum (individual or couple therapy) works best. Another benefit to this approach is that it prevents them from using the therapist as a weapon.

Because it's obvious that when two of them are seeing, seeing two different therapists that it's not keeping, it's not pulling them together as a couple... It's keeping them separate and almost adversarial with each other... "My therapist says...' Well my therapist says..."

While clients may benefit from having one therapist do all the therapies, therapists may struggle to maintain neutrality. When they can, it may be difficult for therapists to establish a safe therapeutic relationship because of clients' fears that they are colluding with the other."

Only one therapist reported trying to keep them in a couple context in all cases because "when they're not there together they will interpret and take what the therapist says and change it... "Well, she said that you said you said that blah blah blah" or "He said that you said ..." When they're both there, both hear..." Thus, having both partners in session prevents misunderstandings. Also, therapists can "take advantage of opportunities to do individual work while the partner is present." The risk may be that the emotional reactivity may be too high. One therapist said that the decision really "depends on if they're too reactive to sit in the same room, then there's no point in doing it. Then we try to get them into some one-on-one or maybe into their own respective groups where they feel like they've got some footing and some support, and then bring them together."

Another therapist suggested, "I think that when the partner is in the room, it is more difficult, especially early on in recovery, for each of them to be as vulnerable as they need to be with me..." Thus, while working in only a couple therapy setting can help

prevent misunderstandings that can challenge alliance, it may also prevent clients from becoming vulnerable enough and/or create too much emotional reactivity.

Making the decisions around the division of therapy is “a real hard call in this field.” One therapist suggested that it may be dependent on the therapist’s abilities/and or preference. Thus, while the majority suggested that at least one other therapist be involved in some way with the process of treatment, it was clear that the decision is a difficult one and that it may be feasible to do any approach and encounter success in balancing the process of individual and couple recovery from sexual addiction.

Intervention. Several interventions focused on building an alliance with clients. One therapist noted,

I think some critical moments were when both of them really knew I was on their side. Developing a strong alliance with both the husband and the wife because they both come in so beat up... And so I think, over... sessions, really developing an alliance where they could see, “Hey, I am championing both of you, and I want to see the best outcome for both... I don’t have a bias one way or another.”

Thus, it is important to create an alliance where both partners feel the therapist is unbiased and wanting the best for both partners. In addition to the decision around the division of therapy, several therapists shared ways that alliance can be created. One therapist suggested that part of creating safety was to ensure that “both of them feel like their issues are significant. Talk to each of them about what’s going on with them and their feelings and getting them to talk to each other about their feelings.” Alliance occurs “when they begin to see that you are rooting for their strengths and that you see them and you value them individually....” Thus, one major component in creating alliance is helping each partner feel they are understood (including both issues and strengths).

Because clients feel heard and respected, they are able to trust the therapist even when they are being pushed to do difficult work.

...there are so many times that I had to be confrontational with one or the other of them, and particularly with him, and if we hadn't had the kind of therapeutic relationship where he trusted me and we understood each other, I don't think that confrontation would have been the least bit successful.

Thus, therapists can push clients in their individual and couple recovery work without losing alliance when trust is established. Finally, one therapist suggested that it is critical to check in with clients regularly to ensure that each is feeling valued and heard.

I think its real easy working with sexual addiction for one or the other members of the couple to feel like the therapist is taking sides. And I check that all the time now. "Are you feeling like we're going too far with this or are you okay with this" or "What's going on for you?" And I say that to the husband and the wife because I want to constantly monitor that feeling of 'I'm not all wrong and I'm not all right.' And that feeling that the therapist is just siding with him or something like that.

Thus, checking in regularly with each individual can ensure a balanced alliance.

Therapists also discussed how alliance can be better established as therapists are clear about who the identified patient is. Several therapists suggested treating the couple as the client while recognizing when individuals issues arise. Others suggested that they are "not in the business of saving a marriage. I'm in the business of helping each individual gain a sense of self, self-esteem boundaries, and abilities or options for a healthier lifestyle, whether they're together or not." No therapists interviewed in this study indicated that the spouse or the addict alone were the identified patient. Thus, either the couple or both individuals were the identified patient(s), thus holding each partner accountable for his/her part in the process of recovery.

Alliance was also established through honesty. In order to help promote honesty, a few therapists suggested that "it's a good idea for each one to have a session at least

where they can—toward the beginning—just kind of talk freely about what they’re afraid of saying...” Another therapist shared what she did in these individual sessions.

Usually in any couples work that I do, though, I do a long session with him and a long session with her where I do a genogram, family job description, find out anything that they need to tell me that they’re afraid to tell them. Set up guidelines about, “I’m not keeping secrets for you and if I tell you you need to do some work, you don’t know how to do the work then you can say ‘I don’t know how to do the work and I want to work on that.’ But if you don’t do the work, then I won’t continue to see you.” So that’s how I get around, I’m not going to keep secrets for you. Because sometimes people aren’t ready to share everything, they’re too scared, and I don’t want them to drop out of therapy. So I will continue to work around that, of saying “I’ll work with you but we have to work. There’s a reason why you’re afraid, and let’s get to that fear and work through that fear so you can be your strong independent man in recovery, so you can honor yourself.”

Thus, this therapist set up guidelines to delineate what she would do with secrets and how she would work with clients as they struggled through their fears. One therapist did not like to split couples up because she “would rather not know what’s going on before somebody else does.” Thus, while more therapists were open to meeting separately at times, one therapist did not meet separately so she could avoid holding their secrets.

As therapists work to form alliance, one caution was given by a female therapist. She warned, “I think being a female therapist, I’m aware of the risk of the husband feeling alienated in the session and feeling like its two women against one man...” Thus, particular attention may need to be given to gender-related alliance issues.

The final intervention in balancing individual and couple recoveries is related to balancing that process in couple therapy. One therapist shared that she often uses three hula hoops in therapy to distinguish between the relationship, the addict in recovery, and the spouse in recovery.

They come into couples’ therapy the first thing. And I said, “So here you guys are firmly implanted in the coupleship hula hoop, but you have no idea what you’re

bringing from your own hula hoop into this. And so first, we've got to figure that piece out." So kind of taking them back into their individual hula hoops, and then when they've gotten that figured out, keeping them planted, a foot in their own hula hoop, but bringing them back as a coupleship to say, "Now how do you think what you know about yourself now impacts the coupleship?" What is your vision for doing it differently? So I think even a lot of my couple therapy in the beginning about doing individual work is doing it together... I think it is helpful.

Thus, the hula hoops provided a way to physically distinguish between couple and individual recovery issues, and created a concrete way to address individual recovery issues in the couple context. As part of therapy, she would have each put him/herself firmly in their respective recovery hoops and then discuss how to step into the relationship hula hoop while still keeping one foot in their own recovery.

This is really helpful for the wives because... their whole process is, "Let me jump into his hula hoop and help him figure it out." And I just keep those out in a session, and as soon as she does that I make them [go] back, physically I put her in his hula hoop and I say to him, "How does it feel?" Usually he's saying, "I'm out of here. I can't tolerate it." Usually that's oftentimes where a lot of acting out happens. And so to really say, "OK, now how can you get back into your own hula hoop?" Now, and usually that's with I statements and focusing on yourself and your own family, not trying to be his therapist or figure out his issues. And so it's a really kind of a fun, helpful way to just give them a visual image of always staying in their hula hoop for awhile, and figuring out their own hula hoop before they jump into the couple's hoop. And I think a lot of the wives feel like they're in the couple's hula hoop, but in reality they're jumping into his hula hoop.

Thus, using the hula hoops helped this therapist to help each partner to focus on their individual recoveries while simultaneously working to improve the relationship.

The ability to help couples balance their individual recovery with the couple recovery provides

...a shift from the "If only you did or didn't do this, then I would feel better" to an understanding about how I influence the dysfunctional problems in the marriage and work them out. And what I can do to alter that"... so that they see themselves as responsible for what's happening to them rather than blaming their partners.

Thus, a gradual process in couple therapy occurs where individuals begin “to buy into the concept that the only thing they can control is their part.” One therapist shared that

we can invite both of them to be involved while at the same time giving them different responsibilities in that healing... So it's recognizing both of you have needs. You've both been through the ringer with this. Let's work together. And it's attending to both of them while giving them different roles of responsibility. Only he can fix the problem, but it honors the fact that in a marriage she does play a role in the healing of that relationship.

Thus, individual recovery helps couples to be on the same page, take responsibility for their part rather than attempting to change the partner, and provides clearer boundaries around responsibilities each have in the couple recovery process.

Recovery as a Process

In addition to balancing individual and couple recovery needs, several other elements of the process of recovery were highlighted by the therapists in this study. I divide these into components that occurred early in treatment and later in treatment. First, assessment was a major aspect early in treatment. Assessment includes looking at “What is the couple's... education level about this problem, the triggers and vulnerabilities that led to it occurring in the first place?” Therapists suggest assessing the severity of the addiction and making decisions about the type of resources that are most appropriate. One therapist commented, “If somebody was really severe in their addiction, if they could get into intensive outpatient or residential, I'm going to put them there. Because if you continue to act out you can't continue to do anything much with the couples work.” Thus, a higher level of care may be appropriate for some clients. Also, therapists discussed the importance of determining whether groups, individual, couple, or some combination may be best for each couple.

I've had couples where they've started out with individual work and had couple interspersed in that, and then did group as well as couple. Or started out with group and the group helped shed light on individual issues they needed to work on so then they did individual and couple. It really depends on the learning... and the skill set that the client brings, too. I've had women say to me in my research interviews, they would not have been ready for individual work if that had been the first support they'd received. The group was the setting where they could hear other women's stories and for the first time in their lives learned about how they were responding was different or similar to other people.

It may be important in this process to recognize the level of motivation to change, because initially addicts may struggle to give up the addiction, because "it's their primary coping mechanism." Early assessment also includes making the decision about the couple's readiness for couple therapy.

The majority of therapists addressed the need to assess for other disorders and/or problems. One therapist suggested that sex addicts

...are more on the extreme end of the continuum come in with more psychological baggage... They tend to be the people who have the worst childhoods, more psychological disorders, just the extreme of everything. And so they are more difficult to work with because you've got a lot to manage. They oftentimes are chemical nightmares, so they need a lot of medication management and there's just lots of different issues.

Therapists also suggested assessing for ADD/ADHD, anxiety, depression, body image issues/eating disorders, other addictions, sleep problems, grief issues, post-traumatic stress disorder, nutrition, diabetes, and overall health level. While limited details were given regarding how to intervene (i.e. medication management), therapists strongly suggest that failing to address these issues can prevent other progress from occurring.

After assessment, "there's all this pretreatment work that has to be done, there's all this repair work" and "crisis work in the beginning." Much of the work is focused on stopping the sexual addiction. Couples "want this to go away. Period. He wants her to be happy off his back, and she wants him to stop doing what he was doing, and let's get

back to the way we were. And that's part of what got them there in the first place." While only trying to make the acting-out behaviors go away may limit progress, it is essential early in therapy to try to stop the behaviors as part of helping manage the crisis. Stopping the behavior may require "more educational stuff up front, and this is typical of the addiction... it's just the kind of stuff that I think of as sort of speed bumps and guard rails—the kind of things that I think people need to get installed in their lives to keep from slipping." Thus, therapists help develop awareness of ways to prevent slipping. Gradually, couples transition out of crisis and a sole focus of stopping behaviors to addressing other issues connected with long-term recovery.

Therapists also suggested assessing couple goals, which several therapists noted are often very different perspectives. Typically, the

...wife is at a place of having to express her anger and being really sad and lonely, and oftentimes the addicts are... in a much better place because they're going, "I'm finally talking about this." There's finally hope, and so they're looking ahead and can't understand why their wife isn't excited that they're in therapy, excited about their recovery. And the wife is sitting there devastated, and really angry and hurt and lonely. And so developmentally, they're just in really different places, because the guy's lived with this and known about this forever, and maybe she's just finding out about it.

Generally, the addict may want to move through the process quickly while the spouse is hesitant; thus, couples may need help to understand that recovery is a process over time, that recovery "is an ongoing thing, as opposed to you get fixed and then that's a done deal." One therapist suggested that "the biggest challenge for them as a couple was staying with it long enough to see something change." Therapists suggested that couples commitment to therapy as a process over time is considered an indicator of success with sexual addiction.

Therapists also shared that “early on in recovery, the first six months to the first year, it is really critical that they have a sense of separation because they’ve been so enmeshed and they’ve been so dysfunctional in this dance.” Thus, early treatment focuses on establishing boundaries. “Unhooking” from the addict is “a long process” that allows the partner to focus on self-care. It can be facilitated via seeing others model the process of managing their boundaries may also be helpful. One therapist suggested that boundaries were particularly important for when couples became emotionally reactive.

Actually, the other piece of homework was that, if they were going to talk about a serious topic, then we need a brief period of time where they actually had to set a timer and what was comfortable for each. And 20 minutes was about it... That was it. There was no more talking about it. Now they could say, “OK. Tomorrow at 5 O’clock, I want to talk another 20 minutes.” But that was about it... That was done fairly early on. It kept them from constantly picking the scabs off.

Thus, setting couple boundaries around discussing difficult issues also helped couples to not over-engage in a damaging way with each other. Additionally, therapists explained a shift from blame toward individual responsibility.

I think this is the first attainment in any therapy of couples with sexual addiction or not, is that there is a shift from the “If only you did or didn’t do this, then I would feel better to an understanding about how I influence the dysfunctional problems in the marriage and work them out. And what I can do to alter that.”

Thus, early in treatment there is emotional reactivity and a blaming stance that gradually shifts toward a focus on what they can do within their realm of individual responsibility.

Finally, a few therapists suggested that “at the beginning anything they could do to facilitate some good experiences, good feelings was helpful.” This may not necessarily occur in the couple relationship, as one therapist suggested.

These couples have basically stopped being intimate with each other. And so they need to experience that in some way. And it’s very difficult to have them, especially early on in recovery, experience that together. So if they can start

learning how to do that with other people. That's why the 12-step community is so important. Then they can bring that back into the primary relationship.

Thus, therapists help partners each focus on having positive experiences both inside and outside the relationship.

In the middle and later phases of treatment, therapists reported several shifts. First, "as we get healthier and healthier the focus isn't on relapsing. Actually, you will see the spouse not even ask questions. It's his recovery. It's his program. They get very good at realizing that this isn't their stuff, that they don't need to go there." One therapist suggested that eventually "You can get to the place where the sex addiction is just something you manage like crab grass. You just keep plucking, you just keep weeding it out and weeding it out and weeding it out, and it's not the central focus any more." A therapist noted that "early on the addiction is so much the center of the universe that it kind of gets right-sized again, and parenting, fun, spirituality, whatever else is there comes back in." As things get "right-sized," couples focus less on the addiction and more on bringing in positive aspects.

One therapist suggested that addicts shift from being motivated by fear of their wives leaving to more of a self-motivation. She remembered that shift taking places as she saw "the husband start taking seriously the suggestions, recommendations, homework assignments in therapy... or report on how things had been instead of me having to drag that out of him then, then I knew we were in a new phase." Thus, "his recovery really becomes his recovery, and he becomes less dependent on external motivations and his wife's ultimatums, if you will, to be the impetus... for his recovery." Another therapist noted that as this shift occurs, "he starts disclosing... his own pain, then he's got that this

is about something for him, not something he's doing because his wife is going to leave.” Thus, motivation begins to come from the client rather than external sources.

Partners also shift focus more to the underlying issues. One therapist suggested that addressing underlying issues related to traumas may be critical for long-term sobriety. “So it's essential in the second half of recovery... for people to start looking at the trauma because otherwise I think it's very difficult for people to stay sober.”

In early recovery, therapists “really worked with the individual about figuring out, ‘Who's the person you want to be? How do you want to live life?’” Middle and late recovery focus on

...holding that course within the couple system, within other systems: your family system, your friendship system, within all systems. And that it's really hard for people to understand that once you figure that out and start making those changes, its going to feel worse, not better. And it's going to get worse, not better, because people around you will want you to go back to the status quo. And so I think it takes a couple of tries, and sometimes a lot more than a couple, to stay with the course that you have selected for yourself.

Thus, changes made in early stages may be challenged and need to be maintained as part of later phases.

Therapists also noted a shift in the couple dynamics, toward sharing “their feelings with each other, rather than walking on eggshells... the tentativeness that people demonstrate at the very beginning, tends to wane after a while.” Another therapist noted, “Well, the first thing is people stop being so scared—of each other, of the process. They weren't acting in such a defended way with each other... less time in sort of blaming, scared kind of dynamics.” Thus, couples become less scared, defended, and blaming.

No longer being scared, partners could also express more empathy. In later stages, the addict shifts towards

... really looking at taking full responsibility for their behavior and understanding the way it impacted her so it's slanted towards empathy as opposed to the first drafts that we get that are these groveling "I'm so sorry" pathetic person letters that I often hear.

Additionally, the addict learns to take responsibility for the impact of his behaviors on his partner by saying,

"Thank you again for reminding me of the consequences of my behavior." That's enormously healing for both of them. And so to be able to do that when in all of the preparation the addict finds up to that point is to lie and defend and escape conflict, is a tremendous attainment. It's something that takes some time to get to.

Thus, an ability to take responsibility and share appropriate empathy for the other partner was a shift that occurred later in the therapy process.

Therapists also noted a "progress in the intimacy" and a resultant increase in couple therapy. "Now during the middle and end, in the end it's almost couples exclusively because that's the point where we're rebuilding the intimacy." The therapists noted that it occurred only after "both had been focusing on their own behaviors, their own recovery" and had "a better understanding about the disease process and solution." One therapist also suggested processing fears prior to couple therapy and making "preparation... learning to self-soothe in an appropriate way." Thus, intimacy began to be built upon the foundation of individual responsibility/recovery and knowledge of the disease process. It is also important that sex therapy occur in the late stage of treatment when couple's are able to be open and vulnerable.

Gradually, therapists noted that communication shifted from going through the therapists toward interacting directly with each other. "It took about six months into it... I pointed out to them that they weren't communicating to one another, that they were using

me as a sounding board, and at some point in time that they needed to be able to face and talk to one another.” As couples were able to shift, consistently

...coming from an “I” place... [instead of] coming from a “you place”... then the progress in the communication and the progress in the intimacy and the trust restoration becomes clearer. But I don’t ever see that happening fast. That doesn’t happen in a session where both of them say, “Ah ha!”

Thus, middle and later stages include a shift toward direct communication (not through the therapist), empathy, intimacy, and trust.

Eventually, many therapists noted that couples begin to transition from therapy and establish what one therapist called a “phase of stability.” In this stage, couples “reduce the number of times they’re going to their therapist... and reduce the number of meetings they attend. Although I believe that the individual and couples work is important for the rest of their lives, I don’t necessarily see that doing the intense work.” Therapists shared the importance of other support systems at this stage.

The women get together. The men get together. And then I think once or twice a month the couples get together. And they’ll kind of all initiate it without any suggestions from the therapists... And as they have weaned out of therapy, that’s kind of an important piece of support for them.

As a way of supporting couples in maintaining a program that isn’t too “lazy,” several therapists suggested doing follow-up calls or sessions to help provide a few check-ins.

Overall, then, early therapy consists of assessment, crisis/repair work, and managing emotional reactivity (i.e. setting boundaries, reducing blame), and building positive experiences inside and outside the relationship. Middle and later stages are less focused on stopping addictive behaviors and more focused on working on underlying issues connected to the addiction. Individuals increase less fear and more empathy,

intimacy (including physical intimacy), and trust. Couples begin to do more face-to-face work in therapy, and gradually enter a “phase of stability” and a less intensive program.

Intervention. A few therapists noted factors that may impede individuals from moving through the processes described above, and a few indicated interventions that might help couples to overcome the obstacles. One therapist shared that some addicts are just not motivated to change yet. This is indicated by unfulfilled assignment, missed appointments, and not engaging in therapy when they come (avoidance). “It’s kind of like you can lead a horse to water, but you can’t make them drink kind of thing... I think client motivation is huge.” Another therapist discussed how sometimes the addict can also appear very motivated and more fully in recovery than actually is.

...he’s just seems to be very interested intellectually. So he was often coming in with a lot of those things and those things are great but they can also make somebody look really good kind of like a flight into health where he’s spouting all the great language but his behavior’s not congruent with the language. And I think therapists can get fooled by that. It’s like “Wow, this guy looks great, he presents great” but it doesn’t line up with what’s happening for him in terms to connecting to her and effectively.

Thus, therapists suggested lack of motivation and incongruence between the recovery portrayed and behaviors displayed may be two issues that impede progress. When clients are appearing unmotivated, one therapist suggested various ways to help them.

I will talk to them about consequences and give them some educational kinds of things. I’ll talk to them about what they’re going to lose... I’ll just be real open with them and say, “You don’t seem really ready to deal with this... You don’t seem real invested in this. I’m just real curious as to why you are here? And if you’re not here mentally and emotionally and spiritually, being here physically, is being here physically doing any good?” I may do it a gentle way. I’m not mean, nasty... It’s just I hope that someday they’ll come back to some therapist when they’re ready. But it is just obvious that they’re not going to work.

Thus, therapists can be attentive to signs that the client is not motivated and address it.

Two specific cautions were given regarding helping spouses early in therapy. Therapists suggested that “it’s harder for the wives in the beginning. And sometimes we have to do it really gently.” One therapist also noted that spouses may struggle to open up and share their feelings because they think the addict needs to be protected.

...they’re [the addict is] saying, “I really can’t do this alone. I need your help. I need you to be here with me. I need you to understand. I need you to forgive me. I need you to tell me I’m not a horrible person.” Whatever that is, but then what happens with the spouse is the spouse is left with the, the idea that they’re supposed to protect the addict from their own truth. So it takes a while to let, for the spouse to be able to reveal and to grieve their own sense of betrayal and their own feeling that, that they weren’t enough to keep this spouse from acting out.

Thus, spouses may take time to share their feelings and work through their own grief.

When clients are progressing, several factors may disrupt the process if not addressed appropriately. Relapse frequently causes the spouse or addict to stall, and one therapist suggests that “the second six months of recovery is the most likely time for somebody to have a relapse.” Others are successful “in the beginning, and then I see that kind of resistance, there’s something that they’re not getting to. And so... I just try and ask what that’s about.” Another therapist suggested that when clients are “really stuck someplace... I might do [EMDR] resource installation and safe place installation with them to just get them so they can actually do the work, talk about the situation.” Thus, therapists can be aware of and address when clients stop progressing.

While certain aspects of these shifts through the process were linked to certain interventions, a few therapists noted that “there were moments that things really changed, but I think that was just the moments when all the things they were doing would kind of come together for them. I don’t think it was one specific thing that they did that helped them get those moments.” In some cases, these changes or shifts were imperceptible to

the therapist, but they did occur. One therapist remembered, “I thought I wasn’t making much a dent and then... there was a month hiatus and they came back and things had just shifted more, and then I heard more back from them that I was getting through more than I thought. They were just not the kind of people that would give me feedback. So I was doing a lot of cheerleading, but I wasn’t sure it was really getting through.” Thus shifts through the process are often linked to multiple efforts and may be occurring even when unperceived by the therapist.

Education

The analysts also identified three other themes (education, accountability, and couple perspective) that they found to be related to the overall process of recovery. The first, education was an intervention used in establishing early recovery, but it also occurred throughout the process of treatment. All but three of the therapists in this study discussed some facet of education regarding addiction. After assessing for their level of understanding, one therapist recommended reviewing the criteria for sex addiction and Carnes’ core beliefs of sex addicts. When she does that, “it really helps the wife to be able to understand that it’s not something that she’s done by default or done something wrong but rather it’s a result of unresolved issues in a guy’s life that he hasn’t resolved.” Educating about addiction can help the client diagnose the addiction as well as provide some help to the wife in understanding better that the addiction is not her fault (depersonalization). While education about the addiction is important, one therapist noted that it is only the first step in the process: “...he understands why he's doing it. It doesn't mean that he has stopped it at that point, he just now knows why. Now he's beginning to learn how to change that behavior into something that is not hurtful to the other party.”

Thus, therapists saw education about the addiction as a beginning step in the process of recovery.

Therapists can then describe the long-term nature of recovery and the reality that “what’s going to predict whether you’re going to be successful is, are you willing to put the time into this process.” Educating couples about the long-term nature of recovery can help them to not be too disappointed as they work through the process. Because it can be overwhelming initially, therapists suggested approaching the topic carefully with a focus on hope for change. Educating clients about markers of success in the process was a major way to help couples focus on small changes and successes and find hope.

So I tend to, in order to infuse my work with hope, focus on markers. If a couple is able to adjust lifestyle points in a better way, I think that’s great. That doesn’t mean automatically the behaviors going to go away, but I see that as success. It lays a foundation... for eventual overcoming it.

Thus, hope in the long-term process can occur as couples look at markers of success (changes in certain aspects). Relapse can challenge that hope, so therapists recommended preparing couples to know how to measure success even if relapse occurs.

I deal a lot with the process of change and that within change relapse is a part of the process of change. And the key is, “Is the relapse as bad or does it last as long?” There is a lot of educational pieces around that... My hope is that when the relapse occurs it won’t be as bad as the original acting out.

Thus, this therapists helped her clients to see relapse in the process of change and learn to gauge that successes are occurring by the severity and/or length of use. Another therapist shared that some of her clients “still are struggling with relapses, but I would still count them as in the success process... I am a great believer in process, so I tend to look at the process and say, ‘Along the way, there are successes’ rather than saying ‘success is an end goal.’” Thus, being able to see progress in the “success process” may be helpful to

clients, because, as another therapist noted, “even if the behavior isn’t eradicated, they’re building a stronger foundation for it to be down the road.”

Several other aspects related to education about the process of recovery were discussed. One therapist mentioned the importance of both partners understanding the plan for therapy, including why individual or couple therapy is occurring, thus avoiding alienating the client. Another therapist suggested that part of outlining the process included helping define the spouse’s role in the recovery process, particularly what roles she needs to take (see boundaries section for more details). Also, one therapist felt it was important to educate couples about how their experience compares to others’ experiences. “I will say, ‘This isn’t uncommon. This is quite normal.’” Thus, keeping the couple informed about the process even during individual therapy, defining roles each partner needs to take, and normalizing were aspects related to education about the process.

Another piece of education was related to couple dynamics. One therapist shared that couples often

...don’t have any reference points. What’s it going to mean if our coupleship is starting to work? The reference points are pretty distorted.... it might be doing a workshop, a couples’ workshop in terms of communication skills. Sometimes it’s just sitting down and talking about, “OK, these are some of the things that healthy couples do. Healthy couples have arguments like this.” Give them some kind of reference point as to a ballpark of what normal might be.

Education about what success in couple therapy might look like helps give couples a point of reference to measure against. Another therapist noted,

It’s a pretty big educational process involved in what the couple’s learning about what is a healthy marriage? Well, it’s not problem-free. It’s having a map through, having a mine field of issues that comes up and learning how to stay in there long enough to get some resolution.

Thus, educating couples about what healthy relationships are can help couples to maintain the process long enough to resolve issues. Another therapist suggested that educating couples about potential communication pitfalls may help them better prepare for those experiences and for the reality that change will not always happen perfectly.

The last element of education was homework. Therapists indicated doing assignments like letter writing (including exchanging of letters), doing projects (including doing genograms together), reading and journaling, (particularly for women, because “for most men it’s like pulling teeth to get them to do any of those”), and going “on dates and talk about certain issues together, even sex dates or sex homework where they have to learn to have healthy sex.” Additionally, some couples self-educated via reading and attending workshops or retreats.

One therapist noted the particularly powerful way that a foundation of education could be used throughout treatment.

He was particularly unaware of some of the elements of a sexual addiction, some of the things that were going on for him and his lies, some of the things that were triggering him. And so we did some educational pieces throughout the first part. As he started to grasp those and recognize them in his life, then we moved more into raising that consciousness, self awareness, talking over different things he had experienced, analyzing, identifying his emotions and learning to express those emotions.... If they don’t understand those, then our foundation isn’t very steady as we talk about other things. When we try to raise self-awareness, I say, “Remember when I talked about some certain educational thing” and they say “Oh yeah.” And I say, “Can you see how that’s kind of going on now”? So that’s one of the reasons I do some education first.

Thus, having an understanding of addiction and the process of change can provide a reference point and a foundation at various stages as individuals and couples work through the process of change.

Accountability

Accountability was the next theme that extended across the process of recovery. Much of the focus of these therapists was on holding the addict accountable. One therapist noted that wives may be “too angry to come in,” in which case her “tendency is to start with the guy and to hold his feet to the fire until he’s made enough progress that I feel like she’s coming around through these reports.” This early accountability work with the addict may provide a better environment to invite the spouse into later, and can provide a context for rebuilding trust.

Accountability was created in various ways. Some therapists were more confrontational. One therapist noted that she tended to “be somewhat more challenging to the guys I work with, and I kind of put them on the spot. I don’t just kind of lay back and listen. I get more actively involved... just continuing to hold him accountable.” Another would confront the addict heavily early in treatment if you sensed that he was lying. She noted, “I think if people can’t make it through that confrontation, they don’t have a lot of respect for me in terms of my savvy... I think there’s a hopelessness too that they’re going to get away with this—they’re going to go through a therapy and it’s not really going to work.” Thus, in some cases it may be necessary to challenge the addict, and this therapist suggested that it could actually lead to more respect and hope. Another therapist helped the addict to see accountability as the ability to have power to address problems while still being responsible for their behaviors. Thus, clients may be motivated to stay accountable if they see ways it empowers them. Another therapist reported that accountability occurred for the addict by charting himself, noting the positive things he is going to do each day, a list of things he can not do, and rating “himself on a scale of 1-5

of how he's doing spiritually, emotionally... behavior, and then relation..."Having a form to remind the addict of positive behaviors he wants to do and to track how he is doing in various areas can provide accountability. Thus, a variety of ways were used by these therapists to hold the addict accountable for his behaviors.

While much emphasis was placed on the addict, several therapists noted that both partners should be held accountable. One therapist shared,

I stress that both of them have a role in the healing, but yet we can invite both of them to be involved while at the same time giving them different responsibilities in that healing. Because I'm so keenly aware that women are very sensitive... to any message that it's their fault or that they're the one that needs to fix it, because these women come in overfunctioning 9 times out of 10 anyway, and so I don't want to exacerbate that overfunctioning or that self-blame that most of them come in with. So it's recognizing both of you have needs. You've both been through the ringer with this. Let's work together. And it's attending to both of them while giving them different roles of responsibility. Only he can fix the problem, but it honors the fact that in a marriage she does play a role in the healing of that relationship.

Thus, while taking caution to not blame the spouse for the addict's behaviors, therapists indicated that both partners have a role in healing with different responsibilities. Another therapist shared that she works with couples to have each partner ask themselves "'How am I going to be responsible for my behavior in this relationship?' And I hold people to holding on to their own need to recover." Thus, both partners can be held accountable in appropriate ways, helping them to focus on their own responsibilities in recovery.

A major component of holding both partners accountable is the establishment of a written contract. Once individual boundaries have been clarified (see Boundaries section under Individual Responsibility in Recovery), couples bring their own boundaries to the table and work to put the contract in place. One therapist shared,

I encourage couples early on to set parameters around what needs to be disclosed and what doesn't need to be disclosed. So once the addict has established bottom

lines... the partner has set boundaries around those bottom lines... I think establishing an agreement—it's very businesslike and very precise—about what I will disclose and when that will happen—and it's critical to maintaining recovery, because otherwise the secrets start to build up.

In this contract, then, the couple outlines what behaviors will be disclosed, the spouse's boundaries around those behaviors, and how each will interact around the disclosure in a way that supports recovery. In addition, other therapists recommended helping clients to delineate when (time between the relapse and disclosure) and where disclosure will occur. The plan can also include what will occur when the spouse relapses into her codependent behaviors. Thus, some basic ground rules can be used to help provide the couple a pattern for handling relapses into addiction or codependency.

While appropriate disclosure is important, the contract needs to be clear that the spouse is not to be “a babysitter” or “probation officer and he's the probationee... and that becomes then a parent-child kind of hierarchy in your relationship...” where the addict might feel like “the bad child that was being punished.” Using the wife as an accountability partner “keeps the addict in a ‘one-down’ position.” Thus, therapists should “not allow her to be his accountability partner.” When the wife is not the accountability partner, she can focus on expressing her feelings and avoiding codependent behaviors. Thus, appropriate boundaries around disclosure can prevent partners from being the accountability person and avoid negative relationship patterns.

Although each partner is not to be the accountability person, the contract can outline how partners “can be recruited in to support, or to not get involved and to have good boundaries...” For example, one therapist shared how she processed with the spouse to develop a plan for when she relapsed into codependency.

“Well, how can the addict help you with that, and do you want help with that? And what’s going to be a motivator for you? How do you want the addict to bring that to your attention if he sees that you’ve fallen off of your wagon or do you want him to say something?” And so giving clarity about how we’re going to let each other know that there’s stress and pain going on. And I think that that helps, just to kind of set some ground rules. They don’t always do them. But it’s easy then for me to go back and say, “Well, you requested this. Do you still want it? Was it done? When he did do that was it helpful?”

Thus, couples can work on developing appropriate ways to be supportive when one partner is struggling. The contract may also delineate ways the couple can work together to support each other in achieving their goals. In one instance, the couple worked

...together to set up the house so that it would be virtually impossible, at least for him, to get on the computer... so they put the computer out in the living room where she could also see whenever he was on the internet. So they worked together in that respect....

Thus, the couple can delineate ways to create an environment that is supports recovery.

Additionally, the contract will set up a plan that permits partners to check in with each other if they are feeling insecure or scared. Although being an accountability partner is not appropriate for spouses, a therapist shared that one of the things a spouse “said early on was, ‘I want to know when you’re triggered. I want to know when you’re struggling, and I want to know what you’re doing to take care of it.’” One therapist said that the addict “needn’t come home at the end of the day every day and say, ‘Here’s the 20 things that I felt tempted by today, hon.’ Because that’s a problem.” Instead, the contract can put a structure in place that outlines how partners can check-in.

But it’s important that periodically through the recovery if she has—not that she’s allowed to badger him—but even if she has questions 2, 3, 5 years down the road, just a general question. “So I’m kind of feeling insecure, honey. I’m just wondering, how are you doing?” He can certainly say, “I’m doing fine. Sometimes I struggle. But I haven’t acted out. I’m going to my meetings. I’m doing fine.” I think they can keep that communication open between them.

Thus, open communication where the spouse can communicate her fears and connect with her spouse is one way to check-in. Another therapist set up a rating scale,

...where 0 to 100—and we had discussed in therapy what 0 meant, what 100 meant—and if she at anytime was feeling anxious or sensed that a relapse occurred, she had permission to inquire, “Where are you at?” And they had this very simplified language that was not attacking. They could just in a very non-defensive way say, “I’m at a 57.” And... she could then gauge the direction of progress as well. And so couples that are... successfully dealing with this have developed a way to talk about this that works for them.

Thus, the contract outlines the appropriate ways for partners to check in with each other.

Part of the check-in process can include on-going amends. One therapist suggested doing “a 10th step around it with their sponsor and apologize to their partner, not just you know ‘I’m so sorry’ but ‘Wow I really see the impact this behavior has on you and this is my best understanding of what happened.’” When the wife is upset, one therapist suggested that the addict be supported so that he can “be in a place where he genuinely looks at his wife in the eyes and says—she’s furious at him—‘Thank you again for reminding me of the consequences of my behavior.’” The wife also can be urged to own her part of things when she slips into her old behaviors. One therapist shared how a spouse was able to do that:

...she admitted her side of the interaction that went between them, and even though he went back to his drug of choice, she also went back to her drug of choice. And so she also made amends for that, redid some things they had done early in the couples work that worked really well for them at critical moments, and then it just reestablished their commitments to each other in their own recoveries and their couple stuff.”

Thus, making amends as part of the check-in process provides appropriate accountability for both spouse and addict.

Finally, it is important that the couple (a) writes down the agreement, (b) is held accountable to it, and (c) revisit it on a regular basis. One therapist shared that

...because we had kind of that structure set up they, they honored it and... I really do believe honoring a plan is important. Its okay to change the plan, but honoring the plan that you have is really important. And so I tell them that. That's why we've set up these times to revisit plans. So they decided they would keep that one for the future. What she worked on was to develop her own accountability plan as well. And so she developed one of those... saying, "In my recovery I will be accountable as well, because I wasn't accountable either."

Thus, honoring the plan and being accountable to the agreed-upon contract was important. Another therapist shared that the plan could be changed and needed to be revisited on a regular basis

... we came up with some sort of solutions that they could write down and agree to and then revisit... revisit in three months, revisit at your year anniversary. They decide when they're going to revisit it... because we had that structure set up, they honored it. And I really do believe honoring a plan is important. It's OK to change the plan, but honoring the plan that you have is really important.

Thus, the disclosure contract should be honored and reviewed regularly.

A successful contract ensures that "it happens in the context. He knows what he has to do because he knows his program. He needs to stay away from here or do this. He got hungry, angry, lonely, tired, or whatever. And that she isn't devastated, that this isn't about her and her body." In other words,

...as long as they're both doing what they should be doing, he doesn't go into a shame spiral and then continue to act out. And she doesn't go into a shame spiral and go into taking it personally... So they don't go from point A to point B in a nanosecond. They don't go from, "I'm in recovery, and now I've slipped to relapse, and now we're going to divorce." It doesn't go automatically fatalistic thinking.

Thus, a collapse does not occur. The couple is, instead, able to say,

"This is just a speed bump in the recovery. Let's see what we've missed." That something was being missed. Maybe something hasn't been talked about. Somebody's emotions are getting all stirred up. So let's find out what happened. So... that is success, because they're continuing to move up, and they've kind of weathered that storm.

Thus, a good couple disclosure/relapse plan helps couples to respond less reactively and focus on learning/growing. The contract is written, includes boundaries for what behaviors need to be disclosed, how and when to disclose, ways to check in and/or support each other appropriately (without being the accountability person), and times to revisit the contract. If the contract is done well, it can help couples to create a context that allows them to move forward in their individual and couple recovery process.

While this contract provides commitment to how each partner will follow through and thus holds them accountable, it is important that someone else be the one who's holding their "feet to the fire," thus being "accountable to somebody." Several therapists suggested that religious leaders who took the addiction seriously and could approach the couple in a balanced way could establish positive opportunities for accountability for couples. "This bishop seemed to be really well-grounded where... he was good on telling him about consequences, but he was also very understanding, very empathetic to both of them as a couple and he was willing to talk to each of them separately and together."

Another therapist suggested that

... RCA works really well... helps them to look at their coupleship as an entity in and of itself. Sort of the coupleship is bigger than the both of them and also it has a life of its own. And so it helps to really reduce not only the shame, but it also holds each accountable in the coupleship so that they're not just pointing fingers at each other and blaming each other."

Ideally, one therapist suggested that the addict should be "sharing it with his sponsor, he's sharing it with me, he's working through it in therapy, he's being accountable with his group..." Thus, therapy, sponsors, groups, RCA, and religious leaders can help provide accountability.

Couple Perspective

The final theme that the analysts noted across the process of recovery is taking the couple's perspective. In the initial assessment process, several therapists commented on the importance of meeting each client where they are in the process. Because addicts frequently struggle to see the negative consequences of their behaviors, therapists suggested that it is important to understand the addict's perspective while still processing with the addict to open up his perspective to other possibilities. Other therapists suggested being sensitive to how the addict's perspective may not be empathetic to the spouse: "He tells me that just because he's looking at porn on the internet, at least it's not with another woman.' And she says, 'It feels like it's with another woman.'... And so, it doesn't have to be with another person to be serious." In assessing the spouse's perspective, it was noted that it was important to look at the severity of the consequences of the behaviors, including STD, HIV, abortions, pregnancies or children outside the marriage, money spent, losing his job, acting out with prostitutes, minors, patients (for doctors), or parishioners (for clergy). In addition to the types of behaviors, it is important to look at how the woman is impacted by the behavior.

Like what's the story leading up to therapy? I mean this woman really could be on her last leg with this issue, versus the woman that comes into therapy after three weeks of discovering it... try and get a good context of, "Where is this person in light of this problem?"... And also with that, what is this person's threshold? We have people that we kind of generally expect should be dealing with this, when in fact this may be way over the top for what someone's able to deal with. So I try to be compassionate that every single woman's going to be different.

Thus, therapists need to be sensitive not only to the consequences of past behaviors but also the individual's experience of those consequences.

Ten out of the fifteen therapists also suggested the importance of letting couples guide the process of therapy via the clients' goals. Thus, clients can "set the goals and

then they then have the measure of their own success.” Another therapist noted that it was important not to impose the goals.

“What is your measure of success and change?” Not mine. I mean, for all I know it could have been he only participates in his phone calling on weekends and not during the week. And if that would have worked for them, hey, it’s a success. In this case it was not. That was not the case. Their idea of success was that he would no longer participate in those activities.

Thus, therapists suggested sensitivity to allowing the couple to set their own goals.

Couple perspective also relates to pacing/timing of therapy. Some therapists suggested that they do not want to guide the therapy process or have a specific plan for the couple but rather leave that to the couple’s guidance, which one therapist suggested would lead to a sense of “control over the therapy.” Therapists also suggested that it was important to help clients with the timing related to the type of support they seek. One therapist noted, “I’m not adamant that it has to be one type of support. I like to assess where they’re at, what kinds of supports they’ve had in the past, what’s their preference, what’s been most helpful before, and design that treatment plan with the client and where they’re at in mind.” Carefully deciding what type of therapy is most useful at each stage based on the client is part of pacing/timing. With regard to couple therapy, several therapists suggested that it is important to pay attention to the level of reactivity with couples in assessing the right timing for couple’s work. Additionally, one therapist suggested being sensitive to financial needs. Assessing the individual’s perspectives, including finances, can help therapists provide the most appropriate type of support.

The last aspect is using the couple’s language. One therapist noted that one way to “open space [for change] is to use the client’s language, that they really perceive me as wanting to connect with them, and witness this with them.” When clients used certain

language, this therapist suggested processing it with the client: “I define that with the client... ‘What does overcoming it mean for you?’, if that’s the word they use, or ‘getting over it’ or ‘moving on with my life.’ I will stop them and say, ‘We need to be clear on what that means for our sessions.’” Thus, working to understand the client’s language was seen as an important by this therapist.

Other aspects of languaging included collaborating with clients in defining their experience via their own language. While it may be helpful to describe addiction to the client, one therapist suggested “letting them help me describe what’s happening, the cycle of addiction and identifying different triggers and things like that.” Thus, therapists can use the client’s own perspective and language in defining the addiction. One therapist was sensitive to one client’s dislike of the word addict. “He just associated that with somebody that just absolutely just didn't have any control over himself.... He saw his behavior as... selfish, but not addictive... he didn't mind the word obsessive compulsive behavior. For some reason that was acceptable.” Thus, these therapists suggested using the clients language to help them develop a better understanding of themselves while avoiding the language that may create struggle or prevent progress in treatment.

Intervention. Several interventions were connected to the various aspects of taking the couple’s perspective. Therapists can also “collaborate with the client as to what their goals are and what successful means to them”, thus having “a mutual understanding of success.” In some cases, the client may still be looking for direction instead of attempting to see their own goals. One therapist noted,

I often work with [religious] people who are used to receiving counsel, and... I call myself a therapist purposefully, that my job is not to give them counsel. My job is to create a context wherein they can discover for themselves what’s right for them. But in that I feel I do have a duty to educate sometimes because people

may not know aspects of this problem or recovery that would be useful for their decision-making. And so there's a difference between counseling versus educating in my view.

Thus, this therapist educated clients about aspects of recovery that might inform their decision while avoiding counseling them as to what decisions to make.

Once goals are set, one therapist suggested offering "some tools that you might learn to use or windows to look through to give you some different insight about what's going on." Thus, therapists can highlight goals as a measure of accountability or success.

Therapists can then checking back in with goals. One therapist shared,

...we would go back over, "Are the goals still the same? What are we looking for? Is there a new goal that you want to focus on for this session or the next few sessions?"... It gives them a base line of what they could see if there was progress... With the setting of the goals and then getting to evaluate and how they were doing...

Therapists who suggested doing this process varied in suggesting that it occur somewhere between every week to every month. Another therapist noted that it was important to generally refer back to goals in helping clients take responsibility. "I keep the responsibility on them. I keep turning back you know 'What do you want to accomplish? How am I helping in that process or not?' And sharing with them what I see them doing or not doing." Thus, this therapist suggested continuing to refer back to goals to ensure they are being accomplished effectively.

Regarding pacing of therapy, one therapist suggested a specific way to help couples to develop a shared view of the pacing of therapy.

I commonly, and I did with this couple, ask her "What's your time frame of when you expect this to be overcome according to your definition?" and hear that from her. And then ask him, "Knowing what you do about yourself and this problem and your commitment to change, or lack thereof, what's your time line?" And then explore with one another, "What surprises you or doesn't surprise you about your partner's time line?" And then that's when I may jump in with my

experiences with other couples and what I read in the literature. And then we come up with something new sometimes... So I really collaborate with that. And I don't, especially if there's differences with the couple, I don't just leave it there. I really try and work together to create something that's mutually understood and acceptable.

Thus, this therapist suggested helping couples understand their individual view of expected time frames and then work together to establish a mutual vision.

Once the goals and pacing of therapy have been addressed, several interventions were suggested for helping clients who struggle to see other perspectives. When clients take a rigid view, one therapist suggested,

I try to be understanding... when they take a very clear-cut stance, and just ask really quality questions that can open space for this person to feel safe with me. Because when someone becomes so polarized, if I become equally polarized, she's just going to become more closed in that position. So I see... the goal [is] to really open space for her to explore it... I would ask, "What would be the pros and cons of that? What would be the impact on all areas of life if that decision were to be played out? Would there be any regrets?"... Asking quality questions, open-ended questions. "Tell me what this would look like? Tell me more about that?" Asking systemic questions, questions from all different angles... being curious...letting her know, "I don't have an agenda for you...but can I kind of shoulder, go side by side with you in looking at this decision, and will you permit me to ask some tough questions on the pros and the cons of it? And my motive for doing that is to explore it, to be curious, to really ensure that this is going to get you where you want." But I think that curiosity, that desire to look at it from all different angles is how I would open space.

This therapist was collaborative by carefully asking appropriate questions to help her client explore her goals while still leaving the decisions ultimately with the client.

Therapists can also share their perspective without imposing it on the client. One therapist pointed out the importance of shifting the interactions within the couple process.

I pointed out to them that they weren't communicating to one another, that they were using me as a sounding board, and at some point in time that they needed to be able to face and talk to one another. And I said, "And that's just your time, not mine... I've got all the time in the world..." And I don't remember if it was the next session or the one following after that, and they did. So they come and it was kind of halfhearted, it wasn't directly facing one another. That, they kind of

moved, kind of progressed to that. At first it was kind of the chairs became a little closer, and then they were kind of turned, and until they were, at one point, really just face-to-face, and I kind of on the side looking back and forth at them, and just kind of helping that way.

Thus, this therapist helped the couple by highlighting what she saw in the process and suggesting a need to shift toward more direct communication while still giving the couple permission to do that at their own pace. Therapists can also “throwing out ideas—but really them picking from my ideas or growing an idea into something that worked better for them—of how to make a shift in how they were doing things within the coupleship.” Thus, there are several ways that therapists can share their perspective and expertise without imposing their view on the clients, thus allowing them space to change in a way that is the best fit for them. One therapist shared what she would do in the case where education or exploration of the problem via questions may lead to the client feeling pressured by the therapist.

If I sense that, I would acknowledge it. “My fear in sharing this with you is that you may perceive this as my attempt to convince you one way or the other.” I would acknowledge that concern if I sensed it, if I was picking it up. Or touching base with the client: “How are you hearing this? What do you think my purpose in sharing this is with you?”

When therapists sense a client is feeling pressured, they can acknowledge it, discuss it with the client, and distinguish between sharing information and having an agenda.

Finally, therapists also suggested that interventions, including amends, need to be timed appropriately. “And so if I sense that they’re not ready for that or that’s not the right timing, I really let the couple inform when we do that kind of thing.” Therapists should be careful to bring up specific interventions or information in a judicious manner.

Addiction versus Affairs

The last theme, the delineation of the difference between sexual addiction and affairs, was described as being “stand alone” (not directly related to any of the three major areas previously discussed) by the analysts. Thus, I include it here outside the context of any of the other themes. There was considerable disparity between therapists’ opinions regarding the difference between sex addiction and affairs. Seven of the therapists suggested that affairs and sexual addiction are similar in terms of treatment and overall impact on the individual and couple.

I think the wounds are two things: there is the sexual betrayal itself, and then there is all the deception that gets piled on top of it, which is this exquisitely torturing experience for partners because they are confronted with their intuition—and this is affairs or sex addicts—which is telling them that something’s going on. And then they’re on the other fork they’re blind. They’re hearing their partner say, “Oh, that’s not true”—the person who they love and trust most in the world.

Thus, these seven therapists suggested that both the sense of sexual betrayal and the deception are important components for both affairs and sex addiction. The factor that mitigates the degree of betrayal is the level of severity in the behaviors (for either the addiction or the affair) and the resulting consequences (i.e. STD’s, law issues). Therapists suggested that a lower degree of severity and consequences may allow clients to move more quickly through therapy, although in similar stages.

Therapists suggested that treatment would also look similar. They would still discuss the dynamic in the family-of-origin and the impact that had on them “spiritually, emotionally, physically, health-wise...” Therapists would also need to address spouses’ tendency to blame themselves for their partner’s behaviors. Another “similarity is having compassion for his spouse, and hearing the emotional consequences for her.” Thus, empathy is another component for both affairs and addiction. Finally, one therapist noted

that you would “still have to tend to the grief and the trust issues, and the reconnection, development of intimacy, true intimacy...” Thus, helping couples deal with grief issues, trust, and intimacy development was another similarity mentioned by the seven therapists that saw affairs and addictions as similar.

The remaining eight therapists saw affairs and addiction as different. Of the eight, four suggested that affairs were more difficult to treat, three suggested that addiction was more difficult, and one saw them as equally difficult to handle but different. The first major difference was that “couples where there is addiction have to accept that there is this chronic risk, and that nothing will ever make it go away and relapse is always possible...” An addict is “going to have to struggle with, if the stress gets bad enough, they’re going to probably revert to old patterns, old ways of being able to cope. They’re going to have to... consciously be aware of it for the rest of their lives.” With affairs, “the person who had the affair can make a conscious commitment never to do that again...” Additionally, addiction is “more pervasive. It’s right there. The temptation is twenty four hours a day, seven days a week. I think for an affair there’s... it’s more specific to an individual and so it isn’t there constantly...” Because it is chronic and pervasive, these therapists felt that “the timeline for care is longer with sexual addiction because... aside from the relational impact, you’re dealing with an addictive element...” Despite these challenges to the couple that struggles with sexual addiction, one therapist noted that with “couples where’s there’s an addiction, there’s so much more compassion. There’s more empathy because of it being an illness...” Thus, while the chronic nature of addiction can be more difficult, the reality that it is an illness can create more compassion.

Affairs are also seen as “much more cut and dried, like ‘This is inappropriate behavior.’ Many times they just divorce them... [or] it’s “here’s the affair. We need to clean it up... and move forward.” Additionally,

...most partners of sex addicts are co-dependent, whereas, partners in affairs are less likely to have that co-dependent part as part of their spouse so they don’t have to work through that... The capacity to attune where I end and somebody else begins is not as clear to some people as it is in non-codependent people. So somebody who is already pretty clear who she is, strong, and able to listen and understand without feeling like she loses herself just doesn’t have so much work to do in therapy.

Thus, these therapists suggested that affair spouses tend to not be codependent and have better boundaries and that, therefore, the decisions with an affair are more cut and dried.

While spouses of addicts may have more personal work to do, therapists did suggest that it may be easier for spouses of addicts to take the sexual acting out less personally. Therapists “can point to alcoholism and all those other things to talk about the nervous system and how it’s wired and how we all cope with that, but with affairs I think it’s a lot stickier.” Thus, it may be easier to depersonalize addiction than affairs. Whereas with affairs, “they’re sharing intimate detail of their lives and feelings. And I view that totally different than something that is... uncontrollable... They view that as like taking a drink or a hit of heroin.” Affairs can also be more personal because they more frequently occur with someone that the spouse knows. “If you have sex with a prostitute, or if you have an affair with somebody I don’t know or I’ve never seen, versus you had an affair with Susie next door, and I see her taking the garbage out, usually for the spouse, that’s a bigger betrayal.” Thus, while affairs may be less complicated in some ways, they may be more difficult to depersonalize.

Affairs were also seen more as a relational issue while addiction was seen more as an individual issue. A therapist shared the difference.

To me an escape is a long-term method that someone uses to cover up emotions that are unpleasant for them... "I don't want these feelings. I don't want to face my inadequacy or my loneliness or whatever it is. I don't want to face my core hurts, so I'm going to go to this momentary solution that has these long term consequences." That to me is more what an addict does. I think when I say their needs aren't being met [for affair partners], I pretty much mean their couple needs, although sometimes it's more loneliness and things like that... But it's not as much the "I can't deal with anything, I can't deal with any of my emotions." It's more frequently... "It seems like we've stopped loving each other. It seems like we've stopped caring about each other. It seems like we don't spend time together. He doesn't understand me she doesn't understand me. I don't even know if I love her anymore." It's more specific to the couple, whereas, the addiction seems more specific to how the person reacts to themselves in the world... I think affairs are terrible, they're so damaging... somebody became very enticing... the relationship was paying off emotionally, intellectually for the couple member that was kind of strained... I'm not getting what I need in this relationship and so this looks very enticing...

Thus, affairs are viewed as stemming from relational issues while addiction is seen as a more global way of trying to cope. Also, addiction is also "more triggered by self esteem issues... lack of intimacy skills, depression, anxiety" and trauma (Big T and little t).

Thus, three of the therapists suggested that addiction is harder to treat because of the number of underlying issues addicts and their spouses may bring to treatment.

Affairs may also be easier to treat, according to some therapists, because the level of intimacy is higher with affairs.

I think something that started after the marriage got started, it's been my experience that the couple is a little more willing to look at: "How did we get to this place? How did we become so distant and disconnected that we had room in our relationship for this to occur?" Whereas with pornography it's been there all along, and so it's for the partner to come to terms with, "Have I ever really known this person?" And that doesn't happen necessarily with a real life affair that started into the marriage, because they did know that person. And their sexual and intimate relationship perhaps got off on a very good footing. Whereas with the pornography I think there is an immaturity or a difference about their sexual relationships right from the get-go that's different.

Thus, with pornography intimacy has been lacking/immature from the inception of the relationship, whereas couples who come to treatment for affairs often have had some level of true intimacy. One therapist referred to sex addiction as “an intimacy disorder, an inability to attach and an inability to connect and be truthful.” Thus, addicts and spouses may struggle to understand and develop intimacy. Finally, while affairs happen in real life and require social skills, addicts may lack the skills to be social and intimate.

While the fact that the person is real may be beneficial, it may make it more difficult to leave the affair behind.

Affairs are often much more difficult in terms of rebuilding trust because there’s an emotional involvement... And they’re much more difficult to break... What we have to do is to help them see that they probably got into the affair addictively, dysfunctionally, which is really difficult... to tell somebody who they think they’re in love with that they fell in love with this person out of addiction or out of dysfunction, is not something that most people want to hear. Because it’s a Cinderella fantasy... I saw her across the room, and then “Some Enchanted Evening” was playing in the background. God came down and spoke to me and said, “You have to be with her.” So to break that denial and help him to see that even if hypothetically, he’s really in love with her, and you’re supposed to be together for the rest of your lives, that you probably got into the relationship, into the affair, in a dysfunction and addictive way. It’s a fantasy. It’s really one of the most difficult pieces of therapy.

Thus, the initial decision to leave the affair behind and move forward in healing the marriage may be more difficult to make and take longer than the decision to leave the sexual addiction. Because of this long period, some therapists suggested that “affairs are just the most painful things in the world to work through.”

Intervention. Therapists recommended that the “first session is determining about whether it is a sexual addiction or not...” Several of the ideas discussed above were used to help assess, but even with these tools, one therapist suggested that “it’s so hard to tell.” Once you have determined it is an affair, several therapists suggested that working with

the couple is a better choice “because you’re not... looking so much at distorted thinking and at the compulsive stuff and visualization... You’re also not looking at a lot of historical disclosure... [you’re looking] at relational skills, and at healing, and at some kind of appropriate period of amends usually.” Thus, in treatment with affairs, therapists suggested working with the couple to heal the relationship. Therapists suggested working to first stop the affair, then focusing on helping both partners to deal with the triggers that may continue to occur due to the affair. Additionally, therapists can explore “What was the history? What lead up to it? Why did you drop your guard?” Therapists suggested processing “what their payoff was from this relationship” by “asking both, ‘What's missing for you?’ What were their expectations of this relationship to begin with?” After determining what led up to the affair and what is missing in the relationship, therapist can then help couples to do “the things that will strengthen that couple’s relationship so they can ‘fall in love’ again.”

In contrast, therapists suggested that there is significant repair work and education that needs to occur with sex addiction. Additionally, sex addiction has “more of a medical aspect to it... I will often refer these men for full medicals and encourage a discussion between their doctor and them about an antidepressant as a support to help with the impulsivity.” Thus, repair work, education, and medical aspects were additional components related to sex addiction. Therapists also noted that it was important to be “very aware of the shame and not helping to create it, and working through it, and having the spouse not put the person or say things that create more shame.” In conjunction with shame reduction, several therapist suggested 12-step groups “simply because they need to get out of the shame that thinking that they’re the only ones that this is happening to....

they need to be able to talk about it to other people because that begins to diminish the shame that they're carrying. It gets them out of isolation." Only one therapist suggested 12-step for affairs, and she recommended Al-Anon or Codependents Anonymous.

One therapist noted, "I'm sure you talk to ten different people they're going to tell you ten different things." In our study, that was verified. Therapists' opinions may have been based more on their own familiarity with the treatment of affairs or addiction. While several suggested family-of-origin would be more important only for addicts, others suggested intergenerational work for affairs. While some suggested affairs would be easier to manage due to the familiarity in our culture, others suggested that addiction "is more familiar to people—the whole model of treatment." While some suggested that honesty about the affair was not important, others suggested it was, noting that clients who keep secrets in affairs are "creating this covert secret relationship... The more secrets you share then the more intense the relationship begins to be, etc. It siphons off the energy... that you have with your spouse." Thus, therapists differed greatly in their opinions sex addiction and affairs. Several therapists even questioned themselves as they shared.

But the affair couple, it's more about the behavior... because once he promises he's never going to do this again, they don't stay that long. He says, "OK, we've fixed it." But I still think that for affairs, I'm wondering how much truth they do tell, because they just got into so much trouble because they got caught... I tend to think that it takes the addict so long to get honest that I'm wondering how much of the affair stuff that we don't find out.

Thus, there was significant confusion between therapists and within therapists regarding the differences between sex addiction treatment and affairs.

CHAPTER V

Discussion

Therapists working with couples who are struggling to recover from sexual addiction must understand the process of individual and couple recovery as well as key factors in balancing that process. A thorough understanding allows therapists to effectively assess, intervene, and guide both individuals and couples through recovery. Interestingly, much of what therapists reported to be effective in treating sexual addiction are general components of “good therapy” with any client (i.e. taking the clients perspective, responsibility, etc.). While it is clearly beneficial to understand and practice “good therapy” with any client, the therapists in this study indicate that therapists must practice consistent attentiveness and strict adherence to such practices in order to be successful with clients who are struggling to recover from sexual addiction. Below I offer a sequential overview of the key components of change that were identified in this study as well as important considerations for therapists who work with couples struggling to recover from sexual addiction.

Assessment

A thorough assessment can ensure that interventions for stabilization and later recovery are effective. As part of a thorough history, therapists in this study suggest assessing for comorbidity with other addictions (Eisenman et al., 2004; Kalichman & Cain, 2004; Wan et al., 2000) and comorbidity with other DSM diagnoses such as depression (Weiss, 2004) and ADHD (Blankenship and Laaser, 2004). Additionally, therapists suggest assessing for anxiety, body image issues/eating disorders, sleep problems, grief issues, nutrition, diabetes, and overall health level. An appropriate

assessment will allow therapists to determine if medical intervention should occur, including medication when appropriate (as was also previously suggested by Cooper & Lebo, 2001; Kafka & Prentky, 1992).

Based on the findings, therapists should assess the level of trauma related to the discovery, including the time the couple has been dealing with the sexual addiction, the consequences related to the sexual behaviors (i.e. pregnancy, STD's), and the traumas experienced historically (noting any borderline or narcissistic traits that are frequently related to high levels of trauma). Therapists should be sensitive and empathetic to the *perceived* experience of the trauma, as each person's perspective and capacity will differ. Life stories, time lines, and trauma eggs are ways therapists in this study suggest assessing trauma.

Assessment also includes identifying family-of-origin issues or patterns that may impact the individual and relationship (Adams & Robinson, 2001; Carnes, 1992; Laaser, 1996; Martin, 1989). Therapists recommended genograms as an effective tool for assessing family patterns and issues. Findings from this study are supportive of other authors suggestions that addicts and spouses may have felt very alone as children (Carnes 1992); received negative, critical, and punitive responses from the family of origin (Adams & Robinson, 2001); had poor modeling from parents (Carnes, 1992); learned poor communication (Martin, 1989); experienced confusion about family roles, expectations, and boundaries (Martin, 1989); and lacked healthy bonding or nurturing from parents (Adams & Robinson, 2001; Carnes, 1992; Laaser, 1996). Additionally, therapists in this study suggest that some clients experience a low level of support from parents and, therefore, often lack the appropriate abilities to achieve success in various

ways. Because of these family patterns, addicts and spouses may lack effective coping strategies. Due to poor connections in their family-of-origin, they may also struggle to develop trust and form intimate connection in the present (Reed, 2000).

As a result of past traumas, family-of-origin issues, and the trauma of the spouse's discovery, couples often experience a high level of emotional reactivity, including a wide variety of feelings, including shame, anger (at spouse, God, parents, etc.), grief, sadness, loneliness/disconnectedness, betrayal, boredom, fear/anxiety, powerless, and inadequacy. These findings are consistent with available literature (Adams & Robinson, 2001; Bergner, 2002; Carnes, 1991, 1992; Earle & Crow, 1989; Sprenkle, 1987; Wilson, 2000). Due to emotional reactivity clients often experience what the first step of the twelve-step program calls unmanageability and powerlessness. Therapists should be attentive to the emotional experience clients are having and assess for the ability clients have to tolerate and/or cope with those feelings effectively. A realistic assessment of emotional reactivity is best obtained through a combination of self-report and the partner's perspective, but may also benefit from other perspectives (family, friends, etc.).

Appropriate care

Based on a complete assessment, therapists can determine the appropriate level of care. For addicts, this involves assessing whether or not a higher level of care (e.g. intensive outpatient, residential) is best for the client. Regardless of the level of care, appropriate assessment of both partners' levels of reactivity can help therapists to determine whether individual therapy, couple therapy, group therapy, or some combination is best suited to client's idiosyncratic needs, as was indicated previously by Wan et al. (2000). While the timing of couple therapy may be different for each couple,

therapists in this study suggest that couple therapy is a critical component for providing insight and creating couple patterns that can more effectively establish long-term individual and couple recovery. This finding is important given the general indications in the literature that marital therapy is an adjunct possibility rather than an essential component of long-term recovery (Cooper & Lebo, 2001; Gold & Heffner, 1998; Goodman, 2001; Schneider, 1989; Wolfe, 2000).

Therapists in this study suggest that individual and couple recovery can occur in group, individual, and couple therapy contexts, regardless of the stage in therapy. Individual and group therapy can be useful in helping addicts and spouses sort through their issues in a less emotionally reactive context, be able to share more honestly, and build a foundation of support to help facilitate individual recovery. Couple therapy can be helpful in several ways. It may permit partners to gain insight into each other (empathy) and themselves as well as build intimacy (which increases hope and motivation to change individually). It can also change couple patterns in a way that lowers emotional reactivity, which then has a positive impact on individual recovery. Systemically viewed, then, individual and couple recovery may occur simultaneously and mutually influence each other, regardless of the type of therapy. Therefore, therapists should attend to both individual and couple recovery issues in the context of all individual, couple, and group therapy, a recommendation previously alluded to by Milrad (1999).

Therapists in this study also strongly recommended that therapists assess which outside resources might be most beneficial to the couple, noting that the ongoing process of change will most likely be slower unless therapists help clients access other resources that can provide additional support to reduce emotional reactivity (including shame

reduction), provide further connection, and fight against well-engrained negative patterns. In addition to the balance of individual, group, and couple therapy, therapists recommended considering various other types of support, including (a) 12-step meetings such as SA/SLAA, COSA, CODA, S-Anon, RCA, etc., (b) sponsors, (c) spiritual/religious supports (church, church groups, church leaders, confessor, etc.), (d) family, (e) other healthy relationships/ friendships, and (f) any other supports that may be available and appropriate (Schneider et al., 1998). Therapists should ensure these resources are made available while carefully fitting these supports to each couple's idiosyncratic circumstances, abilities, and needs (e.g. finances, level of emotional reactivity, amount of time struggling with the addiction, etc.). Therapists noted that resources should be adapted to fit the couple's needs as they progress through the recovery process.

Alliance

Prior to shifting into intervention (and out of primarily assessment), therapists in this study suggest that it is essential to determine how much of the individual, group, or couple work the therapists can do while still maintaining a strong therapeutic alliance. Even when the therapist has extensive experience and is well-qualified to manage all the therapy (individual, couple, and group), it may be difficult to form an alliance because couples often have difficulty trusting the therapist in highly emotionally reactive situations (especially due to initial fears about being “ganged up on” in therapy).

I began this study with the belief that couple therapy was the best option for treating sexual addiction. Clearly, therapists in this study suggest that there is not one specific solution to the decision regarding what type of therapeutic involvement is best

for the therapist. The decision is a difficult one and may be idiosyncratic for each couple. The majority of authors suggest that individual therapy is most appropriate early in treatment (Laaser, 1996; Schneider, 1989), perhaps because there is such a high level of trauma and resultant reactivity. While some individual responsibility in recovery must occur prior to beginning the process of couple recovery, therapists in this study suggest that either individual or couple therapy can provide a context for change at any stage of therapy, even early in treatment (Kerr & Bowen, 1988), depending on the skill set of the therapist.

Therapists also suggested that, regardless of the type of therapy, it is important to keep a systemic perspective and/or be aware, at least, of the overlap between individual and couple processes. This finding is significant due to the fact that much of the literature approaches recovery from sexual addiction (and addiction in general) as an “individual” issue. Seeing it as an “individual” issue, therapists often lose sight of the important relational processes that are intricately intertwined with individual change processes. Viewing even individual therapy as a form of couple/family therapy (Kerr & Bowen, 1988) may help therapists to avoid missing important opportunities for relational and systems change. Likewise, approaching couple therapy with an awareness of individual change processes is important. Failing to address both couple and individual processes of change simultaneously throughout the course of treatment will significantly negatively impact successful long-term recovery.

If therapists decide to maintain alliance by dividing the therapeutic work between therapists, therapists should work to collaborate with each other. By so doing they ensure that their specific therapeutic work is supporting each partner and the couple by

providing a consistent message (e.g. splitting, recommendations that are different) and continues to help both focus on their responsibilities in recovery. Additionally, therapists should develop a common language that helps to reinforce couple learning and avoids confusion that might prevent more rapid growth in the recovery process. Separating the work may also help prevent therapist burnout (which is a risk given the high level of emotional reactivity that must be managed).

Alliance can also be maintained via couple therapy which gradually shifts the process from communication through the therapist (while clients are more emotionally reactive) toward face-to-face communication as emotional reactivity reduces. This finding is consistent with the process of managing emotional reactivity via enactments (Butler & Bird, 2000), a five-phase process for managing the gradual shift with couples (Butler, Davis, & Seedall, 2008; Butler & Gardner; 2003; Davis & Butler, 2004). Overall, the positive outcomes associated with couple therapy (improved communication, empathy, etc.) can be capitalized on while problems associated with dividing the therapeutic work (splitting, different approaches) are eliminated. In cases where the couple cannot be structured via enactments, the some therapists recommended doing a few individual therapy sessions to work on individual recovery issues (including de-escalation of emotional reactivity) and then continuing couple therapy when appropriate. In more severe cases, therapists could divide the therapeutic work with other therapists (as previously discussed).

Couple Perspective

Therapists in this study indicated that using the couple's perspective (world view) is critical in assessing, setting goals, pacing, working on solutions, and creating a

language for therapy. Using the couple's language displays attentiveness to their world view and can help clients more quickly develop self-awareness (not having to wrestle to adapt to the therapist's language, they can more readily engage in individual recovery work). Avoiding language that may create struggle or prevent progress in treatment (e.g. insisting that the client accept the label addict or codependent rather than accommodating to their languaging of the problem) may also more quickly help clients identify their desires for change and increase motivation (Miller & Rollnick, 2002). Using the couple's language also helps to create solutions that are best fit to the couple's world view and needs. If couples become stuck or are struggling for solutions, therapists can provide options while helping couples to apply those options (or some variation) in their own idiosyncratic way.

Therapists in this study indicated that it is important to be sensitive to the pacing, including the timing of interventions (considering the stage and readiness) as well as the types of support that are engaged in at different times during the process of recovery (including types of therapy). If therapists sense that there is a need to increase or decrease the pace of therapy (e.g. pushing too fast for intimacy, needing to shift toward face-to-face couple work), therapists in this study indicated it would be important to express that perspective while still allowing the couple to determine when that change will occur. If a therapist perceives that a client might be feeling pressured to make a specific goal or decision, or move at a certain pace, findings suggest discussing it openly with clients, helping the client understand that the therapist has no particular agenda but is attempting only to discuss options, share information, or make suggestions that can help them to make better informed decisions.

Intervention: Transitions in the Change Process

In the early stage of therapy, much of the motivation for change is provided by fear and loss of control (powerlessness). Therapists recommended focusing on crisis management and establishing basic aspects individual recovery to help reduce those negative feelings. During the middle and later stages (when stability is greater and fears are reduced) there is a gradual transition for addicts from other-focused motivation (fear) to personal desire (internalized). Likewise, spouses tend to focus less on motivating/ changing the addict and gradually shift focus toward changing themselves. Therapists in this study suggest that creating an accountability contract could help facilitate that shift by holding both partners accountable (including to other supports) while avoiding having the spouse be an accountability partner (which includes stopping policing/monitoring behaviors, as was also noted by Milrad, 1999). Couples gradually focus less on stopping addictive behaviors (although still managing that process) and more on working on underlying issues connected to the addiction. Work on underlying issues is connected to their efforts to move forward in becoming who they want to be come.

As fear reduces, couples begin to be less blaming and defensive and more able to listen and be empathetic to their partner. They are more able to experience empathy, intimacy (including physical intimacy), and trust. Couples begin to do more face-to-face work in therapy, and gradually enter a “phase of stability” and a less intensive program (attending fewer sessions, fewer groups, etc.). Therapists can support couples during this stage by discussing how best to make a successful transition while maintaining and building on the changes they have already made. Increased focus on building outside resources can also help the transition from therapy to be more successful.

Crisis Stabilization

Findings in this study were consistent with Milrad (1999) in indicating that the discovery of sexual addiction by a spouse creates an emotional destabilization, sometime to the level of creating PTSD. Both spouse and addict have generally experienced a wide variety of additional traumas historically (Carnes, 1991; Carnes & Delmonico, 1996; Earle & Earle, 1995), including both “Big T” (sexual abuse, physical abuse, neglect, and abandonment) and “little t” traumas (peer rejection, negative experiences in the family of origin, etc.). Because these traumas lead to feelings of powerlessness/loss of control, therapists in this study suggest that it is particularly important in the early stage of therapy to engage in efforts to help the couple gain a sense of stability. Therefore, the focus of therapy initially should be on crisis management and stabilization work, which includes (a) addressing the decision to stay or leave the relationship, (b) establishing realistic couple goals that provide a “road map” to recovery, (c) developing awareness of emotions as well as ways to tolerate, soothe, and cope more effectively with those emotions, (d) managing the initial full disclosure, (e) setting boundaries around addictive behaviors (both sex addiction and codependency), (f) holding couples accountable to those boundaries, and (g) creating positive experiences individually and relationally.

Staying or leaving. When the spouse discovers the sexual addiction, s/he may feel confusion about whether to stay in the relationship (consistent with Milrad, 1999) as well as pressure to make a decision immediately about whether to stay or leave. Because spouses are in a state of crisis, therapists in this study recommended helping spouses to recognize that it is not necessary to make the decision immediately and that it may be helpful for them to take some time to before making any long-term decisions (ideally a

minimum of three to six months), deescalate, care for themselves, and then more clearly consider the decision. While perhaps it may seem counterintuitive to postpone the decision (spouses could be empowering themselves through making a decision), spouses often feel out of control and pressured to decide, and giving them permission to take time can give them back a sense of control and an ability to make a more informed decision. Therapists also recommended assisting couples in eliminating threats to leave during this period, thus helping couples to stay focused on the work of recovery instead of being overwhelmed/triggered by fears of rejection or abandonment.

Road map. Additionally, therapists in this study recommended providing an overview or “road map” to clients by assisting them in developing an understanding of their goals for both individual and couple recovery. Therapists noted the importance of ensuring that the couples are setting the goals that are meaningful for them rather than a reflection of the therapist’s desires, thus ensuring a better alliance and creating less struggle in accomplishing those goals (Butler and Bird, 2001). Because couples may struggle to set these goals effectively, therapists can provide guidance and education (based on the therapist’s own understanding of the process). This may include (but is not limited to) educating about addiction and sharing how other couples have experienced the process of individual and couple recovery (goals that were helpful and struggles they have encountered, normalizing their experience to other couples’ experiences, etc.).

Once established, these goals provide a set of markers of success that may provide greater hope for couples because they can more easily identify a variety of successes as they struggle toward the long-term success of sobriety. Because recovery requires facing the consequences of their behaviors, experiencing their emotions, working to develop

coping skills, and taking emotional risks to connect with each other and a support network, couples may often feel worse initially instead of better. Therapists should warn couples that this may occur while helping them to see it in the context of the overall process to avoid overwhelming them. Therapists can help couples to understand the importance of having a support network and help them to access as many appropriate outside resources as possible (including both people and tools for self-education) to help them through the process of recovery.

Emotional awareness. Throughout the early process of recovery, therapists in this study noted the particular importance of emotional reactivity. Therapists suggest tracking, validating, and being empathetic to clients' emotions, which can help deescalate as well as model appropriate behaviors. To help clients reduce reactivity, therapists can help improve each partner's ability to recognize and identify emotions. Additionally, therapists can help clients to become more educated about emotions (wherever possible via eliciting dialogue; Butler & Bird, 2000), including how those emotions are linked with triggers (to addictive and codependent behaviors). As clients become more aware of their emotions, therapists can help clients to tolerate (contain), deescalate (soothe), and cope with those emotions effectively. This is particularly important as clients engage in the difficult processes of disclosing, developing and setting boundaries, and contracting for accountability. Therapists in this study noted that, while the process of recognizing, identifying, containing, soothing, and coping effectively begins in early treatment, it continues to be important throughout the entire process of treatment.

Depersonalization. Therapists in this study noted that gradually gaining the ability to recognize that the other person's behaviors are not meant as a personal affront

(depersonalization) is one important means for helping decrease emotional reactivity, a process previously discussed by Bergner & Bridges (2002). Early efforts to depersonalize are accomplished initially through education about addiction. While didactic education can be helpful, therapists suggest that spouses may understand and integrate better when the therapists helps the spouse to “educate” by describing their experience (the context of the behaviors, including family-of-origin and trauma issues), the emotions s/he struggles to manage, and the reasons it has been difficult to stop. Because spouses may struggle with the concept of addiction being a disease, therapist suggest holding clients accountable for their individual responsibilities in recovery while understanding that addicts are certainly not responsible for their tendencies (genetic predisposition; Goodman, 2001). Therapists might also capitalize on the idea that the addictive personality exists on a continuum (Washton & Boundy, 1989) and help the spouse to connect how s/he may have experienced addictive patterns in her own life, thus building greater internalization of an understanding of addiction. While Carnes (1991) suggests that our culture may have a negative impact because of the shame it can create for addicts and spouses, therapists in this study suggest that depersonalization may occur as clients understand the role of culture in creating addiction.

Depersonalization also occurs as couples are able to see that patterns in their relationship are reflective of their family-of-origins. Thus, both partners see reactions less as an attack on them and more as a pattern that they were taught in their lives that they need to change. Eventually, through education and experience, individuals can gradually reduce emotional reactivity as they come to understand that the other’s behaviors are not a reflection of their worth or an affront to them personally. While the spouse did not

cause the behaviors, therapists in this study indicated that it was important to help them to see how their own individual recovery can help positively influence their partner's recovery work.

Disclosure. Findings in this study concurred with Schneider et al. (1998) in recommending full disclosure. Because secret-keeping prevents growth in recovery, therapists can assist addicts in preparing an appropriate, full disclosure that is honest and as complete as possible. Helping the addict to take full responsibility and make amends for past behaviors can provide an initial foundation for building trust (including providing empathy for the spouse).

Therapists in this study also recommended supporting the spouse during the time of disclosure time as well as encourage her to find support via outside resources, being attentive to possible suicidality. Therapists can support the spouse in asking appropriate questions at the time of the disclosure, as was also noted and expanded upon by Corley and Schneider (2002). After the formal disclosure is complete, spouses will need support to avoid obsessive questioning about past behaviors and to focus on finding control in other ways (see boundaries section below).

Boundaries. Despite an effort to be fully honest as part of the initial disclosure, therapists in this study noted that addicts typically are unable to remember everything and therefore may need to disclose other things as they are remembered. Additionally, slips or relapses necessitate ongoing disclosure. Therapists can help couples to develop a plan for ongoing disclosure that addresses both possibilities. First, the therapist helps the addict and spouse to develop a clearer understanding of their boundaries around which behaviors are acceptable to them and which are not. Addicts can delineate what are slips,

relapses, and collapses and determine how to take appropriate responsibility if those occur, including disclosing appropriately. Similar to Bergner and Bridges (2002) recommendations, therapists in this study suggest helping spouses become clear on which behaviors are unacceptable to them as well as how they want to respond if those occur. This includes helping the spouse to determine which boundaries are non-negotiable (and ensuring she will be prepared to follow through on those).

After working on their own boundaries, therapists suggest facilitating couple discussion to help them come to an agreement on the boundaries for what behaviors need to be disclosed (this includes things from the past that the addict may remember after the initial disclosure), how and when to disclose, and the appropriate way for the spouse to respond when disclosure occurs. This is particularly relevant given previous findings that couples may not have a plan or may not feel they have agreement on a plan to deal with boundary violations (Schneider and Schneider, 1996). Addicts can invite spouses to be aware of their boundaries and ask for appropriate support. Therapists in this study suggest supporting spouses in providing that support while helping the spouse to avoid policing, monitoring, or being the accountability person in any way (Schneider, 2000b). Spouses can then share their boundaries (those things they will not tolerate) as well as the negotiable boundaries (those things they can be patient with), including the ways the spouse will take care of herself when boundaries are crossed. The couple then makes a commitment in writing to the contract and schedules a regular time to revisit the contract. Thus, both spouse and addict have a clear understanding of each other's boundaries and, therefore, clear expectations of how to interact with each other appropriately and what to expect from each other when boundaries are crossed. These clear expectations can help

couples to avoid “working each others programs” to the detriment of both individual and couple recovery.

Findings also indicate that an appropriate contract delineates ways that couples can check-in when they are concerned, scared, or triggered. Check-ins can allow spouses to share fears with the addict without blaming/shaming. Check-ins can also allow addicts to share their struggles in a way that can create connection and appropriate support. Therapists should also help couples to determine the most supportive responses around these check-ins, thus helping these opportunities to connect be a positive experience rather than a relapse into problematic behaviors (i.e. addiction, couple patterns). The contract should also outline any other ways to support each other appropriately (e.g. making the home a safe place for spouse or addict).

Accountability. Therapists in this study suggest using the contract to help hold both partners accountable for the commitments they have made regarding their individual behaviors (addiction or codependency). By holding *both* the spouse and the addict accountable for their behaviors, therapists can avoid creating harmful struggle (Butler & Bird, 2000) due to one individual (usually the addict) feeling like the identified patient. Therapists should be clear with the spouse that she is in no way responsible for the addict’s behaviors, but is responsible for herself and her part in negative couple patterns. While a few therapists in this study suggest that accountability can be accomplished via therapist’s behaviors that confront partners directly, the majority suggest using the couple’s commitments to hold them accountable. This may minimize struggle in therapy because it is fully congruent with the couple’s perspective and goals (Butler & Bird,

2000). Helping each partner to live consistent to his/her own desires and values may also make it easier for couples to be held accountable while avoiding creating shame.

While the contract may initially be established around the addictive behaviors, therapists in this study suggest extending the contract to other behaviors (including couple recovery issues such as communication) in order to outline what responsibilities each partner has and hold him/her accountable for those as well. In this way, individuals can measure their own success clearly, even in the face of the partner's blame. This can help them to avoid shame while focusing on those things they do need to improve.

The contract can also help each partner better measure the progress that is being made by their partner as well as in the relationship. Thus, accountability can be a positive tool to help each partner act congruently in their individual recovery (be the man or woman they wish to be), to help couple dynamics improve, to focus more clearly on those areas that need more work (either when the contract is violated or when problems arise outside the established contract), and helps both partners to see the positive growth (measure successes) that might otherwise go unnoticed due to the variety of other problems that have not yet been resolved. Therapists can help couples to understand these positive aspects of contracting, especially when one or both partners struggle to commit to creating a contract.

In addition to the therapists' role in holding each partner accountable, therapists in this study also recommended helping each partner to develop accountability from outside resources. This additional accountability provides a supportive, connecting environment. With various resources for accountability (which can be delineated as part of the contract), couples may be less likely to attempt to act as accountability partners to each

other. Possible resources include (but are not limited to) sponsors, groups, RCA, and religious leaders.

One significant struggle for therapists in treating addiction in general is how to hold clients accountable for their behavior while still recognizing that addiction is a disease for which they are not responsible. While addicts are not responsible for their disease, they are responsible for what they do to live in a way that promotes health and healing wherever possible. By helping clients develop a contract for a healthier lifestyle and supporting them in adhering to that contract (accountability), therapists can provide clients a better opportunity to develop long-term ways to cope with their addictive tendencies without experiencing the devastating effects of relapse.

Creating positive experiences. Due to shame or fear, couples who are struggling to recover from sexual addiction often isolate and focus on controlling the addictive behaviors at the expense of other positive activities. While it is essential to establish crisis management activities that focus on stopping the addictive behaviors, therapists in this study also suggest helping couples to create (or re-create) positive individual and relational outlets. Therapists can help individuals to explore activities they can do individually to bring positive feelings into their lives. It may be helpful for the therapist to explore a variety of ideas with the client, have them write those down, help them to decide where to begin, and be supportive in helping them accomplish those ideas (accountability). This may necessitate processing through fears that may prevent them from moving forward despite the expressed desire to do so.

Although therapists should facilitate positive couple experiences whenever possible, therapists in this study noted that it is often difficult to do so during early

recovery. Therapists can help clients to access relationships within groups (AA and process) and with sponsors, friends, God, church, or other outside resources to help clients create positive, appropriate relational experiences (e.g. same-sex for heterosexual). Early in the recovery process, recovery-oriented resources may be particularly useful in helping reduce shame, form healthy relationships, process their emotions (reducing emotional reactivity), and practice new skills (i.e. communication). Therapists in this study noted how positive individual and relational experiences provide additional stability, increased confidence, positive feelings, and more support for helping the couple move forward in their couple recovery work.

Individual Recovery

Therapists in this study also suggest several other important aspects of individual recovery in addition to crisis stabilization. First, early recovery may necessitate a focus on past traumas (Carnes, 1991; McCarthy, 1994) or family-of-origin patterns (Bergner, 2002), as they may prevent clients from moving forward in their individual recovery. EMDR is one treatment that therapists in this study suggest for addressing traumas. Family-of-origin interventions include letter writing, empty chair work, and helping tie feelings experienced in the present to family-of-origin issues/patterns. Overall, individual recovery can be supported by avoiding creating shame while focusing individuals on the process of continual learning and individual growth related to individual recovery.

As partners struggle to overcome their individual issues, they may attempt to turn to the other for empathy early in the process of treatment. Therapists in this study warned that this may be premature, as both partners are still working to heal their own wounds and typically do not have the emotional resources yet to offer empathy to the other.

Therapists can caution couples about this tendency as a way to prevent early efforts to gain empathy which could result in feelings of rejection

Couple Recovery

As couples begin to experience stability and establish some initial individual recovery, couple recovery work can begin. Therapists in this study were clear that the steps in the couple recovery process can occur regardless of the type of therapy (individual, couple, or group), and should be addressed therapeutically whenever they arise. I outline the steps in couple recovery below, with particular attention to those facets that can only be addressed in the couple therapy context (because they require both partners to interact with each other).

Communication. In order to begin the couple therapy process in as neutral a way as possible, therapists in this study suggest that it is important to be clear (verbally) that the “identified patient(s)” is either both partners or the coupleship. This can ensure that both partners understand that they have a responsibility in the process. With this understanding, therapists facilitate couple interactions and assist each partner in taking responsibility for their reaction to the other’s behavior. Thus, partners focus on the things they have control over in the relationship (their thoughts, feelings, and behaviors) and avoid blame. Consistent with enactments (Butler et al., 2008; Butler & Gardner; 2003; Davis & Butler, 2004), therapists in this study suggest that much of this work is done through the therapist initially, and the therapist’s efforts to track, validate, and show empathy can provide a model of how partners can do that work with each other. Additionally, therapists can educate couples (in session or via bibliotherapy, workshops, etc.) about healthy relationships (including normalizing their experiences). As the couple

becomes more able to manage their emotions and communicate more effectively, therapists in this study recommended helping the couple shift to face-to-face interactions. Therapists also suggest helping couples to establish rules (i.e. times, appropriate ways) for practicing effective communicating at home, including ways to exit successfully when the communication is not going well.

Therapists also focus on couple patterns, helping relate those patterns wherever possible to patterns in the family-of-origin. This can help the couple to understand more clearly that their issues and patterns are a result of more than just relational hurts, thus reducing blame. Therapists can help couples to gradually focus past the visible issues (the “tip of the iceberg”) toward an understanding of the issues underlying them.

As discussed previously regarding accountability, a contract can be made to help couples establish individual responsibility for their parts in changing the couple’s communication pattern. When partners inappropriately focus on their own or the other’s failures (creating potential shame and blame), therapists can refer to the contract to accurately measure progress (measures of success), hold partners accountable for any violations of the contract, and process ways to improve (within the contract or in addition).

Empathy, intimacy, and trust. Therapists in this study noted that the couple’s work to improve communication gradually can lay the groundwork for developing greater empathy, intimacy, and trust. Therapists can assess how the processes of building empathy, intimacy, or trust can be increased and begin addressing the process that might most easily be increased initially (thus building hope). Because the findings suggest that these three processes are interrelated (e.g. expressing empathy for the other may lead to

greater intimacy and trust while, at the same time, gaining trust may make it possible for greater empathy and intimacy), lack of progress in one area may be linked to a need for growth in other areas. Therefore, when couples become stuck in one process, therapists should be aware that intervening appropriately (after careful assessment) with another process may help move the work forward in the area where the couple is stuck (e.g. if the couple cannot seem to move forward in empathy, working to establish greater trust may open space for increased empathy to occur).

Empathy. According to the findings, partners are often so wounded at the beginning of the recovery process that they can only attend to their own feelings and needs; therefore, requests for empathy are often ineffective and/or lead to rejection (and a resultant increase in emotional reactivity). Therapists can educate couples that empathy may come as each individual's recovery progresses or as the result of open, honest communication in session. Therapists can also help educate partners as to the value of giving empathy, which may help increase partners' willingness to do so.

Therapists in this study suggest that the formal amends (related to step 4, 5, and 9 in the AA program; AA World Service, 1980) provide the first step in the process of creating empathy. Additionally, ongoing amends for slips or relapses into problematic behaviors (related to step 10 of the AA program in this study; AA World Service, 1980) are important for expressing ongoing empathy (for both spouse and addict). Thus, therapists hold both partners accountable for their problematic behaviors and work with them to be empathetic to their partners through active amends. Finally, as couples are able to learn to share their feelings and needs effectively (using "I" statements and

avoiding blame), partners become more empathetic, able to listen and experience the other's hurt without reacting negatively.

Intimacy. Congruent with the finding that sex addicts have higher interpersonal sensitivity (Raviv, 1993) and struggle with closeness (Leedes, 1999), therapists in this study suggest that sex addiction is an intimacy disorder. Thus, couples may often struggle to understand what intimacy is, may not know how to develop it, and may not understand the importance of learning how to become more intimate (not understanding that there is a lack of intimacy, couples typically focus on other issues). Couple recovery can focus on developing increased abilities/skills to lower relational anxiety and create increased intimacy. Therapists can help couples build intimacy by having both partners together in session to experience the other person's individual recovery work as well as interact as a couple. Additionally, experiencing empathy in session can create a level of vulnerability that can lead to greater connection and intimacy. Therapists can also educate couples on what intimacy is and work with them to develop different ways to create intimacy (e.g. developing a list of ways they can spend time together in positive ways). Improvement in couple intimacy has a positive effect on individual recovery, perhaps even greater than interventions to eliminate the addictive behaviors (Leedes, 1999).

Trust. Findings in this study indicate that couples working to recover from sex addiction often have a very difficult time trusting others because of the level of trauma in their past and the level of trauma in their relationships (due to secrets and lies). Therapists can help clients build trust in various ways. Initially, therapists suggest working to establish trust in the therapeutic relationship (see alliance section above). As trust in the therapeutic relationship increases, therapists can help trust improve in the relationship.

The process of establishing trust will be much easier if both partners are engaged in therapy working on their individual recovery (via groups, individual therapy, and/or couple therapy).

The accountability contract can establish effective means for creating measures of success that can help the couple see progress (consistent change in behavior over time; Schneider and Schneider, 1996) and measure improvement. Trust, then, is a process that occurs in various ways over time rather than an event. While the process of change is incomplete and, therefore, complete trust is not warranted, couples can begin to build trust in some ways and establish a pattern of accountability that will ultimately establish higher levels of trust.

Physical intimacy. While findings indicate that work with physical intimacy needs to occur, therapists in the study recommended that it happen later in therapy after significant individual and couple recovery has been established. Therapists can educate about healthy sexuality, including the positive aspects of sexuality. Therapists can also help the couple create a safe environment in the home. Couples who are having limited or no sexual interactions can benefit from gradually increasing displays of affection, and the use of Sensate Focus can help couples to gradually work through all aspects of physical intimacy.

Addiction Versus Affairs

Findings regarding the differences and/or similarities between sexual addiction and the forms of treatment are unclear. Therapists suggest several differences and several similarities (often contradicting other therapists' reports). The findings in this study regarding the impact and treatment of sexual addiction are consistent with the much of

the literature on affairs, including: betrayal trauma that leads to severe emotional stress and potentially PTSD symptoms (Glass & Wright, 1997; Spring, 1996), the need for a stabilization/dealing with the immediate impact (Gordon, Baucom, & Snyder, 2004; Pittman and Wagers, 1995), waiting for a time to make the decision regarding the relationship (Bird et al., 2007); providing a road map (Gordon & Baucom, 1998; Weeks, Gambescia, & Jenkins, 2003), development of greater self-awareness (Gordon & Baucom, 1998) and other-awareness/empathy (Bird et al., 2007), the need for amends (Gordon & Baucom, 1998), and the restoration of trust (Bird et al., 2007). The therapists in this study also suggest several potential differences between sex addiction and affairs. First, addiction is seen as a chronic disease whereas an affair is an event. Addiction may require more individual work whereas recovery from an affair is almost always viewed as couple-related work. While therapists in this study suggest it might be possible for affair couples to find support groups, they note it is rare that couples seek out support. The literature on affairs does not suggest groups, and often couples desire to keep it private (Bird et al., 2007).

Several potential problems exist in distinguishing between affairs and sex addiction. Although sexual addiction has become better understood in recent years, there are still not diagnostic criteria that define sexual addiction clearly (Goodman, 2001). Likewise, the definition of affair is also unclear (Bird et al., 2007). Additional confusion also exists between how on-line behaviors fall under the classification of affairs (Hertlein & Piercy, 2008) and/or sexual addiction. Lack of clear definition makes it difficult to distinguish when someone has crossed the line between an affair and an addiction and what treatments may be most appropriate.

Until more clear definitions are agreed upon, Washton and Boundy (1989) suggest that the addictive personality exists on a continuum and that we are all vulnerable to different degrees of addiction (based on genetics). This viewpoint may assist therapists in several ways. Therapists can benefit from using interventions related to both addiction and affairs, considering the level of severity and perceived consequences in determining interventions. Therapists can also be more flexible in labeling clients as addicts, using the term only when helpful to their idiosyncratic healing process while still addressing the problems (e.g. inability to manage emotions, connect intimately, etc.).

Limitations and Recommendations

Limitations associated with the current study make the conclusions suggestive rather than definitive. This study is not generalizable to all populations (as is true of all in-depth qualitative research) nor will it be complete in covering every aspect of treatment of sexual addiction. It is certainly likely that other therapists may use different interventions that also facilitate recovery. Nevertheless, it is helpful in providing an in-depth view into therapists' understanding of the complex, processual or sequential interactional profile of the dynamics of individual and couple recovery from sexual addiction. Additionally, it provides much needed clinically relevant guidance.

Due to the sampling method (convenience), the findings related to the therapists we interviewed may not be representative of the larger group of therapist who currently have expertise in working with couples and sex addiction. While the therapists in this study displayed enough variation in their approaches, backgrounds, age, and other factors that the impact on the findings should be minimal, certain demographic homogeneity

(mostly Christian and Caucasian) might also raise a question concerning the external validity or generalizability of the findings.

Additionally, one therapist in this study had only practiced therapy for one year, with sex addiction for one year, with 10% case load of sex addiction, of which 2% were couples. This therapist was not removed from the study because I did not know she was so inexperienced until it was too late to remove her. Even with the low statistics related to this therapist, the overall sample of therapists was generally experienced (overall years practicing therapy) and had worked with sex addiction, including couple work, for a considerable period of time. Nevertheless, the fact that this therapist was not removed may have had some impact on the study.

Bearing in mind these limitations and the desirability of much future research, the current study nonetheless makes a valuable contribution to the focus of such future efforts. While our study was retrospective, future studies might look at the process of recovery during treatment (Blow and Hartnett, 2005b). Such studies might tune into interactional and emotional process (Olson et al., 2002) that might not be assessed in retrospective studies. Addressing the process of recovery from the couples' perspective may also provide greater insight into the process of recovery from sexual addiction. Additionally, complementary application of quantitative methodologies can assist in the ongoing investigation of sexual addiction, including outcome research to identify what treatment modalities might be effective in the process of recovery from sexual addiction.

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Appendix A

Participant Letter of Explanation

June 4, 2004

Dear Prospective Participant,

Mark Bird, Ph.D. candidate in Virginia Tech's Marriage and Family Therapy Program, is conducting research examining **the process of couple healing/recovery from sexual addiction.**

You have been recommended as a therapist who may be willing and qualified to participate in this important research. Your **participation** would include taking part in one recorded interview (approximately one hour in length) in which you will be asked about your previous experiences as a therapist with regard to couple healing/recovery from sexual addiction.

Because your privacy is of great importance, **all materials used in this study will be kept strictly confidential.**

Your participation in the study will assist in an increased understanding of and the development of **interventions for therapists helping couples who are healing/recovering from sexual addiction.**

As this study is completed, the **conclusions and benefits** will be released to the public in hopes of providing assistance for all therapists who work with couples in recovery from a sexual addiction.

Your participation will be greatly appreciated and will help further an important effort in the field of sexual addiction and marriage and family therapy.

In preparation for the interview, I ask that you please think about your past cases and **choose one couple case that you feel is a good example of successful recovery from sexual addiction** and **reflect on that case prior to the interview.** I have enclosed a copy of the questions we will be addressing to help you prepare for the interview.

Sincerely,

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Therapist's Introduction to the Study and Instructions

As I told you before, the purpose of this study is to help us learn more about what therapists can do to help couples recover from sexual addiction. I will ask you some questions to help you talk about your experiences as a therapist with these couples. Afterwards I will ask you to complete a brief questionnaire.

The interview will be taped. Although we will record the interview, the tape will be transcribed and only the written transcription will be studied. Your answers will be kept confidential.

Please feel free to answer the questions thoroughly and give personal experiences if they are applicable. Please be as honest and accurate in your responses as you can.

The surveys will provide us with background information which will be helpful to our study. The survey will be confidential as well.

Your participation is greatly appreciated, and will help further our understanding of what therapists can do to assist couples in healing/recovery from sexual addiction.

Do you have any questions at this time?

Instructions for the Analysts

The goal of this research is to outline the basic picture of what couples must developmentally encounter in order to recover from sexual addiction. The transcripts you have received are the interviews conducted with therapists in this study.

Team analysis provides reliability in analyzing the data. Because there are only three analysts, it is important that you prepare well and mark your transcripts well in order to participate effectively in the analysis. You are to find the major developmental stages of recovery from sexual addiction, including work inside and outside of therapy. Each of these major stages is referred to as a theme in the description of the analysis procedure below. Each theme should be well supported as part of the preparation process. I have put the procedures below so you will be familiar with your part in the study and how the analysis will be conducted.

Each analyst will have received and independently read the transcripts completely through one time in order to obtain an overall picture of how the participants responded to the interview questions. A second independent reading of the transcripts should then be conducted during which each analyst will extract and highlight highly recurring themes. Following the second pass, each analyst will prepare an individual summary of the major themes she/he had extracted from the transcripts. Individual summaries will be distributed to all other members of the team by Friday. No discussion of the data among the analysts will occur prior to this time.

The analysts will then meet together to share their individual summaries, and through a group hermeneutic/interpretive process reach a consensus regarding the major themes represented in the spouse interviews. In an order established by random lot, each analyst will represent to the group the themes that she/he felt were most prominent. During the previous independent reading phase, transcript data supportive of observed themes will have been carefully “coded” or highlighted by each researcher. Once the analyst has described an observed theme, she/he will defend it by reference to this supportive material in the interview transcripts. Cross-sectional support will be emphasized in order to establish a theme. Other analysts may interject for clarification or to detract. Following completion of the entire data analysis, the first author will return later to the interview data and “coded” or highlight all transcripts in terms of the consensus findings.

Whenever a consensus seems to have developed regarding a particular theme and its articulation, it will be put to a vote. In order to be considered a major theme, result, or “finding,” two of the three researchers have to concur; otherwise it will be discarded and no longer under consideration.

Once consensus is attained regarding the major themes, each analyst will conduct a third reading of the transcripts, individually searching for further information and clarification of consensus themes. Elaborations, refinements, and clarifications of these themes will again be recorded in individual summaries.

At the second meeting, individual summaries will be shared, and the group hermeneutic/interpretive process will be repeated. Again, analysts will be required to substantiate and defend their clarifications and refinements by reference to the interview data, emphasizing cross-sectional support.

In this manner, all the major themes from the couple interview transcripts will be identified, elaborated, refined, and clarified. This process of repeated triangulation helps to enhance consistency of the findings. Both the group hermeneutic discussions will be audio recorded and later transcribed.

Appendix B

Structured Interview Questions

I'd like to begin by having you reflect on one of your sexual addiction cases with a couple consider successful.

1. First, what is your measure of success with the couple?
Possible probes: How does disclosure and relapse fit into that measure?
Is that specific to this couple, or is that how you would define success generally?
How would you define success generally then?
Would the couple's definition of success in this case be the same as yours or different? In what ways?
2. In the case you have chosen, do you feel like there was a critical moment or moments in therapy that were helpful to the process of change with the couple? What did you do that was particularly helpful to the couple?
3. What experience or experiences first indicated to you that change was occurring or that the couple was making progress? Could you describe what happened at that time? Did you do or say anything that helped? How did the couple know they were getting better?
4. Was there anything about the couple that helped them to be successful in therapy?
5. What do you see as the main challenges this couple had to face as a result of the sexual addiction? What do you see as the main challenges for each partner?
As s/he answers, clarify each response with the following questions:
What did you do or say to help them meet those challenges successfully?
How might therapy have been different if they were in individual therapy with you? What would you have done differently with each?
6. How do you as a therapist handle the delicate balance between facilitating individual recovery and facilitating couple recovery?
7. Were there other ways you helped the couple?
Probing: In other words, what additional things, if any, did you do or say that helped change to occur?
8. In what ways, if any, is the process of working with sexual addicts in therapy as a couple different from working with affairs? What do you think you do differently, then, when you work with couples who are experiencing sexual addiction? How is therapy different with each? Can you explain?
9. What, if anything, took place outside of therapy that helped in the healing process?
Probing: These things could include homework assignments from therapy, individual accomplishments, things they did as a couple, or events that happened outside of therapy that had a significant impact on the healing of the relationship.
10. Is there anything that we have not covered that you feel was particularly important to the recovery of this couple?
11. We've discussed a specific case today. Generally, do you feel that there are other critical change events with couples in therapy for sexual addiction that were not covered?
Final Probe: Is there anything else before we finish?

Thank the therapist and ask him/her to fill out the questionnaire.

Demographic Questionnaire

What is your gender?

- a. female
- b. male

What is your age?

What is your ethnicity?

- c. African-American
- d. Asian
- e. Hispanic
- f. Pacific Islander
- g. White/Caucasian
- h. Mixed race (Please specify) _____
- i. Other _____

What is your religious affiliation?

- a. Buddhist/Hindu
- b. Christian
- c. Muslim
- d. Jewish
- e. None
- f. Other _____

On a scale of 1 to 5 (one being not religious at all and five being very religious), how religious are you?

1 2 3 4 5

On a scale of 1 to 5 (one being not spiritual at all and five being very spiritual), how spiritual are you?

1 2 3 4 5

How long have you been practicing therapy?

_____ years

How long have you been practicing therapy with sexual addiction?

_____ years

What percent of your case-load is related to sexual addiction?

_____ %

What percent of your *sexual addiction* case-load is with couples?

_____ %

How much formal education have you completed?

- j. Bachelors
- k. Masters
- l. Doctorate
- m. Other _____

What is your field?

- a. Education
- b. LPC
- c. MFT
- d. Pastoral Counseling
- e. Psychology
- f. Social Work
- g. Other _____

What is/are your theoretical orientation(s)?

INFORMED CONSENT TO PARTICIPATE AS RESEARCH SUBJECT

Mark Bird, Ph.D. candidate in Virginia Tech's Marriage and Family Therapy Program, is conducting research examining how therapists can better help couples who struggle with sexual addiction.

You have been recommended as a therapist who may be willing and qualified to participate in this important research. Your participation would include taking part in a recorded interview in which you will be asked to reflect on previous therapy experiences.

Your participation may further our understanding of how therapists can better help couples who struggle with sexual addiction. The results of this research may specifically help couples who come to therapy to resolve problems due to sexual addiction. As this study is completed, the conclusions and benefits will be released to the public in hopes of providing assistance for therapists who work with couples who experience sexual addiction.

You were selected for participation in part because you were identified as a therapist who works with couples who struggle with sexual addiction.

Participation involves completing an interview and a brief written questionnaire at a mutually determined location or by phone. The interview (including the questionnaire) are anticipated to take approximately one hour to complete. In the interview, you will be asked various questions regarding your experiences as a therapist for couples who struggle with sexual addiction. The interview will be recorded in its entirety for later transcription. Because your privacy is of great importance, the transcription process and all handling of the data will be kept strictly confidential.

While reflecting on your experiences as a therapist with individuals and couples who struggle with sexual addiction may lead to some emotional discomfort or distress, we do not anticipate any negative effects.

YOU MAY REFUSE TO CONTINUE YOUR PARTICIPATION IN THIS RESEARCH AT ANY TIME.

Possible benefits of this experience may include a better understanding of how therapists can help individuals/couples who have experienced sexual addiction. However, it should be understood that this is not a therapeutic session.

Although the cassette tape used to record the interview becomes the property of Mark Bird, Ph.D. candidate in Virginia Tech's Marriage and Family Therapy Program, full confidentiality is guaranteed. The tape and all other materials will be marked by an identification number only, and will be maintained in a locked file cabinet. The tapes will only be used to develop transcripts, which will then be analyzed. No identifying information will accompany any transcripts. Only research project staff will have access to this material without your prior written consent otherwise.

Questions regarding this research may be directed to the following persons. Mark Bird, Ph.D. candidate in the Marriage and Family Therapy doctoral program at Virginia Tech, is the primary researcher in this study.

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By signing this form you acknowledge that your participation in this research study is voluntary.

I have read, understood, and received a copy of the above consent, and desire of my own free will and volition to participate in this study and accept the benefits and risks relating to this study.

Research Participant Date

Witness Date

If you have any questions regarding your rights as a participant in this research study, you may contact Dr.

David Moore, Chair of the Human Subjects Institutional