

Compulsive and Addictive Sexual Disorders and the Family

by

Jennifer P. Schneider, M.D., Ph.D.

Published in "CNS Spectrums," Vol. 5(10), October, 2000:53-62

ABSTRACT

In the treatment of sexual addiction and compulsivity, the family unit is often neglected. Yet this disorder has a major impact not only on the identified patient, but also on the spouse or partner (the coaddict) and on the family as a whole. Moreover, the family unit is the context in which the sexual addict continues to live, and the mental health of the partner has a significant impact on the sexual addict's recovery. Increasing evidence points to a family history of addiction or dysfunction as a primary contributor to both sexual addiction and coaddiction in adulthood. When compulsive sexual behaviors are present within a family, treatment of both members of the couple improves the couples' relationship as well as the mental health of each partner. In addition, treatment of children in such a family can help break the cycle of sexual addiction and prevent its perpetuation into the next generation.

INTRODUCTION

Addictive sexual disorders affect couples and families, and may be a risk factor for development of a range of disorders, such as substance abuse and sexual addiction, in the next generation. Sexual addiction significantly impacts the couple relationship. Although often neglected, early involvement of the family in treatment of the sexual addict is an important ingredient to successful treatment outcome¹. This paper will describe the sexual addict's spouse or partner, the role of the family of origin in the genesis of sex addiction, the dynamics of the sexually addicted family, and treatment issues of couples and children. Because most partners of sex addicts are women, I will use female pronouns to refer to the partner (also termed coaddict), unless specified; however, the discussion applies equally well to coaddicts of both genders.

Although there is still some disagreement in the field about appropriate terminology for this disorder², for the purpose of this paper, the terms "sexual addiction" and "compulsive sexual behavior (CSB)" will be used interchangeably. However, the author prefers the term sexual addiction, because it is a reminder that addiction-model treatment, such as is well known for substance use disorders, has been successful for many sexually compulsive persons whose problematic sexual behavior has not ceased despite traditional psychotherapy. This is addressed in more detail in other papers in this issue of *CNS Spectrums*.

THE SPOUSE OR PARTNER

In the initial crisis of disclosure of the compulsive sexual behavior (CSBs) (e.g. pornography dependence, compulsive masturbation, voyeurism) which leads to treatment for the sexual addict, it is typical for the partner or spouse of the sexual addict to consider herself an innocent

victim^{3,4}. Later on, it usually becomes clear that the partner is in some ways responsible for maintaining or enabling the sexual behavior and may be termed a "coaddict." Carnes⁵ defines coaddiction as "an illness in which reactivity to addiction causes the loss of self." The tendency of partners of persons with CSB to tacitly allow (or "enable") the sexual behavior is an aspect of coaddiction. While the term is often used to describe the partner of an alcoholic person, it can also be used to describe the partner of a person who has any addictive disorder, including sexual addiction.

The roots of the spouse's disorder often precede the current relationship, and it likely is no accident that the couple chose each other⁶. Both partners tend to have a similar family background, as will be described below. Typically, the partner will have had clues early in the relationship that some sexual concerns were present, but may have discounted their significance. For example, one young man told his fiancée that he knew he compulsively masturbated, but believed that marriage would alleviate the problem; years later he was revealed to be a compulsive user of pornography and a participant in sex with other men in adult book stores. In another instance a young woman had multiple sexual partners during her high school years; her boyfriend (who became her husband) saw her as vulnerable and in need of rescuing. During a messy divorce 20 years later it was revealed that she had had multiple affairs beginning one year into her marriage. In each case, it was clear that CSBs had persisted over the years.

Based on experience⁷, the author has identified a set of dysfunctional core beliefs that characterize the sexual coaddict:

1. "I am not a worthwhile person": There is often a wide gap between the kind of person she appears to be and the person she believes herself to be. Despite outward appearances and accomplishments, the spouse feels that she is deeply flawed and worthless and does not deserve to be happy. She measures her worth by what other people think. She is so dependent on someone else that she has little or no sense of self.

2. "No one would love me for myself": The coaddict believes she must earn love and confuses being needed with being loved. She is drawn to a man who is needy, and she makes herself indispensable to him. Believing that the more she can do for him the less likely he is to leave her, she assumes increasing responsibility for his life. Fearful of abandonment, the sexual addict's partner does anything she can to maintain the relationship, ignoring her own feelings and needs, excusing his hurtful behavior, and avoiding conflicts and confrontation.

3. "I can control other people's behavior": Believing she can manipulate those around her to carry out her wishes, the partner typically helps others do things they should do for themselves ("enabling"). Yet her continuing involvement in the addict's behavior works only to perpetuate the status quo rather than to stimulate change, because it prevents the addict from experiencing the consequences of the compulsive thinking and behavior.

It may be that the controlling behavior of the coaddict is a defense against feelings of helplessness and powerlessness. In childhood, she often felt helpless to influence events around her; in adulthood, she tries to control and manipulate her environment in order to avoid feeling helpless.

4. "Sex is the most important sign of love": The coaddict tends to confuse sex with love, and assumes that when a man is sexually intimate with her that indicates he loves her. She also believes sex is the price for love and will often accede to her partner's request for sexual activities which are uncomfortable for her; in some cases this may even involve other sexual partners.

Many sexual coaddicts report having been sexually abused as children, which Carnes⁸ hypothesizes may have led to hyposexual or aversive desire disorder, a condition he calls "sexual anorexia;" such persons may either tacitly encourage their partners to find sex elsewhere or else may consider sex simply a price to be paid for maintenance of the relationship rather than as something to be enjoyed

Carnes⁵ describes nine traits which characterize partners of sexual addicts:: Covering up for the sexual addict, keeping secrets (collusion); 2. Obsessive preoccupation about the sexual addict 3. Denial of reality and ignoring the problem;

4. Emotional turmoil; 5. Manipulation (including using sex to control); 6. Excessive responsibility (blaming themselves for the problem); 7. Compromise or loss of self (i.e., making a constant series of compromises which erode one's sense of self); 8. Blame and punishment (i.e., becoming self-righteous and punitive); 9. Sexual reactivity (e.g., shutting down sexually, numbing their own sexual needs). According to Carnes, these characteristics of the partner contribute to the dysfunction of the couple's relationship and may lead to a vicious cycle in which the sexual addict perceives the partner as being controlling, critical, and overly responsible, while the partner feels emotionally abandoned, pursues the sexual addict, and sees the sexual addict as being irresponsible, distant, erratic and self-destructive.

Partners of sexual addicts may go to any length sexually in order to avoid abandonment by the sexual addict^{3,6}. In fact, I have seen cases in which the women partners of sexual addicts resemble female sex addicts in their behavior. A key distinction between sexual addiction and coaddiction is the goal of the behavior³. For example, a woman who explains, "The sex was always to hold on to the guy," is describing coaddictive behavior; the woman who seeks a sense of power over another person is describing addictive behavior. Kasl⁹ has observed that "the potential [sexual] addict denies her neediness and seeks power, while the potential coaddict denies her anger and searches for security." To complicate the picture, however, some women behave like sexual addicts when they are single, but develop behavior typical of coaddiction when in a committed relationship.

THE MALE COADDICT

Men in relationships with female sexual addicts face particular challenges. First, men's self-esteem is often so bound up in their sexuality that in some countries killing a wife's lover has been considered justifiable homicide. Learning that one's wife has been unfaithful can be such a source of shame for men that the derisive term "cuckold" has long been in use.

Second, there is less societal acceptance of female CSBs.. For example, a man who has multiple affairs is termed a "Don Juan," "skirt-chaser" or "ladies' man." In contrast, a woman who has

multiple sexual affairs is labeled with more derogatory terms such as "whore," or "slut." In the author's experience, men whose wives exhibit CSBs are less likely to stay in the relationship than are women whose husbands are sexually addicted.

In their study of 24 recovering couples in which the woman was sexually addicted and the man chose to stay in the marriage, Schneider & Schneider³ reported that most of the husbands were sexually addicted themselves, and/or were alcohol or drug dependent; the remaining husbands likely suffered depression and were emotionally dependent on their wives. The two most important factors that determined a man's reaction to the disclosure of his wife's sexual compulsivity was whether he was a sexual addict himself and whether or not his partner had been sexually active with other persons. Sexual addicts who were actively working toward recovery from their CSB (by going to counseling and attending self-help meetings based on the Alcoholics Anonymous [AA] model) had the easiest time coping, as they had a greater empathy for their wife's problem; husbands who had no alcohol or drug dependency had the most difficult time, because they tended to deny or minimize the problem, or give it an explanation other than addiction.

WHEN AN ADDICTIVE SEXUAL DISORDER BECOMES PROFESSIONAL SEXUAL MISCONDUCT

In a review of 137 health-care professionals who underwent extensive evaluation because of allegations of sexual misconduct with patients, Irons & Schneider¹⁰ found that 55 percent had an addictive sexual disorder, often in combination with drug or alcohol dependency. The remaining group had either a poor understanding of what constitutes appropriate professional sexual boundaries with patients, a life event which made them particularly vulnerable at that time to emotional involvement with a patient, such as death, illness, divorce, malpractice suit, loss of job; an Axis I or II psychiatric disorder such as bipolar disorder or narcissistic or antisocial personality disorder; or a medical disorder that affected their judgment (e.g., organic brain syndrome, or a medication side-effect.).

Sexually compulsive physicians, therapists, clergymen, and other professionals who become sexually involved with patients, clients, or parishioners may eventually be exposed and subjected to public humiliation and loss of their professional license and career. The wife of such a professional is significantly affected in multiple ways¹¹: Her reaction to the public disclosure is observed by others (e.g., neighbors or the congregation,) and she is expected to "stand by her man," at least until long after the publicity dies down. She is often blamed for her husband's behavior (e.g., "If she hadn't been so busy, or if she'd been more attractive, this wouldn't have happened.") She is often perceived by her husband's victim(s); by the media; and by the professional's patients, clients, or parishioners as part of the problem -- an extension of the perpetrator -- rather than as a secondary victim, and she may be ostracized by her community.

In addition to the public's expectation that she will support her husband, the wife's frequent financial dependence on her husband motivates her to ignore her own pain and anger and present a unified front with him. If she was involved professionally with his work, the potential loss of his professional license will cost her her job as well. Her social status and self-esteem may also have come from her husband's profession and the respect with which he was treated. In the

aftermath of the disclosure of her husband's sexual misconduct, she feels her identity is threatened and her self-worth tumbles. Her public role, however, is to support the offender and become a pillar of strength to their children.

FAMILY OF ORIGIN

Based on a survey of over 1,000 sex addicts and their partners, Carnes⁵ concluded that both sexual compulsivity and coaddiction have their roots in a dysfunctional family in which the child has been either abused or neglected. In survey of sexual addicts in treatment, 83% reported having been sexually abused as children. In such cases, as children, they learn to confuse sex with nurturing. In a survey regarding childhood sexual, and physical, and emotional abuse suffered by sexual addicts, Carnes and Delmonico¹² found a significant predictive relationship between the frequency of sexual and physical abuse in childhood and the number of reported types of compulsive behaviors in adulthood. Sexual addicts with the most severe childhood abuse history tended to have multiple addictions or compulsions in adulthood (sex, substance dependency, eating disorders, compulsive gambling, compulsive spending, etc.).

One way of categorizing families is the circumplex model developed by Olson and colleagues¹³. This model positions families along two axes, one related to the degree of cohesion in the family (ranging from enmeshed to disengaged), and the other describing the family's adaptability (from chaotic to rigid interactions). A matrix formed from these two axes results in 16 cells. In Carnes' 1991 survey, when the respondents were asked to classify their family of origin using the circumplex model, a clear majority (68.1%) fell into a single one of the 16 cells, the rigid disengaged family⁵ (Table 1) . Such a family has inflexible rules and insufficient nurturing; the rigidly religious family is a prototype. The families of origin of many sexual addicts have a multigenerational history of disturbed behavior, including substance abuse, sexual addiction, eating disorders, and pathological gambling.

Carnes⁵ and Schneider⁷ reported that partners of sexual addicts often come from a family background similar to that of sexual addicts: The majority (62.5%) of coaddicts characterized their families as rigid and disengaged⁵ (See Table 2). Partners described a dysfunctional family often riddled with addictions and compulsions, and in which their emotional needs as children were not met. Many were sexually abused and grew up believing that sex is the most important sign of love, or that love must be earned with sex; alternatively, they feared sex and had disorders of sexual desire, arousal, or orgasm. They described a great need for approval from others and had difficulty setting appropriate boundaries. They often had a string of relationships with people suffering from various addictions and/or compulsions. An example of a couple whose disorders complemented one other was a sexual addict who preferred prostitutes to marital sex, while his wife, who was sexually abused in childhood, had no interest in sex, and was grateful for her husband's lack of sexual interest in her. When the husband sought treatment for his sexual addiction, his wife for the first time was able to confront her own past childhood abuse and sexual dysfunction.

THE CHILDREN

In households where one or both parents suffer from an addictive sexual disorder, most children are aware of some part of the parent's inappropriate sexual behavior. They are often asked to keep secrets for the parent with compulsive sexual behavior (e.g. they are told not reveal the parent's extramarital sexual affairs, extensive involvement with Internet pornography, or the parent's pornographic magazine collection). They may have been the victims of overt (or covert) incest.

Even when the children are not fully aware of the parent's abnormal sexual behavior, they may eventually replicate it themselves. In their survey of sexual addicts and their partners, Schneider and Schneider³ reported that some adult sex addicts who later queried their relatives were surprised to learn that a parent or grandparent also engaged in CSBs. For example, one man who revealed his CSBs to his mother wrote, "My mother informed me of an affair my father had. Cousins have told me of uncles' incestuous behavior and grandfather's sexually abusive and incestuous behavior." Another sex addict said, "I discovered that my mother and brother are sex addicts." The partner of a sex addict reported, "I learned that my sister is an incest survivor, and also my grandmother." These reports support the finding that, like drug dependency, CSBs may be found across several generations of a family.

Marital discord itself affects the emotional state of children and can lead to or promote compulsive sexual behavior by the children when they grow up¹⁴. Thus, it is vital to the addiction treatment of the patient and to the healing of the family to include work with the family system as part of the therapeutic process.

Whereas adult sexual addicts and their partners may feel powerless to stop the cycles of addiction and coaddiction, children are often trapped, intrapsychically and physically. Dependent upon their parents or other adults for care, children have little power. In working with children, the therapist must help them recognize the assets, positive characteristics, and limited power that they do possess. Earle et al.¹⁵ suggest that children be empowered by offering them the opportunity to choose their own therapeutic modalities -- art, play, games, talk, and the option of sharing their output or not sharing it with the parents. The therapist also helps children develop resources and plans to protect themselves when they are powerless in certain situations. For example, they describe the case of a boy who in a children's support group was delighted by the expression "like water off a duck's back." Thereafter, in verbally abusive or demeaning situations, he visualized himself as a duck, with his father's harsh words falling off his back and disappearing; through this method, he learned how to deflect his father's abuse. Additional specific tools for working with children are described by Corley & Alvarez¹⁴.

In families where addictions and compulsions are present, secrets and lies contribute to the family dysfunction. Family therapists who treat such families report that honesty is part of the healing process^{5,14,15}. According to Corley and Alvarez¹⁴, "Honest means saying the truth as it applies to how the behavior affected the family members. This does not mean the children need specific information about each incident or the exact behaviors involved. They are interested in areas that relate to their lives." Corley & Alvarez give an example of what a 5- to 8-year old child who observes his mother crying might be told by his sexually compulsive father: "I did some things that upset Mommy, but we are working them out. It is normal if someone is upset to cry. Like when Billie yelled at you, that upset you and you cried. . . "

In turn, a 10- to 13-year old child might be told by his sexually compulsive mother: "I hurt your dad and you by lots of things I have done. I have told big lies. I did things with other people that went against what your dad and I had agreed we would do. I was so busy doing these things, I wasn't here when you got home from school and missed things like your school play. For these things I am sorry. None of this was your fault. . ."

A teenager might be told by a parent who comes back from inpatient treatment, "I have been away, working to get healthier. I want to tell you a few things about what my problem is and what I have done that has hurt your mom and you. . . I want to tell you these things because I will be changing some things about my behavior around the house. I have a problem called sex addiction. Like drug addiction, I used sexual behaviors to try to escape from my problems, but like a drug addict, it didn't work after a while. "

Schneider & Schneider³ surveyed self-identified sex addicts and their partners about the consequences of talking with their children (in age-appropriate ways) about CSBs. Most reported a positive experience, with improved openness and communication in the family. For example, in one family where each parent was attending separate self-help meetings as well as talking with friends on the phone about sexual addiction, a mother wrote,

"We told our daughter that our meetings are to help us not use sex to feel like we're okay people. She's been exposed to drug information at school, so we told her sometimes people use sex to get high and hide feelings just like they do with drugs and alcohol, and that we're trying to learn not to do that. She said she'd been wondering why we went to separate meetings when they were about sex, and generally seemed to appreciate the opportunity to have her questions and concerns addressed." A father with a 9-year old son wrote, "I told my son that I have a sexual problem that has hurt the family by my inattention, resentment, and abandonment.

Now I try to right wrongs as they come up."

Sexual addiction in some cases includes sexual molestation. In families where incest occurs, the perpetrator must be removed from the home for the safety of the child, and the entire family receive specialized treatment. (Removal of the offender is such a widely accepted axiom in sex offender treatment that a whole literature exists specifically on the subject of potential family reunification.) In such families, the children see first-hand the consequences of the parent's abusive sexual behavior, including his removal from the home; clearly, they must be given some explanation.

An adolescent whose mother or father has been identified as sexually addicted may benefit from attending S-Ateen, a 12-step program based on A1-Ateen, the support group for teenage children of alcoholics. This program is now available in the Detroit area and supplies written material to assist adults in beginning similar groups elsewhere. Teens with a sexual abuse history may particularly benefit from the support they can garner by attending such a group.

Adult children of compulsively sexual persons, like adult children of alcoholics, often have low self-esteem and unhealed emotional wounds. Counseling and attendance at mutual help programs

such as Adult Children of Alcoholics (ACOA) can facilitate their healing. Robinson's¹⁶ first-person account of growing up with a sexually addicted father can be a useful resource.

MEDICAL ASPECTS OF SEXUAL ADDICTION

Family members of alcoholics and drug addicts are often high utilizers of the health care system. Although no studies have specifically addressed the utilization of medical resources by family members of sex addicts, it is likely to be equally high. A patient who presents with multiple somatic complaints, insomnia, or depression should raise concern in the health-care practitioner's mind that family dysfunction, including addictions and compulsions, may be contributing to the patient's medical problems.

Depression is a frequent complaint among partners of sexual addicts. Concern about sexually transmitted diseases (STDs) is a red flag for the presence of extramarital sexual activities in a family member. Partners of sex addicts may be overly concerned about their appearance and may even undergo cosmetic surgical procedures in an attempt to appear more attractive to the addict⁷.

COUPLES TREATMENT

Treatment of the couple is frequently indicated when dealing with the problem of sexual addiction. Perhaps because sexual issues are so intrinsic to the marital relationship, a marriage is typically troubled by the time sexual addiction is recognized. This poses a problem for therapists who treat sexual addicts. Addiction counselors recommend that persons recovering from an addiction (as well as their partner) focus their energy on their own treatment for at least the first year. This is also true for treatment of persons with CSBs.

However, especially when sexual addiction is present, practical consideration demands that attention be given to the couple's relationship as well. Thus, many couples find themselves in marriage (or couples) counseling almost from the time the sexual disorder is disclosed. If the sexual behavior resulted in sexual, physical, or emotional abuse of the partner (e.g., coercing the partner to engage in unwanted sexual activities), the couple's relationship requires significant attention.

The challenge in treatment, therefore, becomes balancing the needs of the individual with the needs of the family or the couple. The person with CSBs, the partner, and children may each need their own therapist. In addition, the couple may see a marriage counselor together. In these situations, a collaborative team approach is ideal, with one therapist coordinating the overall plan. All the therapists should be knowledgeable about sexual addiction, family dynamics, drug-use disorders, and other mental health conditions so that they don't work at cross-purposes.

Additionally, an agreement must be reached on the appropriate sequence of treatment elements. Individual rather than couples work is the first priority. In Carnes' experience⁵, when the patient has a history of childhood sexual abuse, consideration of this problem is usually best deferred until the person's recovery is solid; otherwise opening up this area can trigger relapse for addicts.

The author and colleagues favor a family systems model of treatment¹⁵. Instead of viewing the person with CSBs as the identified patient, family systems therapists treat the family as a whole. The addict is seen as the symptom-bearer for the family, and his disorder forces every member to seek help. In this model, it is understood that changes made by one family member will affect the other members.

A family systems approach explains why the entire family may benefit when only one member initially seeks help. For example, the author was consulted by a woman whose husband frequented pornographic book stores and had multiple sexual encounters while on business trips. He also considered it his "right" to have sexual relations with his wife whenever he felt like it. He did not consider his sexual behavior a problem, but she was depressed and had contracted several STDs from him over the years. She was so fearful of abandonment that she was unable to express her needs or set appropriate boundaries within the marriage. The author referred her to a therapist and to a support-group. As she improved her self-esteem and began to accept that she too had rights in the relationship, she first asked him to use condoms in their love-making, then decided she did not want to be sexually intimate with him while he was having sex with other women, and finally began to consider whether the benefits of staying in the marriage outweighed the emotional costs. As her husband noted her increased assertiveness and the real possibility that she would leave, he decided to get help for his CSBs.

Denial and evasiveness are also addressed in the family systems model. For example, a spouse's insistence on complete honesty may "invite" more secrecy from the sexual addict. Likewise, the sexual addict who withholds information encourages the partner to seek information, even to the point of reading the addict's mail or personal diary, or listening to private telephone conversations. In this situation, both partners must make amends: the sexual addict to be more open, and the partner to back off and find ways to manage her uncertainty.

Another common occurrence is an intensified lack of trust by the family when the addict initially shows a pattern of improvement, followed by a relapse. The family's doubts discourage the sexual addict in his efforts to overcome CSBs, as he questions whether he will ever regain their trust.

For the spouse or partner of the sexual addict, a key element of early treatment is to provide validation of her observations. As described earlier, characteristics of partners include denial of their own observations, a tendency, to blame themselves for the disorder, a fear of abandonment, a belief that they have to earn love, and, in the process, becoming so externally referent that they no longer even know what they want. They often have clues about the sexual addict's behavior, but choose to ignore their instincts. They allow themselves to be reassured by the sexual addict's denial, and then believe that they were completely fooled when the truth finally emerges. "How could I have not seen this? How could I have been so stupid?" is a common lament. The therapist can assist the partner to cope with these feelings, and to learn to trust her instincts, a crucial building block in her eventual willingness to trust her spouse again. The partner eventually comes to recognize that if she learns to trust her own observations, she will be less likely in the future to be misled by lies and excuses.

Other key elements early in the treatment of the partner include clarifying her personal boundaries and becoming committed to consequences of boundary violations. For example, a mother of several children may decide not to permit pornographic magazines or videotapes in the home. If she tells her husband that any pornographic material she finds will be removed from the home and destroyed by her, she must be prepared to follow through even if her husband becomes angry as a result. Another woman may decide that she is unwilling to risk acquiring an STD and will no longer have sex with her husband as long as he continues his pattern of having sex with prostitutes. Before she can convey this boundary to her husband, she needs to be committed to following through, even if one consequence might be her husband's increased involvement with prostitutes.

A word of caution about the recommendations in the above paragraph: If there exists a significant risk that the sexually compulsive person may become physically abusive to the spouse or partner in response to destruction of pornographic materials or denial of sexual relations, then the partner is urged to put her safety first and consult with a therapist before undertaking any actions which may pose a risk to her safety.

Based on a survey of sexual addicts' and their partners' experience with disclosure of the CSBs, Schneider et al.⁶ concluded that the manner in which the disclosure takes place can have an important impact on the future of the couple's relationship. Often the initial disclosure takes place before the sexual addict (or the couple) seeks help, so that the role of the mental health professional is limited to dealing with the fallout of the disclosure. This may be revelation of an affair, an arrest, bankruptcy, or acquisition of a sexually transmitted disease.

If the initial disclosure occurs at a time when the therapist is already involved in treating the addict, however, a recurrent complaint among sexual addicts' partners who responded to the survey was that they received insufficient support. For example, several wives reported that when their spouses were undergoing inpatient addiction treatment, they phoned them and revealed devastating information about their sexual behaviors at a time when the wives had no therapist or other person for support. One spouse became suicidal after learning of her husband's sexual behavior during a family meeting at an out-of-state addiction treatment facility, and had thoughts of crashing her car while driving back to the motel. For this reason Schneider et al. recommend that mental health professionals become aware of potential risk to the partner and provide additional support during the time of disclosure. Some spouses may need to be hospitalized if they become suicidal.

A recurrent theme among partners in the study by Schneider et al.⁶ was the damage of "staggered disclosure" by the sexual addict. When the sexual addict had initially claimed he had revealed everything, but in fact had withheld important information for later disclosure, partners reported even more difficulty in restoring trust in their spouse. Schneider et al.⁶ recommend that persons with compulsive sexual behavior be truthful from the start about the broad outlines of their compulsive sexual activities. However, the partner may wish to discuss with her therapist what details are really important to know and what the likely effect will be on her when they are disclosed.

Sexual addicts, in the author's experience, understandably hesitate to disclose their sexual behaviors because of concerns that their partner will leave them. In a survey of sexual addicts and coaddicts who ultimately chose to stay together in the aftermath of disclosure, 60% of partners reported making threats to leave the relationship⁶. In most cases the threats were never carried out; 34 out of 45 partners (75%) who had threatened to leave reported that they never left, even temporarily. Half the partners who did not leave reported that entering therapy or attending self-help meetings helped them work through the problems with the marriage; the other half reported they simply did not follow through. This latter group appeared fearful of being alone, or described financial or other considerations for staying.

Other issues faced by couples who are dealing with sex addiction include forgiveness, rebuilding trust, establishing a healthier sexual relationship, dealing with the effects of childhood sexual abuse (for example, aversive sexual desire disorders or intimacy disorders), informing family members about the sexual addiction, improving communication skills and methods of handling disagreements, and balancing the needs of the individual versus the couple. (2,3,5,6,14).

The author recommends that each partner, in addition to seeking individual counseling, attend self-help group meetings (such as Sex Addicts Anonymous or Sexaholics Anonymous for the sexual addict, and S-Anon or COSA for the partner). These programs are patterned after Alcoholics Anonymous (AA), the 12 step program originally developed for alcoholic persons. Twelve-step meetings provide an atmosphere in which sexual addicts and their family members can share their experience and receive support and acceptance. If both spouses choose to attend meetings, it is preferable for them to attend different groups; when both attend the same group, one or both are likely to shape their comments in an effort to look good to the other and to avoid hurting the other.

Exceptions are self-help groups established specifically for couples (such as Recovering Couples Anonymous [RCA]). These groups can open up discussion of topics often not addressed at the individual self-help meetings, which focus on the individual. Examples are the couple's sexual relationship, forgiveness, rebuilding trust, how much to share with each other about past sexual behaviors and present challenges, how financial matters have influenced the relationship, communication difficulties, and how to fight fairly. Just as with sponsorship in AA, couples further along in recovery can sponsor couples who are newer. However, attendance at such meetings is most productive after each spouse has attended individual self-help groups. It is the author's experience that if only one partner is involved in 12-step work, the other may feel threatened and find the couple meeting couples too anxiety provoking because of the level of honesty and openness seen in the group.

In treating families for sexual addiction and its attendant problems, Earle et al¹⁵ emphasize that although their philosophy promotes reunification whenever possible, this is never at the expense of any individual. They caution that while family treatment may lead to recovery and restoration, including individual, marital, and family growth, and to clarification of boundaries, it may also lead to family dissolution.

CONCLUSION

In the treatment of sexual addiction, the family unit is often neglected. Yet each family member is significantly affected by the compulsive sexual behavior, and can benefit from treatment. Moreover, the family unit is the context in which the sexual addict continues to live, and the mental health of the partner has a tremendous impact on the sexual addict's recovery. Finally, treatment of children in such a family can help break the cycle of sexual addiction and prevent its perpetuation into the next generation.

Community Resources

The following organizations, offer self-help 12-step meetings for sexual addicts and their families (as well as an increasing body of writings):

For addicts

Sexaholics Anonymous

PO Box 111910

Nashville, TN 37222-1910

(615) 331-6230.

e-mail: saico@sa.org

Sex & Love Addicts Anonymous

PO Box 650010

West Newton, MA 02165-0010

(617) 332-1845

e-mail: slaafws@aol.com

Sex Addicts Anonymous

PO Box 70949

Houston, TX 77270

(713) 869-4902

e-mail: info@saa-recovery.org

web: <http://www.sexaa.org/>

Sexual Compulsives Anonymous (SCA)

Old Chelsea Station, PO Box 1585

New York, NY 10013-0935

(800) 977-HEAL

web: <http://www.sca-recovery.org/index.html>

For partners

S-Anon International Family Groups (for partners)

P.O. Box 11242

Nashville, TN 37222

Tel: (615) 833-3152

Web: www.sanon.org

e-mail: sanon@sanon.org

Codependents of Sex Addicts (COSA) (for partners)

9337B Katy Freeway #142

Houston, TX 77024

Tel: (612) 937-6904

e-mail: COOSA@shore.net

For couples

Recovering Couples Anonymous (for couples with addiction problems)

P.O. Box 11872

St. Louis, MO 63105

Tel: (314) 830- 2600

For children

S-Ateen (for teenage family members of sex addicts)

Contact S-Anon

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The author wishes to thank Sandra Kline, M.A. for reviewing the manuscript.

Address correspondence to: Jennifer P. Schneider, M.D., Ph.D., Arizona Community Physicians, 1500 N. Wilmot Rd., Suite 250, Tucson, AZ 85712.

e mail: jennifer@jenniferschneider.com