"Couple Recovery from Sexual Addiction/Coaddiction:

Results of a Survey of 88 Marriages."

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ABSTRACT

To obtain information on how couples recovering in 12-step programs from sexual addiction and coaddiction were actually dealing with their problems, the authors anonymously surveyed 142 persons representing 88 marriages. Additional information was obtained over a 7-year period through facilitating 12-step couples' retreats attended by approximately 100 couples.

The most common problems identified by couples were rebuilding trust, learning intimacy, establishing boundaries, developing a healthy sexual relationship, and forgiving. Most couples also reported great difficulty in conflict resolution. The factors which appeared most helpful to couples in rebuilding and improving their relationship were individual involvement in 12-step meetings and therapy, and joint counseling and attendance at couples' mutual help and/or therapy groups. Coaddicts typically required over a year to forgive and become willing to trust the addict again. New sexual problems were common in the early recovery period, and tended to gradually improve. Eighteen percent of male addicts had engaged in same sex activities. Despite enormous past hurts and significant relational, financial, legal, and health problems faced by many of the couples, most were actively working on their marriages and were committed to a future together.

These results suggest that for couples in crisis because of multiple affairs, use of pornography and masturbation in preference to relational sex, visits to prostitutes, arrests for voyeurism or exhibitionism, or other compulsive sexual behaviors, survival of the relationship can be enhanced when both members self identify as "addict" and "coaddict," attend individual and joint 12-step meetings and counseling, seek feedback from other couples, and commit to ongoing work on the individual and on the relationship.

Introduction

Persons who have engaged in compulsive sexual activities often come to treatment as a result of a crisis such as disclosure of extramarital sexual involvement, arrest for illegal

sexual activity, or job loss or financial crisis related to the behavior. When such persons are married or in a committed relationship, both members of the couple typically feel shame and tend to maintain secrecy. As a result, most couples are isolated and are not in contact with other couples who have dealt with similar problems.

One subset of such persons are those who come to define themselves as sex addicts and seek help in self-help programs modeled after Alcoholics Anonymous. Twelve-step programs for sex addicts (Sexaholics Anonymous or SA , Sex Addicts Anonymous or SAA , Sex and Love Addicts Anonymous or SLAA, and Sexual Compulsives Anonymous or SCA, are available in many parts of the U.S., as well as in some cities in Canada, Germany, and other countries. Spouses or partners of sex addicts may define themselves as sexual coaddicts, or as relationship addicts, and seek help in 12-step programs such as S-Anon and Codependents of Sex Addicts (COSA), also found in many cities. Salmon (1995) published a therapist's guide to the history and main characteristics of each of these programs.

Couples who had broken their isolation were also attending 12-step couples meetings. Two such programs which have been in existence for several years are S-Anon Recovering Couples, established in 1986 (P. O. Box 111242, Nashville, TN 37222- 1242, telephone (615) 8333-3152), and Recovering Couples Anonymous, established in 1988 (RCA, P. O. Box 11872, St. Louis, MO 63105, telephone (314) 830-2600.) Although the latter program is open to couples recovering from any addiction, approximately 50% of the member couples have experienced sexual addiction problems. Elsewhere in this journal the use of the 12 Steps for couple recovery is described (Laaser, 1996).

Common topics for couples meetings include: rebuilding trust, forgiving oneself and one's partner, sexuality in recovery, how to fight fairly, dealing with illness in one member of the couple, building communication skills, how to avoid monitoring the partner's recovery program, how to talk to the children about the parents' recovery programs, and how to negotiate financial decisions. These topics are not frequently discussed at separate 12-step meetings for addicts and coaddicts. In these meetings members of each couple have a chance to speak before going on to the next speaker. Couples reported that they felt hopeful after hearing how other couples had dealt with similar problems.

Between 1987 and 1993, the authors facilitated an annual 12-step couples retreat in Tucson, Arizona specifically focused on sexual addiction and coaddiction. These weekends provided a rich source of information about such couples. Twenty to 24 couples attended each year, but several came two or three times, for a total of perhaps 100 different couples. We found that couples' 12-step programs were most helpful to persons who were also individually involved in their own 12-step programs. The couples who had most difficulty are those where only one partner (typically the addict) was going to meetings; in such cases, the coaddict tended to maintain a blaming attitude, believing that the addict was the only person who needed to be fixed. This is also a common complaint of sex addicts in 12-step programs whose partner declines to attend a 12-step program for family members such.

Although 12-step programs provide powerful support, most respondents reported benefitting from couples therapy. Unfortunately, mental health professionals have had few resources for information on the course of couple recovery and on treatment of specific issues . Carnes (1991, p. 262-269), after outlining the stages of recovery for addicts and for coaddicts, discussed the impact of the different stages on the couple relationship. Healthy sexuality for recovering people was described by Sedgwick (1992), Manley (1995), Irons (1995), and Carnes (1991).

Based on personal interviews, Schneider (1989) described the major problems faced by couples recovering from sexual addiction related problems. To assist clinicians working with sexually addicted couples, the present authors sought to obtain additional information by means of an anonymous survey. We asked about the types of problems couples and individuals experience during recovery from sexual addiction and the ways they were helped to resolve them. This paper reports the results of a survey of 142 married sex addicts and coaddicts, representing 88 marriages, in which at least one member was a recovering sex addict. Some of our findings have been published elsewhere (Schneider, 1990; Schneider & Schneider, 1989, 1991a, and 1991b).

Methods:

Over a one year period, married couples attending 12-step support groups for sexual addicts and coaddicts throughout the United States were offered the opportunity to fill out a 14-page anonymous survey relating to their recovery experience. Each survey was completed individually and returned by mail. In addition to requesting demographic information and facts about the respondent's addiction history, family of origin, marriage history, and course of recovery, the surveys included both open- ended questions and forced choices on a Likert scale regarding the effects of the addiction and/or coaddiction on the relationship, what problems had resulted, and how the difficulties were being addressed. Of 400 surveys distributed, 142 (35.5%) were returned . Although completed and mailed individually by each person, the surveys were coded so that the members of a couple could later be matched up. In 54 cases, both members of the dyad completed the survey; in 34 cases only one member responded. Thus, the study comprised 88 marriages.

Results

Demographics

The 142 respondents, 67 males and 75 females, ranged in age from 24 to 71: 4% of the men and 12% of the women were aged 20- 29, 36% of the men and 44% of the women were aged 30-39, 36% of the men and 25% of the women were 40-49 years old, 18% of men and 15% of women were 50-59 years old, 4% of men and 4% of women were 60-69 years old, and one man was over 70. Of the 54 cases in which both partners completed the survey, six couples (11%) consisted of two sex addicts, and in two cases (4%) only the woman was sexually addicted.

Because several people identified themselves as both addicts and coaddicts, we had a total of 76 addicts and 74 coaddicts. (The figure for coaddicts excludes 8 addicts described in the discussion section below). Of the 76 addicts, 64 (84%) were male; of the 74 coaddicts, most (66, or 89%) were female. Sixty-seven percent were in their first marriage, including 59% of the 54 couples whose members both completed the survey; 24% were in their second marriage, and 6% in their third or fourth marriage. They had an average of 2.1 children. This was a highly educated group: 42% of the men and 23% of the women held a graduate degree, 31% of men and 36% of women had completed four years of college, 16% of men and 33% of women had attended college or trade school for some time, and only 9% of the group had only a high school education.

Carnes (1991) has observed that sex addicts have an average of three compulsive sexual behaviors; our results were consistent with this finding. Nearly all the addicts listed compulsive masturbation and pornography among their compulsive behaviors, 68% had participated in extramarital sex, including 20 (28% of the addicts) who had been sexual with a same sex partner, 15% had visited prostitutes, and several addicts mentioned peep shows, massage parlors, and telephone sex. Level Two behaviors (Carnes, 1983) were fairly common: 18% of addicts reported involvement in voyeurism, 12% in exhibitionism, and 4% had taken indecent liberties. Several reported Level Three behaviors, including 4 (5%) who admitted to incest, two to molestation, and one to molestation and raping his wife while she slept. All the men who had done Level Three activities had also been involved in several Level One and often Level Two behaviors.

Multiple addictions, family addictions, and childhood sexual abuse

Most respondents (83% of the sex addicts and 61% of the coaddicts) self identified more than one addiction (the primary addiction of the coaddicts was considered to be their coaddiction or relationship addiction). The other addictions are shown in Table 1:

Table 1

Concurrent addictions of recovering sex addicts and coaddicts

	Addicts	Coaddicts
Chemical dependence	39%	20%
Eating disorders	32%	38%
Workaholism	38%	25%
Compulsive spending	13%	12%
Compulsive gambling	4%	1%

Most respondents (81%) reported at least one addiction in their family of origin. Chemical dependence was reported in at least one parent by 40%, sexual addiction by 36%, eating disorder in 30%, workaholism in 38%, and compulsive gambling in 7% of families of origin. Childhood sexual abuse was also frequently reported by 52% of the men (n= 35) and by 39% of the women (n = 27); these figures are most likely underestimates, since details of the respondents' childhood sexual experiences were not sought; we asked only, "Do you believe you were sexually abused as a child?"

Treatment and Recovery

The respondents were ascertained through 12-step programs, and most were still attending. Their time in recovery ranged from one month to seven years, with a median of 1-3 years; 8% of addicts and 6% of coaddicts had more than five years' recovery. Seventy-nine percent of addicts were attending meetings for sex addicts, and 29% were involved in 12-step programs for other addictions. Most of the coaddicts, 71%, were currently attending S-Anon or COSA, 12-step meetings for coaddicts; 20% were attending other 12-step programs. Nearly half of respondents were attending 12-step couples program.

Nine percent of the addicts had been through an inpatient program for sexual addiction, and 9% of coaddicts went through inpatient treatment for codependency. Additionally, 11% of sex addicts and 5% of coaddicts went through inpatient treatment for chemical dependency, and 5% of the group had outpatient drug addiction treatment. Although 29% of the survey sample said they were also recovering from chemical dependency, only 13% had obtained professional help; most of the chemically dependent persons in the group apparently obtained recovery through AA.

Nearly all the respondents had obtained some counseling or therapy relating to their addiction or codependency. Individually, as a couple, or in a group setting, they saw psychiatrists, psychologists, psychotherapists, social workers, master's level counselors, clergy, marriage counselors, family counselors, sex therapists, and addiction counselors. The majority (79% of addicts and 69% of coaddicts) had seen more than one therapist. One-third had seen two therapists, 20% three, and 23% of addicts and 17% of coaddicts had been to four or more therapists. Only a few had a successful therapeutic outcome with the first counselor or therapist; most professionals failed to understand the nature of the problem. In many cases, therapists were educated about the diagnosis by their patients, who had already found their way to SA, SAA, SLAA, or SCA.

Chief Problems

When asked to rank the most important current problems in their relationship, the respondents rated the following problems as the top three:

Table 2

Rank order of three marital problems

	Men (n=65)	Women (N=74)
Rebuilding trust in my partner	48%	38%
Lack of intimacy	40%	42%
Setting limits or boundaries	38%	39%
Resolving conflicts	31%	19%
Developing our spirituality	31%	20%
Our sexual relationship	32%	28%
Forgiving my partner/being forgiven	29%	22%
Financial problems	17%	20%

Forgiving and Rebuilding Trust

The survey asked respondents, to rate on a scale of 1 to 5, how much they trusted their spouse. Not surprisingly, only 14% of coaddicts, compared with 42% of addicts, said they trusted their spouse completely. An additional 39% of addicts and 37% of coaddicts trusted their spouse mostly. The respondents were not asked to define trust, but many addicts chose to regard it narrowly as referring to sexual fidelity. Thus, one addict replied, "She's never strayed I have no reason to doubt her fidelity or love." Addicts who reported low levels of trust did so because they had long ago learned not to trust other people, or because they perceived their spouses as manipulative or controlling, or because they feared their partners would not understand their feelings, or were continuing to blame and shame them.

Coaddicts typically focused on their spouses' sexual behavior as the basis for confidence and found less to trust. Those who had a high level of trust reported the following factors to support the trust: Most described a real commitment to recovery by their spouse and a long term commitment to a 12- step program. Several mentioned their spouse's honesty in all areas of life. Most coaddicts were in recovery themselves for a significant length of time. They had improved their own self esteem and developed a willingness to risk trust. One related, "If it turns out that my trust is unwarranted, then I know I'll be okay alone."

When the level of trust was compared with time in recovery, no correlation was found for addicts, whose level of trust of their spouses often remained unchanged over time. In contrast, coaddicts increased their level of trust as the period of time which they (and of course their spouses) were in recovery. For example, among coaddicts in recovery 6 months or less, almost half had little or no trust and only 21% trusted mostly or completely. In contrast, among coaddicts in recovery over 3 years, none indicated very little trust, and an overwhelming 83% had great or complete trust in their partners.

When addicts were asked, "What needs to happen in order for you to increase your trust in your partner," those who had less than complete trust offered the following suggestions: " Continued progress in her own program"; "greater sensitivity to my feelings"; "more acceptance of me in her actions and desire to be more with me instead of emotionally distant"; "a little more love and intimacy interspersed with the anger, hostility and distancing" ; "she needs to deal with her rage better, and I need to not be so nice." "I have to be stronger in myself, not relying so much on her opinion of me." The factors most often mentioned by addicts were: Greater acceptance and less judgmentalism by the coaddict, greater willingness of the coaddict to be vulnerable, and continued recovery by the addict.

Coaddicts stressed the passage of time in recovery as a key factor in rebuilding trust in the addict. They wanted to see "a continued track record of success and sobriety." In addition to ongoing commitment by the addict to recovery work, their partners found that continued honesty, dependability and consistency in the addict's actions fostered rebuilding trust. Further, several coaddicts recognized that their own personal growth was an important factor. They wrote, "I need to continue to develop my own self esteem." "I need to work on myself in my own Twelve-Step program. I see my own issues interfering with trust." Other goals mentioned were willingness of both partners to be more vulnerable, and improved communication between the partners.

When asked, "What are you and your partner doing to rebuild trust in your relationship?" respondents reported talking with each other about their feelings, being honest with each other, going regularly to 12-step meetings, to marriage and individual counseling, and to sex therapy, spending more quality time together, doing fun things, and improving their communication.

Forgiveness is a key ingredient in rebuilding trust. When asked "On a scale of 1-5, how much have you forgiven your partner?" some addicts had difficulty answering, because "she is not the addict," or "he did not betray me." Both addicts and coaddicts showed a considerable level of forgiveness:

Table 3

Forgiveness

Level	Coaddicts

	Addicts(N=50)	(N=64)
not at all or slightly	2%	6%
somewhat	28%	31%
mostly or entirely	70%	63%

When the reported level of forgiveness was compared with the respondent's time in recovery, the willingness of addicts to forgive their partners did not change much with time, in agreement with their responses to questions about trust. The responses of coaddicts are shown in Table 4:

Table 4

Coaddicts' level of forgiveness as a function of time in recovery (N=65)

Time in Recovery	Slightly	Somewhat	Mostly or Entirely
0-6 months	14%	43%	43%
6-12 months	12%	47%	41%
1-3 years	0%	19%	81%
Over 3 years	0%	15%	85%

These results clearly show that many coaddicts require at least one year in recovery before they are ready to forgive their partners.

We also asked, "How much do you think your partner has forgiven you?" By comparing the responses to this question with people's response to the question, "How much have you forgiven your partner?" we were able to correlate the actual versus perceived level of forgiveness for 33 men and 39 women. Men (mostly addicts) had forgiven their wives (mostly coaddicts) more completely than vice versa, as is shown in Table 3. Not surprisingly, then, women (mostly coaddicts) had reasonably accurate perceptions of how much their husbands had forgiven them; many did not believe there was much to be forgiven. In contrast, husbands (who were mostly addicts) tended to underestimate their

wives' level of forgiveness. When women had in fact forgiven their husbands, the men tended to think they hadn't. On the other hand, when women actually had not forgiven their husbands, the men appeared to be aware of this. It appeared that men tended to believe their wives had not forgiven them, whether or not this was true.

Sexuality in Recovery

Results of the survey questions about sexuality before and during recovery from sex addiction have been previously published (Schneider, 1990) and will be only summarized here. Only 27% of men and 28% of women considered their sexual relationship to be very good or excellent before identification of their sexual addiction or coaddiction. (Comparable data on the general population are not available, so no comparisons can be made). In recovery, 39% of men and 39% of women rated their sexual relationship as very good or excellent. Comparison of the sexual relationship before and after recovery (Schneider, 1990) is reproduced in Table 5:

Table 5

Comparison of Sexual Relationship Before and During Recovery

	Men (N=65)	Women (N=65)
Better	74%	66%
Worse	17%	12%
Same	9%	12%
Different	0%	9%

Although the level of sexual satisfaction varied widely, the majority of respondents believed their sexual relationship improved as a result of identification and treatment of the addiction problems. However, a significant minority believed the sexual relationship was worse or no better than before. In response to the question, "Have any specific sexual problems occurred since you began recovery?" 44% of addicts and 46% of coaddicts replied affirmatively. They described ten basic types of problems which interfered with sexual interest or performance. These were described in detail by Schneider (1990) and are summarized in Table 6:

Table 6: ***Sexual Problems Which Began After Diagnosis of Sexual Addiction/Coaddiction***

I. Problems originating primarily with the addict

1) feelings of guilt and shame

2) loss of libido and erectile dysfunction

3) unrealistic expectations about the sexual relationship

4) confusion about sexual orientation.

II. Problems originating primarily with the coaddict

5) anger, betrayal, loss of trust

6) disclosure of the coaddict's underlying problems (e.g. unresolved incest issues) when the addict's behavior changes

7) fear of sexually transmitted diseases and negative reaction to need to use a condom

III. Problems originating with the dyad

8) new fears and excessive analyzing about characteristics of healthy and addictive sexuality.

9) decreased intensity of the sexual experience

10) change in the balance of power in the relationship

Most couples reported attempting to address their sexual problems through improved communication, professional individual and/or marriage counseling, and the use of 12-step programs. The majority (73% of addicts and 69% of coaddicts) had experienced at least one period of sexual abstinence, and most felt that the abstinence period had been beneficial for at least member of the partnership. Several respondents who felt negatively about an abstinence period reported they had not been consulted about the decision, or that it was simply a continuation of a longstanding pattern in which there was no sex within the marriage (while the addict had been acting out outside the primary relationship).

Same sex extramarital sexual relations were reported in 16 of the 88 marriages comprising the survey (18%). In addition to the 28 individuals (representing the 16 marriages) who completed the survey, an additional 6 couples (12 persons) were found by the snowball technique and were interviewed by the authors by telephone. Information was thus available on 22 marriages in which the husband had had same-sex extramarital relations. No couples reported same-sex extramarital activity by the wife.

A detailed description of these couples has been published (Schneider & Schneider, 1990). Some of the men considered their bisexuality an integral part of their sexual identity, whereas others distanced themselves from their gay side by considering it to be

their "addict," and regarded it as a part of their life they wished to avoid. Current marriage ratings were good for 47% of the couples, average for 37%, and poor for 17%. Ten couples (45%) believed their current sexual relationship was good, 27% rated it poor, and 27% were abstinent at the time of the study. In two cases the decision to remain abstinent was related to the husband's positive HIV status; at least one of these men is known to have subsequently died. Several couples who were celibate expressed high marital satisfaction and believed they were actively working on the relationship. Nonetheless, it appeared that the men who experienced the least heterosexual arousal had the most difficult adjustment to a monogamous heterosexual relationship.

Establishing Boundaries

Setting limits and establishing boundaries was one of the problems mentioned most frequently by couples. This generally refers to difficulties encountered by addicts' partners in defining situations they would consider intolerable, and planning a course of action should the situation occur. These lessons are learned by most coaddicts in recovery, in conjunction with developing self-esteem and self-empowerment; during the active addiction and coaddiction phase, they are so fearful of abandonment that they feel they have no choice but to "tolerate the intolerable."

In response to the question, "Do you and your spouse have an agreement on what sexual behaviors are not acceptable in your relationship now?" 70% responded affirmatively. Unacceptable behaviors included sex with anothe person, forcing the spouse to have intercourse, and using pornography. Interestingly, of the 49 couples for whom responses were available from both members, one-third disagreed about whether or not there was an agreement. Among the coaddicts, 82% had a plan for dealing with boundary violations, most commonly consideration of ending the relationship. The second most common consequence would be seeking counseling. Several coaddicts recognized that their ability to enforce the stated consequences of a broken boundary would depend on their own recovery process. "I hope I would have the guts to leave," wrote one woman.

Relapse

The survey asked, "What is your definition of a relapse?" "Have you relapsed? If yes, how did you handle it? Did you tell your spouse? If so, how did the two of you deal with the relapse?"

All the addicts were able to clearly define a relapse, which for many also included masturbation. Relapse was a common occurrence during early recovery from sex addiction; 31% of addicts related at least one relapse apart from masturbation, and an additional 21% had had a masturbation slip. Most of the non-masturbation relapses involved other sexual partners. The relapses and slips were usually discussed in the 12-step meeting, with a sponsor, and often with the spouse. In several cases, admitting the relapse to the spouse resulted in a period of separation. Overall, those addicts who were honest with the spouse felt it had been beneficial for them.

Discussion

Alcoholics Anonymous, founded by a stockbroker and a physician, initially appealed to an educated group of people and only gradually drew in more blue-collar workers. At the time of our study, the same pattern was apparent in the sex addiction recovery programs. With less than a 20 year history, the "S" programs initially attracted a largely educated membership. The data of Carnes (1991) supports this observation.

As expected, most of the addicts were male and most coaddicts female. Eight male addicts belatedly recognized they were coaddicts as well. However, this was because of family-of- origin problems rather than because their spouses were sex addicts. Hence they did not complete any portions of the survey which asked about how the coaddiction had affected their marriages. Because over 80% of the respondents believed their parents had at least one addiction, most people were in the role of coaddicts in their family of origin. Only after they had stopped their addictive behaviors did some people recognize they had problems with a need to control others, to please others, and other coaddictive issues. Therapists typically suggest that addicts have at least two years of sobriety before they tackle problems of coaddiction and codependency. Often it is only after several years of sobriety that addicts even recognize their need to address these other issues.

The survey respondents' experience with therapists paints a dismal picture; most had seen a string of professionals before their sex addiction problem was diagnosed. Part of the problem, of course, is denial. They may have reluctantly participated in therapy and may have hidden their problem behavior from family members and from professionals, thus sabotaging therapy. Other sex addicts may have genuinely wanted help but lacked understanding of the connection between their sexual behavior and their interpersonal or job problems. Chemical dependency is often initially suspected only when medical consequences supervene; in contrast, a sex addict may act out for years without medical consequences. Appropriate diagnosis of sex addiction on the part of the professional requires a high index of suspicion and involves asking the right questions.

Seven years ago when this study was conducted, it was finally becoming accepted by most mental health professionals that therapy is not effective with clients who are compulsively drinking or using drugs, and that the therapy must stay focused on the addiction problem. At the time, however, there was not often the recognition that the same holds true for sexual addiction problems. Too often, for example, when the presenting problem was a sexual affair, the counselor did not seek information on other, past, affairs, or ask about other sexual behaviors such as masturbation or use of pornography. Even when one partner's history of multiple affairs was known, they were considered a consequence of problems in the marriage, and the counseling focused on improving the couple's communication, sexual relationship, etc. ; the compulsive behavior was not itself treated as a primary problem.

At present there is more knowledge about sex addiction. We believe we are justified in being optimistic that in 1996, a client presenting with a sex addiction problem is much more likely to obtain a diagnosis that will lead to effective therapeutic intervention.

Unfortunately, there is still considerable debate among treatment professionals on whether the addiction paradigm is appropriate for compulsive behaviors such as eating, sex, and gambling (Schneider, 1994; Smith, 1994).

Because the survey respondents were found through the 12- step network, most were attending individual recovery meetings for sex addiction or coaddiction. In addition, nearly half were attending a couples' 12-step group. Our sample is therefore clearly not representative of the average couple dealing with a sexual addiction crisis, but is rather a sample of married persons who subscribe to the addiction paradigm and are committed to personal growth and recovery. We believe that the optimistic outlook of these couples, many of whom were dealing with medical, psychological, legal, and/or financial consequences of their acting out, was due to their active involvement in the recovering community.

The survey showed that the same recovery steps result in rebuilding trust, ability to forgive oneself and one's partner, and increased vulnerability and intimacy in the couple relationship. These steps include continued work on one's individual recovery through counseling and mutual-help groups, evidence of honesty, consistency, and dependability on the part of the addict, work on being less judgmental and more vulnerable on the part of the coaddict, involvement by both partners in counseling and in mutual-help groups in order to work on the relationship, and education for the couple on improved communication, conflict resolution, and healthy sexuality. Many addicts and coaddicts need psychotherapy to heal the consequences of childhood sexual abuse, emotional abuse, and other childhood trauma, in order to be able to engage in an intimate adult relationship.

A key finding in the survey was that the addict must be actively involved in a recovery group for at least a year before the partner is willing to forgive and begin to trust again, even when he or she is also working on their own healing from codependency. We have encountered many addicts who are perplexed, resentful, or impatient because they have been doing "all the right things" for several months and yet their partners are still distrustful, angry, and keep rehearsing the past. It will be helpful for counselors to inform couples of this typical time frame and to counsel patience during the first year.

Another interesting finding was the tendency of men (mostly addicts) to underestimate the level of forgiveness by their spouse. One possible reason for this is the addicts' guilt about past behaviors and about pain caused to the partner. Talking about forgiveness might be a fruitful topic of discussion for recovering couples.

Another area of miscommunication involved decisions about what sexual behaviors were considered unacceptable in recovery. One-third of couples had differing perceptions about what boundaries they had agreed on. The counselor can facilitate open discussion about this topic, which is particularly relevant in view of the finding that 31% of addicts reported a non- masturbation relapse at some time during recovery.

These specific gaps in communication were symptomatic of a more general lack of skill in communication and conflict resolution. Many addicts and coaddicts grew up in dysfunctional families where open expression of feelings was not allowed and where effective problem solving was never modeled. They can benefit from education about techniques of conflict resolution such as using "I" messages, writing letters to each other, agreeing to listen without responding until the other person has finished, crafting a "fair fighting contract," etc.

Among the core beliefs of sex addicts identified by Carnes (1983), the last is, "Sex is my most important need." Sexual coaddicts, according to Schneider (1988) have a core believe that "Sex is the most important sign of love." Thus, for both sex addicts and coaddicts, sex serves functions other than procreation, recreation, and affirmation of the relationship. Sex and its surrounding rituals become the most important aspect of the addict's life. The coaddict confuses sex with love an uses sex as a currency to win the partner and retain and manipulate him or her. In a relationship consisting of a sex addict and a coaddict, or of two sex addicts, sex occupies a prominent position and may be the source of significant conflict. The survey showed that sexual problems were common before recovery, and even more common during recovery. Nonetheless, only 32% of the men and 28% of the women listed sex as one of their top three problems in recovery. Only 8% of men and 5% of women listed sex as their single most important problem, versus 23% of men and 18% of women who considered "rebuilding trust" as their single most important problem. It is likely that couples recovering from sex addiction problems have to get past the guilt, shame, distrust, betrayal, and unforgiveness, before they can pay attention to the very real sexual problems which the survey shows are often present. The implication for counselors is that sex education and therapy, which many couples can benefit from, is best offered later rather than early in the recovery process.

Same-sex behavior by the husband was reported in 18% of the 88 marriages. This is clearly a significant issue for many couples recovering from sexual addiction problems. The couples ascribed various explanations for this behavior. Although a strong homosexual identity was associated with difficulties in marital satisfaction, viewing the same-sex activities as compulsive facilitated commitment to the marriage and to monogamy.

A period of sexual abstinence, typically 60-90 days, is now a standard recommendation in the early treatment period. The survey results supported the benefit of such an intervention for most couples, but also raised some cautions. Because both sex addicts and coaddicts often equate intimacy with sexuality, many have little experience in being affectionate or close without being sexual. The counselor may need to educate clients about the importance of non-genital touching and non-physical affection. The purpose and goals of the abstinence period should also be discussed with the couple. Discussion of the abstinence period needs to be individualized with each couple. In cases when the coaddict has been unhappy about the addict's lack of interest in a marital sexual relationship, an abstinence period may be perceived as "more of the same." The co-addict's support and understanding of the goals of this period need to be solicited. When the sexual relationship has been absent for many years, an abstinence period may be

counterproductive for the coupleship; such cases require a balancing of the needs of individual and couple recovery.

Balancing the needs of the individual with the needs of the relationship is an ongoing theme in couple recovery, as these needs may sometimes conflict. Because the coupleship can be only as healthy as the individuals in it, we believe that solid individual recovery is the cornerstone of successful relationship building. The counselor may need to explain this to the person who complains of the time their partner spends at 12-step meetings and other recovery activities, or who is unsupportive of an abstinence period. Carnes (1991) described the time frame of recovery for addicts and coaddicts. In the first 1-2 years, the emphasis needs to be on individual recovery for both members of the couple. Support for the coupleship may be garnered by meeting with other recovering couples.

Respondents who attended 12-step couples meetings found them extremely helpful. Such meetings can serve to dispel false beliefs that addicts and coaddicts may have about each other. Some addicts have feared coaddicts, believing that at their meetings women encourage each other to leave their husbands. Some coaddicts feared addicts. Both groups may be greatly relieved to learn their beliefs were false. Addicts can gain new appreciation for the pain their behavior may have caused their partners and may be surprised that coaddicts acknowledge they have as many problems as the addicts. Coaddicts can see that addicts are ordinary people who are struggling and that they can be caring and concerned.

At the time of our study there were relatively few 12-step meetings for sex addicts and coaddicts. Therefore it was not uncommon to find members of a couple attending the same meeting, especially if both identified as sex addicts or as coaddicts. In fact, some couples had actually met at a particular meeting and continued to attend together. Couples who attended the same meeting reported that one or both were likely to be reticent in sharing because they did not want to risk hurting their partner by revealing sensitive information. They tended to censor what they said. The result is that just at those times when the person is most in need of speaking about problems, he or she is least likely to do so. We advise members of a couple to attend separate meetings if at all possible. The exception to this recommendation is for couples' meetings, where couple issues are specifically discussed.

In summary, these results suggest that for couples in crisis because of multiple affairs, use of pornography and masturbation in preference to relational sex, visits to prostitutes, arrests for voyeurism or exhibitionism, or other compulsive sexual behaviors, survival of the relationship can be enhanced when both members self-identify as "addict" and "coaddict," attend individual and joint 12-step meetings and counseling, seek feedback from other couples, and commit to ongoing work on the individual and on the relationship.

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