SEXUAL ADDICTION AND MARRIAGE AND FAMILY THERAPY: FACILITATING INDIVIDUAL AND RELATIONSHIP HEALING THROUGH COUPLE THERAPY

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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). This article (a) presents a synthesis of the research on the impact of sexual addiction on the addict, the partner, and the couple; (b) outlines the process of healing for each based on the research synthesis; and (c) discusses the role of marriage and family therapy in facilitating both individual and relationship healing from sexual addiction. Implications for future research in sexual addiction, generally, and in marriage and family therapy, specifically, are presented.

The publication of the book Out of the Shadows: Understanding Sexual Addiction (Carnes, 1983) marked a significant increase in the recognition of the term now called sexual addiction as well as the theoretical and empirical literature surrounding the concept. The explosion of the internet has provided a new arena for potential sexual addicts, offering easy access (see Griffiths, 2001, for a review of avenues available), affordability, and anonymity (Cooper, 1998). Young, Griffin-Shelley, Cooper, O'Mara, and Buchanan (2000) suggest that these factors may open the door to sexual addiction for individuals who previously did not express vulnerability, or push mild addicts toward more severe addiction. It is estimated that there are now between one-half and two million sexual addicts (Delmonico & Carnes, 1999).

Despite increased awareness of sexual addiction, as well as an increase in avenues by which many can become sexually addicted, many therapists still experience uneasiness about or lack knowledge of sexual addiction. This may cause therapists to miss many important cues and/or completely fail to address sexual addiction in therapy.

Because couples experience intense emotional reactivity, particularly during early stages of recovery, many therapists who are knowledgeable about sexual addiction prefer to offer treatment for sexual addiction without the spouse, at least initially. However, many of the conceptual and etiological explanations (i.e., past relationship degradations, Bergner, 2002; a subjectively high degree of life stressors, including relationship difficulties and social isolation. Carnes, 1983) suggest that marital therapy might be more helpful than group or individual therapy for facilitating healing with couples (and particularly for monitoring emotional reactivity early in the recovery process). Although the role of marital therapy in helping individuals and couples heal from sexual addiction has been sparsely discussed in the literature (Carnes, 1986; Corley & Schneider, 2002; Earle & Crow, 1998; Laaser, 1996; Schneider, 1989; Sprenkle, 1987; Young et al., 2000), those articles that do address marital therapy suggest the following themes: restoration of trust, improved awareness of individual issues and emotions, improved communication and assertiveness, forgiveness, dealing with sexual problems, establishing boundaries, improving intimacy (positive interactions, activities together, etc.), reducing defensiveness, and reducing shame. Despite the increased recognition of the role of marital therapy in healing sexual addiction, marital therapy still is considered primarily an addition to individual and/or group treatments.

EMPIRICAL REVIEW

Because of 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 (Rothman, Damron-Rodriguez, & Shenassa, 1994) to understand more fully 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. Although 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. The articles chosen are a culmination of all empirical articles that have been written since the inception of the concept of sexual addiction. Because the bulk of research draws a distinction between the nonparaphilia and paraphilia sex addictions (Kafka & Hennen, 1999; Kafka & Prentky, 1992), I also eliminated the articles addressing paraphilia.

METHOD

The articles selected are the results of an extensive literature search in several databases, including PsychInfo, Google Scholar, and ERIC. 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." In addition, 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. Because of the low number of articles (only three studies), 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: (1) studies of addicts; (2) studies of spouses of addicts (also referred to as co-addicts); and (3) 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 in which 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 in which 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 to survey clinicians' perceptions of the addict in therapy, including perceived helpful interventions with sexual addicts. 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, and three are qualitative (Chancy & 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). 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 (Chancy & 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 (1996) surveys only women (some of whom had comorbid diagnoses), thus limiting generalizability to these specific populations. Less than one-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.

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., 1999, 2000). 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 pretherapy 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 posttests 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 audiotaped women displayed 10 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) e-mail 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 were 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 interrater reliability). Although 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. Although quantitative measures were used to compare their sample with samples from other studies, the major findings of their study are qualitative, but no specific methodology is described. Although 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 frequently than did men's (80% and 30%, respectively). However, Schneider's (2000a) 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 in which women experience power through manipulation, seduction, and objectifying of others. Schneider (2000a) 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

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 HIVpositive sexual addicts had significantly lower perceived responsibility for disclosure (p = .034) and lower disclosure rates (p = .04) than HIV-positive nonaddicts (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. It is interesting to note that, although treatment did not focus on increasing relationship stability, the percentage of individuals who were involved in a primary relationship increased from 20% at pretreatment to 40% at posttreatment for the sexual addiction group, a finding that approached significance when compared with the control group (p

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 obsessivecompulsive than a control group. Leedes's (1999) study indicates that addicts have significantly more discomfort with closeness than do those who did not self-identify as sexual addicts, with 95% of the sexual addicts in his study displaying insecure attachment styles. Leedes (1999) 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. Although 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 10 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. Although 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. Although 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 diagnoses, such as depression (Weiss, 2004), ADHD (Blankenship & Laaser, 2004), and OCD (Schwartz & Abramowitz. 2003); time spent in the activities Cooper et al., 1999, 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, 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 that 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 online 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 three 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 affected by their partners' sexual addition. Demographics include means and ranges for age and time in cybersex addition 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 e-mail. 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 (1999) study, 22.3% of the spouses in Schneider's (2000b) study, and 8% of clergy wives in King's (2003) study had divorced their partners. 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 spouses 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, isolated, confusion about whether to stay in the relationship, and having a low sense of self-esteem (Bergner & Bridges, 2002; King, 2003; Milrad, 1999; Schneider, 2000b). In Schneider's (2000b) study, partners who experienced both online 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, although wives recognize that the addiction is not about them, they struggle to believe that it is not. 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, in which 28 of 35 husbands sought at least some type of therapy. Schneider (20006) 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 did not 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 his/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 (20006) 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) used a sample of 54 couples in which both partners reported individually on their shared marriage and an additional 34 respondents who reported individually on their marriages. Schneider et al. (1998) sampled 48 couples in which both answered the questionnaire, 34 with partner-only respondents, and 34 with addict-only responses. Schneider and Schneider (1990b) sampled 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 in which 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 5-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 (1990ft) 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, one-third of couples (in which both partners responded) disagreed about whether or not they had an agreement. Many partners required more than a year to forgive their addicted spouse. It is interesting to note that reports showed that more forgiveness was given by partners than the addicts predicted. Although 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

Schneider and Schneider's (19906) found that bisexual men and their wives experience very similar emotions compared with what is reported for most sex addicts, regardless of sexual orientation. They do note that there the couples mentioned additional fear due to perceived 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, although 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 do not remember everything or do not deem certain facts or events important initially. Also, the reports of less honesty for addicts that were 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 for fear 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 given 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: nevertheless, they offer a significant foundation for current practice as well as further research (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 is causing those feelings. Gradually, they engage in detective behaviors until they discover their partner's addictive behaviors. None of the studies relate an experience in which the addict revealed the behavior prior to being caught by their partner.

When the sexual addiction is discovered, spouses report feeling sad, hopeless, overwhelmed, betrayed, isolated/alone, angry, traumatized, and confused about whether to stay in the relationship. Spouses who experience both online 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 spouses 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 that may suggest that sexual behaviors are negatively affecting 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.

Although addicts and spouses may show some hesitance because of 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 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 may destroy progress in therapy and potentially permanently end the relationship. Although 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 become 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 for fear 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 to 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. Although 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, and so on. 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 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).

In addition, 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 that 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 affect 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 It is not unreasonable that couples might

prefer to deal with the problem privately through marital therapy before going to a more public forum such as groups. Schneider (20006) 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.

IMPLICATIONS FOR FUTURE RESEARCH

The purpose of this article is, through critical analysis of the empirical literature, to provide an outline of the experience of sexual addicts, partners, and couples, their process of healing, and the role that marriage and family therapists can play in facilitating individual and relationship healing from sexual addiction. There are, however, limitations to the synthesis. Although an exhaustive search was conducted using several databases, the articles selected may not be representative because of the biases and limitations of the databases. Although I attempted to correct this bias by searching the reference lists of the resulting articles, this does not ensure that all articles relevant to the topic were located.

Based on the articles found, however, a general overview of the impact of sexual addiction on addicts, partners, and couples was delineated. Although this can increase therapists' general awareness of sexual addiction, more research related to specific interventions is needed to guide therapists in helping addicts in recovery and helping partners overcome the trauma of disclosure of sexual addiction. As Swisher (1995) notes, there is also a need for more outcome research to identify what treatment modalities might be effective in the process of recovery from sexual addiction.

Finally, despite the obvious link between relationships and sexual addiction (including the trauma the partner experiences and the high potential for divorce after disclosure), the role of marriage and family therapists in helping couples to heal is sparsely discussed in the articles included in this review. No empirical studies have been conducted to better understand how couple therapy might assist couples through the process of recovery from sexual addiction. For now, this review represents a research-supported starting place for therapists as well as for researchers as we strive to gain a more complete understanding of how to balance individual healing with relationship healing in the context of couple therapy for recovery from sexual addiction.

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