

## Article 21

# Working With Sexual Addictions in Couples Therapy

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As the age of the internet has provided easy, affordable, and relatively evidence-free access to sexually explicit materials, a new generation of sexual addicts has emerged (Schneider, 2003). With the prevalence of sexual addictions increasing, it is no surprise that a couple involving a sexual addict may end up in your office (Cooper, Delmonico, & Burg, 2000). While sexual addiction is sometimes viewed as a victimless behavior involving solely the addict, there is no denying potential adverse affects on both the addict and his or her family (Earle, Crow, & Osborn, 1989; Milrad, 1999; Schneider, 2003). Recognizing the importance of family, both as victims and supports for recovery, Zitzman and Butler (2005) discovered that conjoint marital therapy is helpful in the recovery from sexual addiction. Keeping this in mind, it is imperative that the effective couples therapist have a working knowledge of sexual addiction, its warning signs, and how to work best with the couple both individually and as a whole.

## Sexual Addiction Defined

The Society for the Advancement of Sexual Health, also known as SASH (2007), defined sexual addiction as “a persistent and escalating pattern or patterns of sexual behaviors acted out despite increasingly negative consequences to self or others” (§ 1). In other words, Carnes (2008) imparted that the addict's life becomes consumed by sex and often overshadows family, friends, and work. He also described that there is no single sexual behavior related to sexual addiction. In fact, any sexual behavior can serve as the focal point of addiction, including “compulsive masturbation, compulsive heterosexual and homosexual relationships, pornography, prostitution, exhibitionism, voyeurism, indecent phone calls, child molesting, incest, rape and violence” (Carnes, 2008, § 3).

## The Cycle

Recognizing the definition of sexual addiction, it is also helpful for both the clinician and the clients to understand the addiction process. To organize and aid in this understanding, Weiss (1998) proposed a cycle of sexual addiction incorporating five

stages. The first stage involves pain agents that result for a need to escape with the addiction. Within this stage, Weiss listed emotional discomfort, unresolved conflict, stress, and the need to connect as the most common pain agents. The second stage involves dissociation, in which the addict attempts to distance him or her self from the above pain agent and disconnect from reality. Dissociation paves the way for the third stage, also known as the altered state, where the addict finds comfort in a fantasy world. The focal point of this stage is that the addict feels safe, in control, and euphoric. Wanting more than fantasy, the addict enters the fourth stage of pursuing behavior and attempts to satisfy the preceding desire. After successful pursuit, the addict in the fifth stage acts out with sexual behaviors. Upon acting out, the addict experiences a sexual release that reinforces the preceding stages and creates the cycle of addiction. Finally, Weiss identified that the last key factor involved with the cycle is the time period between acting out behaviors that creates the addicts' individual pattern. He noted that recognizing this pattern and the involved timing is key in creating effective interventions for treatment.

### **Warning Signs**

Earle et al. (1989) suggested the following warning signs, which may indicate that an individual is struggling with a sexual addiction:

- Often, unaccounted for lapses of time: addicts may disappear for periods of time with little or no legitimate excuse
- Unexpected decreases in efficiency: addicts may not get expected promotions or reasonable projects completed
- Rapid and unpredictable mood changes: addicts may experience intense emotions following the addiction cycle such as increasing excitement or consuming depression
- Other compulsive behaviors: many addicts struggle with addictions in other areas including drug and/or alcohol abuse, gambling, or food
- Family history: many addicts are raised in families with at least one or more sex addicts
- Significant changes in sexual behavior: partners may notice an increase or decrease in the frequency or type of sexual activities
- Physical evidence: partners may discover the evidence such as magazines, pornographic sites, or calls to erotic hotlines (pp. 135-139)

If sexual addiction is suspected, there are free screening instruments that can be utilized with the clinician or at home. SASH (2007) offers four free screening options to address cybersex addiction, gay male or heterosexual male sexual addiction, and female addiction. In addition, Carnes (2008) offers the Sexual Addiction Screening Test (SAST) on his website at no charge.

### **Working with the Sexual Addict**

When working specifically with the sexual addict, keep in mind that there are several issues unique to his or her experience. First, many addicts experience denial,

distorted thinking, and unrealistic expectations in regards to the addiction and its consequences (Earle et al., 1989). Addicts may unknowingly attempt to utilize unreasonable rationalizations or excuses for their behavior and thus, require honest feedback from others, through therapy or a support group, to get back in touch with reality (Weiss, 1998). Also, it is helpful to recognize that addicts often have difficulty expressing emotions and dealing with negative self-talk (Earle et al., 1989). Addicts may be feeling a wide variety of emotions, including guilt, shame, depression, and/or grief, and may need assistance for effective identification and expression (Weiss, 1998).

### **Working With the Partner**

When working with partners of sexual addicts, there are also several unique factors to consider. First, partners often seek professional help only when they are in crisis over the situation and are experiencing intense symptoms such as anxiety, depression, trauma, and/or grief (Milrad, 1999). Thus, one of the first priorities for the clinician would be to work on establishing safety and stability for the partner. In addition to being in crisis, clinicians need to be aware that partners often come to therapy for the addict instead of themselves. Working with spouses of sexual addicts, Milrad (1999) encouraged therapists to focus on empowering the partner to work on identifying and expressing his or her own needs outside of and in relation to the addict. Once safety and purpose has been established, Laaser and Cisney (2007) imparted that there are two major goals in working with partners of sexual addicts: education and being heard. Initially, Laaser and Cisney explained that many partners are still unaware of what is involved with sexual addiction and need to be educated on its process, specifically focusing on how it develops, the warning signs, and what can be done for treatment. Secondly, partners need to be encouraged to share their reactions and have their emotions heard by clinicians. Often, partners do not have a support system, outside of the addict, that they would feel comfortable with sharing the situation, much less their feelings (Dahlen, Colpitts, & Green, 2008).

Recently, Manning and Watson (2008) suggested the C.A.V.E.D. theory to help clinicians remember the common factors of preferred support noted in their study of Christian women from the United States and Canada. Following the acronym, the first factor was connection, which was intended to dispel the isolation associated with their spouses' sexual addiction. Connection can consist of increased time with friends and family, joining a support group, or participating in a new social activity such as a community organization. The second factor was advocacy, in which someone outside of the affected relationship intervenes to stop the addiction cycle and help the couple. This advocacy can take form in the counselor role, but may also be manifested in family members, close friends, or religious authorities.

The third factor, validation, involved "being affirmed as a human and reassured that one's feelings and experiences are understandable and legitimate" (Manning & Watson, 2008, p. 243). Individual, couples, and group therapy can often fulfill this role by promoting validation in their respective settings. Education, the fourth factor, was also essential in understanding their situation in which information concerning the addiction itself, treatment alternatives, and other couples' stories were considered most beneficial. The fifth and final factor, direction, involved the spouses' desire for stability and

guidance during the emotional turmoil of dealing with the sexual addiction. Distinguishing direction from advice-giving, Manning and Watson (2008) related that direction meant having a knowledge of local resources for couples, including possible referrals, support groups, and alternatives to supplement therapy.

### **Working With the Couple**

When a sexual addiction is exposed, it not only affects the individuals involved as described above, but can adversely affect the relationship as well. First and foremost, trust and intimacy are often destroyed during the process of addiction as lies are told and withdrawal takes place (Weiss, 1998). Recognizing these two important relational elements, Earle, Earle, & Osborn (1995) imparted that strengthening open couple communication through contracting and teaching skills is essential. Likewise, Schneider, Corley, and Irons (1998) discovered that the issue of disclosure in regard to the addiction is often paramount when working with couples. Specifically, they described that if disclosure occurs in stages instead of at once, partners may feel it is more destructive to their trust and intimacy. Instead, clinicians are encouraged to help the addict and partner in discerning when, how, and what to disclose about their addictions. Following disclosure, Milrad (1999) suggested that therapists promote awareness of experiences, feelings, and struggles for both partners to work on forgiveness, reconciliation, rebuilding intimacy, and trust.

### **General Tips for Therapists**

- Prior to therapy, educate yourself on best practices for working with sexual addicts and their families (Schneider 2000; Schneider, 2003).
- Recognize that sexual addiction is a “family disease” and can adversely affect family members as well as the addict (Earle et al., 1989; Schneider, 2000).
- Do not make the common mistakes of:
  - Underestimating adverse consequences
  - Misdiagnosing as solely poor communication
  - Asking the partner to join in the sexual behavior (Schneider, 2003).
- Do not be afraid to utilize support groups, for both partner and addict, to supplement therapy (Laaser & Cisney, 2007).
- Focus on promoting open communication and awareness of partner experiences, feelings, and struggles (Milrad, 1999).

### **Case Illustration**

Mary (26) and Joe (28) have been married for five years and have a two-year-old son. They came to counseling after Mary recently discovered Joe looking at pornography and masturbating in his home office. Following the discovery, Mary has slept in the guest room the past three nights and will not speak to Joe. They decided to try couples therapy as a last resort before Mary leaves. During the intake, Joe admitted that he has been struggling with internet pornography and erotic hotline use for the past ten years. Mary says she just wants Joe to be “fixed” so that they can move on or else she is leaving.

Prior to meeting with Mary and Joe, the therapist recognizes her need to gather specific information regarding sexual addictions. Reviewing the current literature and consulting with a colleague, she feels competent to continue. During the first session, the therapist gathers pertinent background information and focuses on hearing from both Mary and Joe. She may also utilize a screening instrument to assess Joe's sexual behaviors. Recognizing that like other partners, Mary has come to counseling in a state of crisis, the therapist focuses on establishing rapport with the couple to create a safe environment. In addition, she assesses the current status of disclosure, which is minimal since Mary and Joe have not been speaking since the incident. The therapist suggests to them several safety precautions, such as putting the computer in a public place, to supplement therapy. She also encourages them to wait on full disclosure until they meet again.

Over the next few sessions, the therapist works with Mary and Joe to determine when, what, and how much will be disclosed in regards to Joe's addiction. Joe says that he would like to come clean with all of it right now to get it over with. He says he knows it was wrong and he has tried to stop but it did not work. Mary says she is unsure of what she wants to know. The therapist explains the importance of a one-time disclosure versus multiple disclosures and explores Mary's thoughts and feelings about the information. Mary decides that she only wants to know in general what he has been doing and if he had an affair with another real woman, but otherwise she would prefer not to know any more details. The couple decides to disclose during the next session with the therapist.

During the disclosure session, the therapist encourages Mary and Joe to actively listen to one another and share their feelings. When Joe has a hard time naming his feelings, she offers him a printed list of emotions to choose from. Joe says he feels relief in being honest, but guilty and sad that it has come to this. After Joe discloses his behaviors and that he has not had a physical affair with another woman, the therapist encourages Mary to share her feelings and thoughts in response. Mary says she feels relief that there was not another woman, but upset that he has lied to her. She does not know if she will ever be able to trust him again. The therapist explains that in situations like this, trust and intimacy often suffer the most. During therapy, they will begin the process of rebuilding trust and intimacy. An important piece in rebuilding is open communication and disclosure like what they did today. To conclude the disclosure session, the therapist and couple draw up a contract stating that from this session onward, both partners will commit to honesty and not keeping secrets.

### **Conclusion**

The increasing prevalence of sexual addiction presents a unique challenge for clinicians as individuals, couples, and families are being adversely affected. Taking the time and effort to learn more about sexual addictions and these affected populations are the first steps in providing effective mental health services to those in need. Continued education and further research are encouraged and anticipated as we rise to the challenge of working with sexual addictions in couples therapy.

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*Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: [http://counselingoutfitters.com/vistas/VISTAS\\_Home.htm](http://counselingoutfitters.com/vistas/VISTAS_Home.htm)*