2006-02-08

A Qualitative Study of the Supports Women Find Most Beneficial When Dealing With A Spouse's Sexually Addictive or Compulsive Behaviors

Jill Christine Manning
Brigham Young University - Provo

A QUALITATIVE STUDY OF THE SUPPORTS WOMEN FIND MOST BENEFICIAL WHEN DEALING WITH A SPOUSE'S SEXUALLY ADDICTIVE OR COMPULSIVE BEHAVIORS

by

Jill C. Manning

A dissertation submitted to the faculty of

Brigham Young University

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Marriage and Family Therapy Department, School of Family Life

Brigham Young University

April 2006

BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

of a dissertation submitted by

Jill C. Manning

This dissertation has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory.

Date	Wendy L. Watson, Ph.D., Chair
Date	James M. Harper, Ph.D.
Date	Elaine W. Walton, Ph.D.
Date	Leslie L. Feinauer, Ph.D.
Date	Richard B. Miller, Ph.D.

BRIGHAM YOUNG UNIVERSITY

As chair of the candidate's committee, I have read the dissertation of Jill C. Manning in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

_____ _____

Date

Wendy L. Watson, Ph.D.
Chair, Graduate Committee

Accepted for the Program

_____

Robert F. Stahmann, Ph.D.
Chair, Marriage and Family Therapy

Accepted for the School

_____

James M. Harper, Ph.D.
Director, School of Family Life

ABSTRACT

A QUALITATIVE STUDY OF THE SUPPORTS WOMEN FIND MOST BENEFICIAL WHEN DEALING WITH A SPOUSE'S SEXUALLY ADDICTIVE OR COMPULSIVE BEHAVIORS

Jill C. Manning

Marriage and Family Therapy

School of Family Life

Doctor of Philosophy

While not included in the diagnostic classifications of sexual disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM), sexual addictions and compulsivities are increasingly being encountered by mental health professionals, and the field of sexual addictions is gaining wider acceptance (Delmonico & Carnes, 1999; Garos, 1997). Research shows the majority of people struggling with sexual addictions and compulsivities involving the Internet are married, heterosexual males (Cooper, Delmonico, & Burg, 2000), and that women who are married to these men are directly impacted by this problem (Schneider, 2000b). Although there is research on many issues relating to wives of sex addicts, there is currently a void in the research literature regarding the kinds of support women find most beneficial when dealing with a spouse's sexually addictive or compulsive behaviors. The primary purpose of this qualitative study was to identify the kinds of support women find most beneficial when dealing with a spouse's sexually addictive and compulsive behaviors. Using grounded theory

methodology (Strauss & Corbin, 1990), twenty-two women from Canada and the United States were interviewed to find out what they found most helpful as they sought support to cope with a spouse's sexually addictive and compulsive behaviors. A theory of support for this population emerged from the data. It was found that women in affected marriages utilize two main categories of support, namely, coping supports, and change-oriented supports such as Recreational, Relational, Professional, Spiritual and Conceptual. Responding to problematic sexual behavior is moderated by numerous internal and external factors. Five common factors of positive support experiences were identified across the sample. These five common factors were: (a) Connection, (b) Advocacy, (c) Validation, (d) Education, and (e) Direction (CAVED). This study did not succeed in identifying distinct pathways of support for women who discover this problem versus those who have it disclosed to them, nor did this study identify specific treatment modalities that are effective. The results of this study provide a useful template for clinicians, support networks and researchers to begin understanding what is helpful and unhelpful when working with this population.

ACKNOWLEGEMENTS

A dissertation is never completed without an enormous team effort and unwavering cheerleading section. I have been extremely fortunate to have been a part of one of the best teams anyone doctoral student could ask for.

First and foremost, my parents, Fern and Gordon Manning, have been "Rock Solid" in their support of me and my work. In my opinion, they have both earned honorary doctorates for the countless hours they listened, encouraged, prayed, fasted, counselled and loved me through this. I will always be grateful they eventually agreed a dissertation on "mother-baby bonding" was not the direction I, nor the world around me, needed to go.

It is no secret that Dr. Wendy L. Watson was the reason I came to Brigham Young University. My admiration, respect and love for her has only increased as I have worked with her and observed her unique therapeutic, professional, spiritual and personal style in action. I also appreciate Wendy for the many ways she worked and prayed to "keep Jill safe" on many fronts.

Michael Feil was an unexpected, yet thoroughly enjoyed surprise/blessing at the tail end of this process. I want to thank him for being a phenomenal support as I crossed this significant finish line. I am also grateful for his impeccable timing; had he come into my life any earlier, this dissertation would not have been completed in 2006!

A doctoral program is an expensive undertaking and I gratefully acknowledge the financial support granted me by Brigham Young University, the Ella Carpenter Jensen Fellowship, The Women's Research Institute and The Heritage Foundation.

I would also like to thank Elizabeth Griffin, Priscilla Asamoah, Rod Jeppeson, and Rory Reid for assisting me in making contact with the various women I interviewed. Had these individuals not been so generous with their time and ideas, the study would have lacked the depth and diversity it ending up having.

Jane Perry, Jacob Nishida, and Brian Mead generously gave of their time and energy to transcribe and code the research interviews – a time consuming and tedious task. Jane, you especially were a lifesaver at a time when your own health was a major challenge for you – thank you.

Expert researchers at the Library of Congress in Washington, D.C. were helpful in opening my eyes to research strategies I was unaware of. Thomas Mann, Constance Carter, and Bruce Martin are "off-the-charts" and people I will confidently turn to when stuck with a research problem in the future.

I readily acknowledge the time and effort of my entire doctoral committee who, despite extremely demanding schedules, graciously gave of their time and fine talents to ensure this project was as strong as it could be. Thank you for making this process an enjoyable learning experience.

Last, but certainly not least, I thank the twenty-five women who allowed me to interview them. Their courage, resilience and personal narratives further fuelled my passion for this issue. These women will be a motivating power in my life for years to come, and representing their experiences and expertise accurately to help as many marriages and families as possible is my goal and prayer.

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION AND CONTEXT OF THE PROBLEM

Although German psychiatrist Krafft-Ebbing described "pathological sexuality" more than one hundred years ago (Krafft-Ebbing, 1886), the field of sexual addictions and compulsivities is relatively new. In 1983, Patrick Carnes' groundbreaking work, entitled *Out of the Shadows*, brought forth a theoretical basis for sexually addictive behavior, and sparked widespread debate, investigation and recognition of sexual addictions as a clinical construct (Carnes, 1983; Delmonico & Carnes, 1999). While not yet included in the diagnostic classifications of sexual disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) due to the ongoing debate about their existence, sexual addictions and compulsivities are increasingly being encountered by mental health professionals, and the field of sexual addictions is gaining wider acceptance (Delmonico & Carnes, 1999; Garos, 1997).

Research into the field of sexual addictions is also growing as organizations such as the Society for the Advancement of Sexual Health (SASH) and *Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention*, now in its tenth year of publication, gain recognition and popularity (Delmonico & Carnes, 1999). This professional and academic growth is helping clinicians and policy makers respond to the estimated 3 to 6 % of the U.S. adult population (Wildmon-White & Young, 2002; Carnes, 1991), or approximately 6,534,000 to 13,068,000 adults (U.S. Census Bureau, 2005) that are struggling with a sexual addiction of some kind. If these estimates are accurate, it is possible there are more Americans adults dealing with a sexual addiction than have been formally diagnosed with diabetes or are living with HIV (Centers for Disease Control and Prevention, 2005).

The rapid growth of Internet usage has been identified as the primary reason for the exponential increase in sexual addictions and compulsivities (Schneider, 2000a; Schneider, 2000b; Cooper & Griffin-Shelley, 2002). Regarding the influence of the Internet on sexuality generally, Cooper, Boies, Maheu and Greenfield (1999) poignantly contend,

> Since its inception, the Internet has been associated with sexuality in a kind of synergistic dance, each fueling the transformation of the other. The influence of the Internet on sexuality is likely to be so significant that it will ultimately be recognized as the cause of the next "sexual revolution" (p 519).

Many agree this influential interplay between the Internet and sexuality, as well as the exponential increase in sexual addictions and compulsivities, has been fueled to a large extent by what Cooper (1998) coined as the Internet's "Triple-A Engine" effect of accessibility, affordability and perceived anonymity (Cooper, Delmonico, & Burg, 2000; McCarthy, 2002; Schneider, 2000a; Schneider, 2000b). Additionally, Delmonico, Griffin and Moriarty refer to the "Cyberhex of the Internet" which includes *intoxicating, isolating, integral, inexpensive, imposing and interactive* as characteristics that make the Internet a unique and powerful medium (Delmonico, Griffin & Moriarty, 2001).

According to current Internet traffic statistics for North America, there are over 221 million Internet users in North America and there has been a 104.9 % increase in Internet usage since 2000, with Internet accessibility now penetrating 67.4 % of the North American population (Internet World Stats: Usage and Population Statistics, 2005).

In terms of who is using the Internet, the 10th World Wide Web User Survey, conducted by the Georgia Institute of Technology's Graphic, Visualization, and Usability

(GVU) Center provides an insightful composite (Kehoe et al., 1999). The GVU survey was conducted between October and December 1998 with a total of 5,022 respondents. Generally speaking, the GVU data helps us understand that the most common profile of an Internet user is that of an American, college-educated, Caucasian, married male of 37.6 years of age who accesses the Internet daily from home and work.

In light of this profile and the fact that a seemingly infinite array of subjects may be searched via the ever-expanding World Wide Web (www), it is significant that 'sex' is the most frequently searched topic on the Internet (Engel, 2001). According to Nielsen//NetRatings (2005), in the United States alone, 34,376,000 unique users accessed adult entertainment websites during the *month* of April 2005. According to Stack, Wasserman and Kern's study (2004), men are also 6.43 times more likely to use Internet pornography than females (N = 531), and experience a 12 % increase in Internet pornography use for every one-unit increase in PC knowledge.

In 1997, approximately one out of every six Internet searches related to sex (Spink et al, 2002). By 2001, e-commerce had affected this sexual monopoly and commerce, travel, employment and economic subjects dominated Internet searches (Spink et al, 2002). While this shift may appear encouraging, a recent Wordtracker report of unfiltered search terms during May and June 2005 found that 10 of the top 20 search terms were directly associated with pornography, with 'sex' and 'porn' taking the top two positions respectively (Mindel, 2005). Additionally, three other search terms in the Wordtracker report referenced female celebrities associated with sexually explicit material (Mindel, 2005).

Spink and Ozmutlu also found that ‘sex’, ‘nude’, and ‘naked’ were high frequency terms used on the *Ask Jeeves* Web search engine (Spink & Ozmutlu, 2002). Analyzing sexually-related queries more in-depth, Spink and Ozmutlu concluded sexually-related queries tend to be longer in duration, contain more queries per session and typically involve opening more web pages than non-sexual searches (Spink & Ozmutlu, 2002). Although research looking at which terms are used most frequently is clearly affected by which search engine is being monitored, it is fair to say that sex is a consistent theme in the virtual domain.

The most popular search topics are further put into perspective when one considers there are approximately 172 million Americans online, representing more than half of the U.S. population, and that 20 to 33 % of those online use the Internet for sexual purposes (Cooper, 2004). The pornography industry has also become increasingly mainstream, with several Internet pornography companies now listed on the NASDAQ stock exchange (Morais, 1999).

It has been suggested that the expanding Internet serves many adaptive and healthy purposes in the area of human sexuality. For example, the Internet enables marginalized or disenfranchised groups such as the disabled, rape survivors, and gay or lesbian communities to share information with each other on topics of mutual interest (Cooper, Boies, Maheu, & Greenfield, 1999). Newman (1997) heralded the educational potential of the Internet as something that would spark greater understanding and more candid discussions about sex because information about safe sexual practices, sexual dysfunctions, reproduction, contraception, and sexually transmitted diseases would be more accessible. The Internet is also becoming an increasingly popular avenue to find

romantic partners (Cooper, Boies, Maheu, & Greenfield, 1999) for traditional and non-traditional relationships (i.e., courtship versus casual sexual partners). In addition, the Internet provides a relatively safe avenue for people to experiment with risky behaviors that, if enacted in real life, may put them at risk for disease or criminal consequences (Cooper, Boies, Maheu & Greenfield, 1999; Delmonico & Carnes, 1999).

While the Internet is having many positive affects on human sexuality, others argue this modern phenomenon is fostering serious consequences and risks. Cooper, Delmonico and Burg (2000) for example, suggest that on-line sexual pursuits are "… a hidden public health hazard exploding, in part because very few are recognizing it as such or taking it seriously" (p. 25). In the research conducted by Young (1996, 1997) and Cooper, Scherer et al. (1999), clear warnings are given regarding the dangers of excessive Internet use for sexual gratification due to the correlations between the amounts of time spent on-line and negative consequences such as poor academic and workplace performance, and sexual compulsivity and distress. Although there is research to support the fact that the majority of people who pursue sexual pursuits on-line do not experience life difficulties (Cooper, Delmonico, & Burg, 2000), Delmonico & Carnes (1999) argue that "despite this fact…there is a significant minority that deems our research and clinical attention" (p. 459).

Research shows that the majority of people struggling with sexual addictions and compulsivities involving the Internet are married, heterosexual males (Cooper, Delmonico, & Burg, 2000). Women who are married to these men are directly impacted by this problem (Schneider, 2000b). Marriages in which a sexual addiction or sexual compulsivities exist are commonly pervaded with diminished intimacy and sensitivity,

anxiety, secrecy, isolation, relationship dysfunction, and decreased temporal security due to the risk of job loss or related debts (Carnes, 1992; Schneider, 2000a; Wildmon-White & Young, 2002). Clearly, the impact of sexual addictions and compulsivities is not limited to the consumer.

Although there is research on many issues relating to wives of sex addicts, the database searches conducted for this literature review (PsycINFO WebSPIRS, PsycINFO EBSCO, Family & Society Studies Worldwide BioLine, and Social Work Abstracts WebSPIRS) revealed no research findings that address the kinds of support women find most beneficial when dealing with a spouse's sexual addiction or sexually compulsive behaviors. The research that is available, however, provides insight into: (a) the effects of Internet pornography and cybersex addictions on wives and families (Schneider, 2000a; Schneider, 2000b); (b) the profiles of women married to sex addicts (Wildmon-White, 2002; Wildmon-White & Young, 2002); (c) the common recovery issues and phases these women encounter (Milrad, 1999); and (d) the effects of couple therapy when combined with individual 12-step meetings designed for sex addicts and family members (Milrad, 1999; Schneider & Schneider, 1996).

Recent studies (Corley, Schneider, & Irons, 1998; McCarthy, 2002; Wildmon-White, 2002; Wildmon-White & Young, 2002) refer to the lack of empirical research that has focused exclusively on the wives of sexually addicted and compulsive men, and have encouraged a breadth of studies of this kind. In light of the fact that one of the most important determinants of successful recovery from sexual addiction is for the wife to receive treatment as well (Carnes, 1991; Schneider, 1991), researching how this

population may best be supported is not only beneficial for augmenting the wife's well-being, but also the sex addict's treatment course and prognosis.

Purpose of the Study

The primary purpose of this qualitative study was to identify the kinds of support women find most beneficial when dealing with a spouse's sexually addictive and compulsive behaviors. It is important to clarify that the word 'support' was used broadly to refer to any structured form of help (i.e., therapy, support groups, or medical attention) or any unstructured form of help (i.e., talking to a friend, or reading a self-help book). The term 'support' also referred to helpful analogies, beliefs, concepts, narratives or metaphors that heightened one's resiliency or expanded one's perspective in relation to a problem.

Using grounded theory methodology (Strauss & Corbin, 1990), the experiences of women who have sought support to cope with a spouse's sexually addictive and compulsive behaviors were studied in order to understand what is helpful to this population from *their* points of view. An analysis of the participants' responses to open-ended interview questions was conducted to achieve this purpose. A theory of support for this population emerged from the data.

The secondary purpose of this study was for the women's experiences to inform clinical work with this population. By clarifying a new theory of support for this population, this study contributes to targeting evidenced-based practices in this area of mental health practice by narrowing the scope of supports needing empirical investigation.

Thirdly, as a marriage and family therapist who has encountered numerous women coming forward to seek help with this problem in diverse settings (private practice, public schools, community and university agencies, and hospitals), my hope is that the findings of this study will assist mental health professionals in understanding what is helpful by honoring the voices and experiences of 'experts' living with or alongside this problem. Indeed, I align myself with Winnie Tomm's (1995) perspective in *Bodied Mindfulness: Women's Spirits, Bodies and Places:*

> …each story has its own specific details, but individual experiences become part of a larger picture of reality. The cumulative effect is to see that the combination of different stories form an evidential basis for knowledge claims about reality. There is truth value to this kind of knowledge that might be considered stronger than mere theorizing without such grounding. A greater reality is given to an experience when it is told to, and accepted by others… (p. 9).

Research Questions and Hypotheses

The undergirding research questions for this qualitative study were: (a) Which supports do women find most beneficial when dealing with a spouse's sexual addiction or compulsivities? (b) How can women's experiences and preferences with support inform therapeutic approaches with individuals and couples who are affected by sexual addictions and compulsivities?

It was hypothesized that women of varying levels of adaptability and well-being would seek out and prefer different supports. This hypothesis was generated from the researcher's conceptual understanding of differentiation (Bowen, 1978), as well as clinical observations. Due to the potential variability in functioning and support-seeking,

a self-report measure (see Appendix A), along with a demographics form (see Appendix B), was included as part of the interview process (see Appendix C). The implementation of a measure and a demographics form were intended to gain a richer understanding and description of the women seeking supports, as well as aid in the development of a theory. For example, it was hypothesized that 'high' and 'low' scores on the measure would correspond to different paths of support, which in turn, could inform clinical decision making with this population in the future.

The research questions and hypotheses were starting points only. Due to the nature of qualitative research, it was understood that the questions might change as the research proceeded and categories emerged from analyses of the early interviews. To get the study underway, however, the questions and hypotheses provided a workable scope of study (Strauss & Corbin, 1990).

Definitions

Defining and clarifying the construct of 'sexual addiction' has provoked intense debate and controversy in diverse fields. Carnes (1983, 1991) proposed that individuals could become addicted to the "mood altering and anxiety abating effects of sex, just as substance abusers become addicted to drugs or alcohol" (Garos, 1997). Researchers who have examined neuroscience findings support this claim (Reisman, 2004; Satinover, 2004).

For the purposes of this study, the criteria outlined by Schneider and Irons (1997) in the *Manual of Therapeutics for Addictions* were used to understand the term 'sexual addiction'. Schneider is currently regarded as a leading expert in the field of sexual

addictions and specializes in addiction medicine. The criteria Schneider and Irons (1997) outline are:

1. DSM-IV criteria met for one of the following: paraphilia, sexual disorder not otherwise specified (NOS), or impulse-control-disorder NOS.
2. Addictive features present as indicated by (a) loss of control over a sexual behavior, (b) continued sexual behavior despite significant adverse consequences, *and* (c) obsession or preoccupation with the fantasies, urges, or behavior.
3. Has reached the established phase of addictive behavior for a period of at least six months.
4. The focus of attachment is usually on relationships wherein the partners are viewed as narcissistic projection – objects to be used for self-aggrandizement and self-gratification and then discarded when they are no longer needed. The goal of entering a relationship is to have sex or romance rather than sex or romance being part of a relationship. The patient may identify with the term "love" or "relationship" addict. Types of nonparaphilic compulsive behaviors include compulsive cruising and multiple partners, compulsive fixation on an unattainable person, compulsive masturbation, compulsive multiple love relationships, and compulsive sexuality within a relationship (pp. 226-227).

Schneider's earlier work was also referred to in order to define sexual compulsivity. According to Schneider (1994), sexual compulsivity is the loss of the ability to choose freely whether to stop or continue a sexual behavior. Sexual behaviors

can include, but are not limited to: autoerotic asphyxiation, cybersex, exhibitionism, fantasy, frotteurism, fetishes, masturbation, pedophilia, phone sex, pornography, sex within a relationship, sex with multiple partners, sex with prostitutes, sexual role play, sexual violence, and voyeurism.

It should be noted that sexual compulsivities can be one aspect of a sexual addiction, as well as behavior that precedes a full-blown sexual addiction. In other words, someone struggling with sexual compulsivities does not necessarily have a sexual addiction, but a sexual addict would almost always suffer from sexual compulsivities. It is not required for sexual compulsivities to be determined within a specific timeline, such as six months as is the criterion for sexual addictions.

CHAPTER II: REVIEW OF RELEVANT LITERATURE

Having only emerged as a field of study within the last twenty years, the voids in sexual addiction literature are understandable and like all areas of research, it will take time for researchers to recognize who and what needs attention. The present voids in the sexual addiction literature also highlight the need for this study, especially when one considers the context of the problem previously described and the following research findings.

Spousal Effects of Sexual Addiction and Compulsivities

Sexual addictions and compulsivities directly impact spouses in diverse ways (Schneider, 2000a; Schneider, 2000b; Wildmon-White, 2002). In two studies on the effects of sexual addictions and compulsivities on the family, it was found that sexual addictions and compulsivities are a predictor of decreased marital satisfaction and martial intimacy and are a major contributing factor to separation and divorce of the couples surveyed (Schneider, 2000a; Schneider, 2000b).

Emotionally speaking, women in such marriages commonly report feeling "hurt, betrayal, rejection, abandonment, devastation, loneliness, shame, isolation, humiliation, jealousy,…anger…loss of self-esteem" (Schneider, 2000b, p. 252), and in some cases suicidal (Schneider, 2000a). The heightened sense of insecurity both emotionally and temporally (due to the risk of job loss or related debts) also increases the levels of anxiety experienced by this population. These women report that a major source of distress are the lies told to them repeatedly by their partners, and that they "overwhelmingly felt that online affairs were as emotionally painful to them as live or offline affairs" (Schneider, 2000b, p. 252). Wives of sex addicts also report comparing themselves unfavorably to

the women featured in pornographic images or the sex service industry, and that they feel hopeless about being able to measure up to or compete with such women for their partner's attention (Schneider, 2000b). Many even blame themselves for their husband's problem and believe they have the power to stop it (Wildmon-White & Young, 2002). This erroneous self-attribution drives many wives to become hypervigilant of their husbands' actions and to engage in "detective behaviors" (Milrad, 1999).

In terms of sexual relations, Schneider's (2000a) study revealed that 68% of couples directly impacted by 'cybersex', or online sexual activity, had lost interest in relational sex and many had had no relational sex in months or years. These findings are congruent with other research that reveals these women often feel sexually inadequate, question their own sexual attractiveness, and are prone to experiencing chronic anxiety and depression (Schneider, 2000c; Wildmon-White & Young, 2002); symptoms that can impact sexual functioning in and of themselves.

With regard to social effects, women in these marriages tend to experience loneliness and isolation because they are vulnerable to getting entangled in secret keeping (Matheny, 1998). As well, they fear they will not be understood if they do speak out, or fear the potential risks, ridicule and consequences of sharing information (Wildmon-White & Young, 2002). The shame, shock, disgust and embarrassment many women describe also affect the manner in which they reach out or withdraw from support.

Many women experience physiological effects such as fatigue, changes in appetite and libido, and other signs and symptoms of depression. Laaser (1996) points out that wives of sexually addicted or compulsive men have often been coerced

physically by being forced or pressured into sexual practices they experienced as abusive such as sex with multiple partners or sadistic practices (Wildmon-White & Young, 2002).

In light of the relational, emotional, sexual, social and physical effects, it can be inferred that women married to men with sexually addictive or compulsive behaviors need various forms of support, including therapeutic and medical care.

Characteristics of Women Married to Sex Addicts

Because there has been relatively little research that has focused exclusively on the wives of sex addicts, much of the information regarding characteristics of this population is clinically supported rather than being empirically supported. Experts in the field of sexual addictions have observed some of the following characteristics in these women:

> (1) …loss of a sense of self (Matheny, 1998), (2) preoccupation with the addict (Schneider, 1988, 2000 [c]), (3) depression (Schneider, 1988), (4) low self-esteem and attempts to control the sexual addict (Schneider, 1988, 2000 [c]; Weiss & DeBusk, 1993), (5) relationship dependency (Schaef, 1989; Schneider, 1989, 2000), (6) a history of sexual abuse and neglect in their families-of-origin (Carnes, 1991; Kasl, 1989), and (7) unmet emotional needs in their family-of-origin, emotional turmoil, and feelings of hyper-responsibility (Carnes, 1991) (Wildmon-White & Young, 2002, p. 264).

Others have found that wives of sexually compulsive men often come from families in which addictions to alcohol, drugs, food and work were present (Crawford, Hueppelsheuser & George, 1996; Schneider & Schneider, 1996; Wildmon-White & Young, 2002). As a result of these family-of-origin addictions, these women often have

difficulty setting healthy boundaries. This pattern is frequently compounded by histories of sexual, physical or emotional abuse these women commonly bring to their marriages (Crawford et al., 1996; Wildmon-White & Young, 2002). In combination with one another, these characteristics are thought to a play role in both the formation and maintenance of the marital relationship between the wife and the sex addict (Wildmon-White & Young, 2002).

Several researchers and clinicians have postulated that women involved in marriages where a sexual addiction is occurring share characteristics with women in chemically dependent relationships (Schwartz & Brasted, 1985; Schneider & Schneider, 1996). Extensive research has been conducted with wives of chemically dependent men. Family-of-origin characteristics for this group include:

> (1) Feelings of rejection and abandonment (Kitchens, 1991; Woititz, 1983); (2) a lack of acceptance and rigid, inflexible, nonadaptive family environments (Kitchens, 1991); and (3) being raised in an emotionally deprived and repressed home (Wegscheider-Cruse, 1985; Woititz, 1983) (Wildmon-White & Young, 2002).

Wildmon-White's (2002) doctoral research examined the relationship between relational attachment, learned helplessness, and the construct of sexual addiction among conservative Christian women who were married to men involved in a range of sexually compulsive behaviors. Wildmon-White (2002) was the first to provide empirical evidence that characteristics such as fear of abandonment, relational dependency and learned helplessness that are commonly found in wives of chemically dependent husbands were similar to those of wives of sexually addicted husbands. This was done

by demonstrating a systematic relationship between scores on the *Sexual Addiction Screening Questionnaire – Spousal* (SASQ-S) and the instrument's two subscales, 'Depend' and 'Helplessness'. A total of 69 women who were over the age of 18 participated in this study. The participants were recruited through a nationally broadcast Christian radio station and Esther Ministries, a non-profit Christian organization that specializes in supporting wives of sex addicts. Women who scored low on the 'Depend' subscale, which measures one's sense of being able to depend on others when they are needed, reported higher levels of sexually addictive behaviors in their husbands. Women who scored high on the 'Helplessness' subscale, which measures one's feeling of being unable to control circumstances in important relationships and life, also reported more sexually addictive behaviors in their husbands. Wildmon-White (2002) therefore concluded that wives of sexually addicted men tend to exhibit unhealthy dependence on others, feel helpless to change their circumstances, and share many key characteristics with women in chemically dependent relationships.

In terms of cognitive characteristics, Schneider (2000c) found that wives of sexually compulsive men commonly hold four core dysfunctional beliefs that may unwittingly enable or exacerbate the problematic sexual behaviors of their husbands. These four beliefs are: (a) I am not a worthwhile person; (b) no one would love me for myself, (c) I can control other people's behavior, and (d) sex is the most important sign of love.

Women as 'Customers for Change'

A valid critique of this doctoral study reported here is the fact that husbands were not included. Some may further contend that researching individual women's

perspectives is not congruent with Marriage and Family Therapy research. From a systemic point of view, however, I subscribe to the axiom of the system theory, or concept of interconnectedness, which suggest that a change in any one part of a system will affect all other parts of the system (Nichols & Schwartz, 1998, pp.127-128). In the field of sexual addictions, this assumption is supported by psychologists and physicians who encourage women to receive individual treatment (Carnes, 1991; Schneider, 1991) in order to increase the health of the individuals and marital relationship affected by the sexual addictive or compulsive behaviors.

Furthermore, women are considered an appropriate focus of this study because they are often the most motivated for change when their husbands' sexually addictive or compulsive behaviors are disclosed or discovered. Working with the person most motivated for change within a family system is often the only respectful therapeutic option available.

Although the term 'customer for change' was first introduced by Steve de Shazer in 1988, both the Mental Research Institute (MRI) and Solution-Focused models of therapy emphasize the importance of clarifying who the 'customer for change' is within a family or client system (Nichols & Schwartz, 1998, p. 366). A 'customer for change' is defined as the person most motivated for things to change and is often not the person with the problem (Nichols & Schwartz, 1998, p.366).

The argument that women are often 'customers for change' is supported by recent research findings. Doss, Atkins and Christensen (2003) found the largest differences in the process of seeking marital therapy were gender differences. Out of 147 couples,

wives were the first to recognize the problem, consider treatment and seek treatment in 67% to 73% of the time according to the husbands and wives respectively.

Furthermore, earlier research suggests wives play a critical role in their husbands seeking therapy. Horwitz (1997) concluded that when husbands did seek individual therapy, their wives were only the persons they spoke to regarding the problem, and their wives more readily identified the problem. Saunders (1996) further concluded that at every stage of seeking professional help, husbands were more likely than wives to report receiving help from their spouse. In short, when there is a marital problem, wives initiate therapy and help motivate their husbands to seek help as well.

Women's General Preferences for Support

Research on coping and support seeking styles reveals significant and consistent gender differences. For example, according to Kunkel and Burleson (1999), when compared to men,

> women are more willing and likely to provide emotional support to others (e.g., Trobst, Collins, & Embree, 1994), to seek support (e.g., Ashton & Fuehrer, 1993), to produce feeling-centered and emotion-focused supportive messages (e.g., Barbee, Gulley, & Cunningham, 1990), to produce qualitatively more sensitive comforting messages (e.g., Burleson, 1982), and to value comforting skill as more important for the maintenance of interpersonal friendships (e.g., Burleson, Kunkel, Samter, & Werking, 1996). (pp. 307-308).

Generally speaking, women prefer distress-reducing strategies and utilize social supports, while men tend to prefer active behavioral methods including high-risk coping behaviors such as substance use (Rao, Moudad & Subbakrishna, 2000).

According to Barbee, Gulley and Cunningham (1990), both men and women prefer talking to their same-sex rather than opposite sex friends about relationship and task problems. The same researchers also found that when women turned to female friends for support, they expected their friends to use more problem-solving and support behaviors in response to relationship problems, and for their male friends to use more dismiss and escape behaviors in response to problems. In a similar study, Vingerhoets and Van Heck (1990) found men tend to use problem-focused coping, talk problems down and look on the bright side, while women tend to prefer emotion-focused coping, expressing their emotions, seeking social support, and self blame.

In a recent study on women's mental health that was conducted in a gynecological clinic, 59% of the women who reported being psychologically distressed expressed interest in talking with a trained professional, and reported they would prefer individual therapy over group therapy (Glover, Novakovic & Hunter, 2003). Twenty-nine percent of the women in the study, however, said they felt adequately supported by their friends and family (Glover, Novakovic & Hunter, 2003).

An earlier study that was also set in a gynecology clinic found the "vast majority" of women were interested in receiving some form of professional mental health support and that individual therapy and psychoeducational classes were the top choices (Alvidrez & Azocar, 1999). Alvidrez and Azocar (1999) found women were less interested in supports that involved group therapy and medication.

Summary

The majority of people struggling with sexual addictions and compulsivities involving the Internet are married, heterosexual males and the women who are married to

these men are directly impacted by this problem. Although there is research on many issues relating to wives of sex addicts, there is a lack of research findings that address the kinds of support women find most beneficial when dealing with a spouse's sexual addiction or sexually compulsive behaviors. Based upon the research that is available, however, it is reasonable to conclude that women married to men with a sexual addiction may benefit from a range of supports in light of the relational, emotional, social, and physical symptoms and characteristics they commonly present with. What these supports are and how they would work in tandem or exclusively could previously only be hypothesized. Because women tend to initiate therapy and seek help before their husbands, understanding how these women prefer to be supported could provide clinicians with valuable information for helping create a context for change for the entire family system, as well as the individual woman. In light of research that has looked at women's general preferences for support, it could be postulated that individual therapy, female friendships and emotionally focused outlets may be supports this population would benefit from and prefer.

CHAPTER III: RESEARCH METHOD, DATA COLLECTION AND ANALYSIS

The Qualitative Research Paradigm

Qualitative research originated in the fields of sociology, anthropology and phenomenology (Denzin & Lincoln, 1994; Strauss & Corbin, 1990). Today, qualitative methods are commonplace in diverse fields of study. In fact, qualitative research is recommended in any field where the research objective is to reveal the nature of peoples' experiences, understand an area in which little is known, or bring forth fresh perspectives in well-known areas of study (Strauss & Corbin, 1990).

According to Merriam (1988), there are six methodological assumptions that provide the foundation for qualitative research. These assumptions are: (a) there is an emphasis on process versus outcome, (b) data collection aims to capture the meanings people attach to their experiences, (c) the researcher is the primary instrument of data collection and analysis, (d) participants are studied in their natural setting, (e) descriptive data such as words or pictures has is emphasized over numerical data, and (f) theories, concepts and hypotheses are generated inductively from the participants experiences and are not established a priori (Cobb, 2001).

Grounded Theory Design

Two sociologists originally developed grounded theory methodology: Barney Glaser and Anselm Strauss (Strauss & Corbin, 1990, p.24; Glaser & Strauss, 1967). Together, they co-created a research approach that emphasizes, (a) the need to get out into the field, (b) the importance of grounding theory in reality, (c) the nature of experience as continually evolving, (d) the active role people play in shaping the worlds they live in, (e) the complexity of life, and (f) the interrelationships between conditions,

meaning, and action (Strauss & Corbin, 1990, pp. 24-25). This methodology is used to help theory emerge from data that are collected (Glaser & Strauss, 1967).

In a grounded theory approach, the researcher starts with as few predetermined ideas as possible, in order to remain open to what emerges in the data (Glaser, 1978). The overarching goal is to build theory that is "faithful to and illuminates the area under study" (Strauss & Corbin, 1990, p. 24) rather than impose theory and test it.

As mentioned earlier, it was expected the research questions and hypotheses would change throughout the course of the study. This evolving process was viewed as being consistent with an emerging design (Creswell, 1994). For example, as new information emerges, the researcher must weigh how this data changes, negates or supports the evolving theory and categories. An emerging design also means that as new information comes to light, participants may need to be contacted again in order to inquire about data not addressed or explored during the initial interview. Participants were made aware of this possibility. Because this research approach emphasizes the expertise of the participants and is conducted from a stance of curiosity, it was considered an appropriate fit for both the nature of the research questions, as well as the researcher's worldview.

Participants & Data Collection

Because a diverse group of women were wanted for this study, several approaches were implemented to recruit participants as well as collect the data once participants were recruited. Women who had had experiences with various supports were especially viewed as assets to this research, in order to learn about the impact, preferences and benefit of different kinds of support. A diverse sample was recruited through means of

professional contacts working in mental health fields in Minnesota, Utah, and Alberta, Canada. A combination of letter writing, phone calls, word of mouth, and contacts made at professional conferences were employed to reach social workers, marriage and family therapists, psychologists, and psychiatrists who either worked with sexual addictions or who would be interested in making contact with women who met the study's criteria from their current caseloads. In two cases, participants who were already recruited made contact with female friends who struggled with this problem and invited them to be involved by giving the researcher permission to make contact with them directly.

Elizabeth Griffin, an author and therapist who specializes in treating sexual addictions, was the primary liaison for all the participants from Minnesota. She was introduced to the researcher at the 2004 S.A.S.H. conference in Washington, D.C. and at that time, expressed interest in helping with this study.

Because the researcher had lived and worked in Alberta for over fifteen years, there were many professional contacts in Calgary and Edmonton, Alberta that were available in order to make connection with a Canadian sample. A social worker in Edmonton was especially helpful in this regard.

With Brigham Young University being the home base for the study, many colleagues in Utah were aware of the study before recruitment began. Clinical directors and therapists at L.D.S. Family Services, The Gathering Place, The Provo Counseling Center, Brigham Young University and private practices in Utah were especially helpful in connecting with a diverse Utah sample.

The recruitment process started by the researcher making contact with mental health professionals and explaining to them the criteria for participation in the study and

the purpose of the study. If a professional believed he or she had women in their respective case loads that would fit the criteria, he or she was sent a copy of the sign-up card (see Appendix D) that could be given to potential participants. The sign-up card was then filled out by the potential participant and returned to the researcher via the postal service so the researcher could contact her by phone or email. In some cases, potential participants gave permission for their name, email address and/or phone number to be released directly by their therapist to the researcher for contact. The sign-up card also gave women the option of contacting the researcher directly and several participants did this.

Providing non-descript, individual sign-up cards versus a sign-up sheet, was intended to assist in maintaining the confidentiality of participants. As well, giving the option of having participants contact the researcher directly was also intended to protect confidentiality and respect different comfort levels around privacy.

Once participants had been identified and contacted, they were asked if they would meet with the researcher in person for approximately one hour and fifteen minutes in order to complete the consent form (see Appendix E), fill out one psychometric measure (see Appendix A), one demographics form (see Appendix B), and participate in a forty-five minute interview.

Upon meeting for the paper work and interview, the researcher described the research process again; reviewed confidentiality and the handling of the audio cassettes used to record the interview, and reviewed the paper work with the participant to ensure everything was understood. The participants were then left alone for approximately twenty minutes to fill out the paper work privately and without interruption. After twenty

minutes, the researcher returned to the interview room and reviewed the paperwork to ensure all forms had been filled out completely as well as address any further questions that had arose while filling out the forms.

Information regarding participants' age, occupation, education, religiosity, marital and family status, previous therapy, and socioeconomic status were collected. To protect confidentiality, first or last names were not required on the forms except for the informed consent form. An identifying number was listed on the top right hand corner to assist in the pairing of forms and interview transcripts.

Women were excluded from the study if they were under the age of 25, single, suicidal, currently abusing substances, psychotic, and if problems related to problematic sexual behaviors were not their primary presenting problem in therapy. To clarify, all of the participants were either actively involved in therapy for this issue or had been in therapy recently due to this problem. Because the study benefited from diverse situations, no cut-off scores on the measures were used to exclude study participants. The professionals involved in recruitment were made aware of these criteria and assisted in selecting women who were an appropriate fit. Three participants, however, had to be excluded from the study after the fact, because it was not realized until afterward that they were either not formally married or not yet twenty-five years of age. Twenty-five women were interviewed in total, but in order to adhere to the approved research criteria, 3 women were later excluded from the study, thereby reducing the total number of participants to 22. Of the final 22 participants, 11 were interviewed in Utah, 6 were interviewed in Minnesota and 5 were interviewed in Alberta. All of the interviews were personally conducted by the researcher.

Table 1 and Table 2 summarize demographic data of the sample.

Table 1. Demographic Profiles: Continuous Variables

Variable	Range	Mean	S.D.
Age (in years)	25 to 56	35.40	9.28
Number of Children	0 to 8	2.86	2.55
Years Married	1 to 28	11.64	7.83
Years Aware of Addiction	0.33 to 28	7.07	6.94

Table 2. Demographic Profiles: Discrete (Categorical) Variables

Discrete Variable	Number of Women	% of Sample
Education Completed		
High School	6	27.27%
College Diploma	5	22.73%
University Degree	10	45.45%
Graduate School	1	4.55%
Current Occupation (4 women cited two professions, i.e., Homemaker/Teacher, making the total percentage 122.79% versus 100%)		
Business	2	9.10%
Childcare	1	4.55%
Computers	1	4.55%
Event Director	1	4.55%
Genealogist	1	4.55%
Homemaker	12	54.55%
Nurse	1	4.55%
Piano Teacher	1	4.55%
Self-Employed	1	4.55%
Student	2	9.10%
Teacher	3	13.64%
Writer	1	4.55%

Annual Income Bracket		
Under $21,000	3	13.64%
$21,000 to 40,000	6	27.27%
$41,000 to 60,000	6	27.27%
Over $60,000	7	31.82%
Religious Affiliation		
Alliance	1	4.55%
Baptist	1	4.55%
Evangelical	3	13.64%
Pentecostal	1	4.55%
United	1	4.55%
LDS (Mormon)	15	68.16%
Current Marital Status		
First Marriage	15	68.18%
Second Marriage	4	18.18%
Divorced & Single	2	9.09%
Twice Divorced & Single	1	4.55%
Manner of Sexual Addiction Disclosure		
Disclosed	14	63.64%
Discovered	8	36.36%

Once the paper work was completed, each participant was given a copy of *Discussing Pornography with a Spouse* (Reid & Gray, 2002) as a form of compensation for their time. Due to the increasing demand for resources and information about problematic sexual behaviors in marriages, the participants welcomed the opportunity to have a current resource in exchange for their involvement in the study. The books were given out during this phase of the meeting so that if for any reason the participant wished to terminate the interview or leave early, they could do so freely while still being

compensated for their time; this did not happen. Once the paper work was completed and the book given out, the tape recorder was turned on, and the interview began.

In addition to the Consent Form (see Appendix E) and the Demographics Form (see Appendix B), a self-report measure was used in this study. Participants were asked to fill out the *Differentiation of Self Inventory – Revised* (DSI-R) (see Appendix A). As mentioned earlier, this measure was used to create a richer description of the women interviewed. Commonalities that arose from this measure were used to assist in the formation of a theory of support for this population.

It was hypothesized that women who scored lower on the DSI-R would prefer different modes of support than women who scored higher. If DSI-R scores can help determine differences within this population, then it anticipated the DSI-R could be used in clinical practice to direct or prioritize the delivery of services (i.e., support group before couple therapy). Because the DSI-R is regarded by the researcher as an indication of many key aspects of one's functioning and adaptability related to intimacy and relationships, it was viewed as a helpful descriptor and potential clinical tool.

Results from the DSI-R were compiled into an excel file along with other data collected in the Demographics Form. These two files were then imported into the analysis software in order to help in determining relationships and connections with the data. The tables also served as a concise summary and description of the population that was interviewed. Because the DSI-R has four subscales, each woman received five scores: four subscales and one total score.

Bowenian theory consists of several constructs. Differentiation of self, however, is considered the hallmark of Family Systems Theory and was considered by Murray

Bowen to be the most critical variable to mature development and psychological health (Titelman, 1998; Skowron & Friedlander, 1998). It is this construct that is measured by the Differentiation of Self Index – Revised (DSI-R) and selected as an important variable to examine among spouses of men struggling with problematic sexual behavior due to the intense emotionality and boundary issues that problematic sexual behavior almost always raise.

Differentiation of self, in simplistic terms, may be defined as the degree to which one is able to balance (a) emotional and intellectual functioning and (b) intimacy and autonomy in relationships (Skowron & Friedlander, 1998; Bowen, 1978). Bowen was clear to point out that differentiation is a *process* by which individuality and togetherness are managed by individuals within a relationship system and over the developmental lifespan (Kerr & Bowen, 1998). One's basic level of differentiation was viewed as being determined to a large extent by the process and degree to which an individual was able to define a 'self' within his or her family of origin.

Murray Bowen created a theoretical scale of differentiation that could be broken into four ranges of functioning: 0 to 25, 25 to 50, 50 to 75, and 75 to 100. The 85 to 95 range considered was rare and the upper 95 to 100 range was a hypothetical ideal (Kerr & Bowen, 1998). Bowen intended for the scale to be a general guideline and a theoretical way to interpret functioning. Although Bowen outlined basic characteristics of the functioning in each subcategory, he was vague in how clinicians were to score clients in a systematic way; which, in light of his 'anti-technique' stance seems congruent (Titelman, 1998). This lack of reliable quantifiable methods and lack of structure for technique

oriented clinicians may explain, in part, why the construct of differentiation of self has not had more widespread recognition and use both clinically and in research.

Measures

The *Differentiation of Self Inventory* (DSI) was first published in 1998 by Elizabeth A. Skowron and Myrna L. Friedlander. The original index consisted of forty-three items and contained four subscales that reflected the multidimensionality of differentiation: Emotional Cut-off, "I" Position, Emotional Reactivity, and Fusion with Others (Miller, Anderson & Kaulana Keala, 2004). Recently, a revised version of the DSI was published, with the only change being the addition of three questions (now forty-six in total) and the change in title (DSI-R) to denote the revisions. Two experts of Bowen theory reviewed the questions in the original index and concurred that the index reflected Bowen's conceptualization of differentiation (Miller, Anderson & Kaulana Keala, 2004) (see Appendix F). Six hundred and nine adults (age 25 +) participated in the testing of the original instrument (Skowron & Friedlander, 1998).

Construct validity was determined by comparing the DSI to other scales related to Bowen's theory of differentiation (i.e., Kear's 1978 Differentiation of Self Scale; McCollum's 1986 and 1991 Emotional Cutoff Scale; Hovestadt, Anderson, Piercy, Cochran, and Fine's 1985 Family-of-Origin Scale; and Bray, Williamson and Malone's 1984 Personal Authority in the Family System Questionnaire). Controlling for age and gender, the DSI correlated significantly with chronic anxiety ($r = .64$, $p < .0001$) and marital satisfaction ($R^2_{semipartial} = .24$, $p < .0001$, with higher DSI scores predicting greater marital satisfaction). Factor analysis demonstrated psychometric support for all four subscales (Miller, Anderson & Kaulana Keala, 2004). The factor loadings for the

respective subscales were as follows: Emotional Reactivity (.91, .80, and .83), I Position (.74, .92, and .70), Emotional Cutoff (.65, .82, and .75) and Fusion with Others (.70, .70, and .71).

Chronbach's alphas were computed for each of the subscales and the total index. High reliabilities were found for the entire index (0.88) and the four subscales: Emotional Cutoff (0.80); "I" Position (0.80); Emotional Reactivity (0.83); and Fusion with Others (0.82) (Skowron & Friedlander, 1998). Subsequent research found the DSI to be unaffected by current levels of environmental stress (Miller, Anderson & Kaulana Keala, 2004; Tuason & Friedlander, 2000).

Data Analysis and Interpretation

In qualitative research, data analysis is occurring simultaneously and recursively with data collection (Creswell, 1994; Rafuls & Moon, 1996). According to Marshall & Rossman (1989, p. 112), this process occurs in five phases: (a) organizing the data, (b) generating categories, themes and patterns, (c) testing the emerging hypotheses against the data, (d) searching for alternative explanations of the data, and (e) writing the final report (Cobb, 2001). In this study, this five-step process began with creating transcripts of the interviews using a standard transcription machine as soon after the interviews as possible. Jane Perry was the primary transcriber, and Jacob Nishida assisted with four transcripts. The transcribers were not given any identifying information regarding the participants; only the interview code was provided (e.g., UT #4) to ease organization of data and protect confidentiality. Participants had also been instructed to not use first names during the interview (i.e., of their husband), and, therefore, transcribers just knew which state or province the interview had been conducted in and the number of interview.

Upon completion, the transcripts were imported into the QSR NVivo 2.0 software program that is designed to handle in-depth coding and analysis of qualitative data. QSR NVivo 2.0 is an updated version of QSR NUD*IST 4.0 and N6 that were originally developed at LaTrobe University by Associate Professors Tom and Lyn Richards during the early 1980s and 1990s.

With the help of QSR NVivo 2.0 software for data organization and coding, grounded theory procedures and techniques were used to explore the significant concepts and relationships surrounding different types of support, as well as the perceived benefits and preferences connected to each type of support. More specifically, the procedures of open coding, axial coding and selective coding (Strauss & Corbin, 1990) were implemented to generate categories, and consolidate answers to the research questions.

Open Coding

Open coding was understood as "the process of breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss & Corbin, 1990). During this stage of data analysis broad, general categories were sought while carefully reading the transcripts and repeatedly asking "What is this? What does it represent?" as discrete happenings, events, and instances of phenomena arose (Strauss & Corbin, 1990). The NVivo program was used to organize the general categories as well as begin to identify the names of categories.

As part of the open coding phase, each transcript was carefully read and coded on three separate occasions, sometimes four, in order to ensure the codes were congruent with what the data contained, and appropriately labeled. A total of four people (Brian Meade, Jane Perry, Wendy L. Watson, and the researcher) participated in this phase of

the analysis, with each of the coders reading between three and twenty-two interviews and participating in discussions with the researcher to further tease out the relevant codes and labels. Coders were given instruction on (a) the nature of the study, (b) the focus on the analysis, and (c) the coding process.

The additional coders, were each given fresh copies of transcripts, to ensure that the researcher's coding did not influence the additional coders. In an effort to keep each coder's experience of the data unique and untainted, the coders were not given examples of the researcher's preliminary coding structure and descriptors.

The additional coders not only assisted in the analysis of data but also in the accuracy of the emerging theory (Rafuls & Moon, 1996). The introduction of additional coders is termed "investigator triangulation" (Guion, 2002) and this process gives credence to the analysis and diminishes the effect of researcher bias on the final results. The coders were viewed as collaborators in the coding process rather than simply confirming a method of organization.

After the additional analyses were complete, comparisons were made to ensure consistency in how the data was being coded and interpreted. As anticipated, the researcher and coders had many one-on-one discussions about the data and coding. Discussions with the additional coders were used to refine the analysis and the clarification of codes and expand the master list of codes. All of the codes were entered directly into the NVivo program by the researcher. The final list of codes generated during the open coding phase is included in Appendix G.

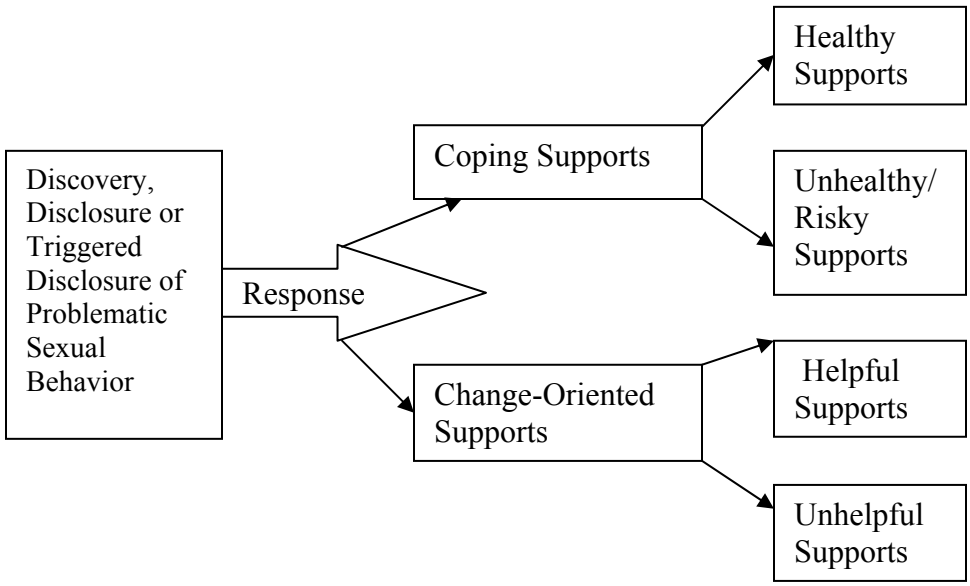
Axial Coding

While open coding fractures the data into workable categories, axial coding reintegrates the data by identifying the relationships and connections *between* categories and subcategories. During this phase, the researcher seeks to verify the emerging relationships as well as find exceptions to them. Axial coding also places emphasis on the conditions and context in which a phenomena is embedded; the strategies by which it is handled or managed; and the consequences of those strategies, thereby resulting in a more holistic, contextual view of the open coding fragments (Strauss & Corbin, 1990).

During the axial coding phase, the researcher looked for relationships between open codes and sought to develop broader, more comprehensive terminology to describe the data, as well as collapse redundant codes into more succinct ones. This process was done by reviewing the open codes and posing questions like, "How are these codes similar and different from one another?" "How are the codes related to one another, if at all?" "Are there codes which could be better described with another term?" For example, through axial coding, broader categories such as 'Professional Supports', 'Relational Supports', and 'Spiritual Supports' were created to describe multiple clusters of support used by participants. The 'Professional Supports' category was created once it was clarified how therapeutic and medical services were related to one another (they both involve paying for a specialized service that cannot be provided through other means), and 'Relational Supports' became an appropriate term once it was determined that turning to relationships was the common denominator in seeking support from friends, immediate family, extended family and/or one's spouse. A list of the axial codes is provided in Appendix H.

The axial phase of analysis also lent itself to examining process more than content. For example, in reviewing the open codes and eventually the axial codes, the researcher inquired about how, when and why participants selected various supports they did and looked to the larger patterns emerging from the data. Looking at process helped the researcher discover that some supports maintained individual, marital and/or familial systems but did not invite change (coping) while other supports were change-oriented (change-oriented supports). Axial coding also helped uncover that the presence of certain codes or DSI-R scores appeared to moderate the presence of others. This aspect of axial coding helped develop the context in which the supports were embedded. A diagram of the preliminary phase of this analysis is shown in Figure 1.

Figure 1. Axial Coding: Process Focused Flow Chart



The analysis of process and relationships between codes was further assisted by formulating a "paradigm model" (Strauss & Corbin, 1990), as seen in Figure 2. This paradigm model helped clarify the theory of support emerging from the data as well as

delineate how the central phenomenon was associated with: (a) other processes in the data, (b) the conditions that give rise to it (antecedents), (c) the context wherein it is embedded, (d) the action/interaction strategies by which it is handled, (e) the intervening conditions that facilitate or constrain the phenomenon, and (f) the consequences or outcomes of the phenomenon (Harrold, 2001).

Figure 2. Paradigm Model (Strauss & Corbin, 1990) used during axial coding

CAUSAL CONDITIONS → ***CENTRAL PHENOMENON*** →
(Events or incidents that lead to phenomenon)

CONTEXT → INTERVENING CONDITIONS →
(Specific set of properties pertaining to phenomenon) (Conditions that facilitate or constrain the phenomenon)

ACTION / INTERACTION STRATEGIES → CONSEQUENCES
(Processes for maintaining phenomenon over time)

The NVivo software also assisted in clarifying relationships between codes through the use of Boolean searches, a technique learned at an NVivo training seminar in Washington, D.C. Boolean searches allowed for the creation of matrixes that showed how often a particular code coincided with another, thereby directing the researcher examine possible relationships within the data that were not 'seen' through other means (see Appendix I for a simplified example; more complicated matrixes could not be incorporated into the document because many of the searches used for the analysis contained hundreds of variables that spanned multiple pages moving left to right, thereby

making it difficult to print off in a legible way). Boolean searches also furthered the researcher's understanding of the context in which certain codes would manifest themselves (i.e., low DSI-R scores and suicidality).

Selective Coding

The final phase of analysis was selective coding. During this phase the researcher began to clarify the overall story the data tells. In short, selective coding involves "making it all come together" by clarifying the core category while systematically relating it to the other categories (Strauss & Corbin, 1990).

Ultimately, a theory of support for women married to men struggling with sexually addictive or compulsive behaviors was inductively derived from the data. This theory was constructed gradually during the coding process and was continually tested against the data to ensure it was grounded in the data.

In order to substantiate the coding process, the principal researcher consulted with the additional coders to verify the validity and reliability of the coding procedures as well as the accuracy of the emerging theory (Rafuls & Moon, 1996). This aspect of the analysis is elaborated on more in the findings section of the dissertation.

Researcher Bias

Because qualitative research directly involves the researcher in data collection, it is important to acknowledge personal biases that are inherently a part of the research process. Acknowledging biases assists those in reading and interpreting the data, as well as those who attempt to replicate the study by clarifying the context wherein the data were collected, as well as the lens through which it was viewed and interpreted.

Personal Biases

I was born to Canadian parents in a British military hospital in Hanover Germany. Needless to say, my birth marked the beginning of an international upbringing, and this continued throughout my life. Although I claim Canada as my country of citizenship and permanent residence, Australia, Canada, France, Germany, Israel, and the United States have all been called home at some point during my thirty-two years of life.

While growing up I had the privilege of having close friends of diverse races and faiths: Bahá'í, Buddhist, Christian, Indigenous, Jewish, Muslim, and Sikh. In most places I lived, I was the minority either in nationality or religious affiliation. Having been raised in a Caucasian family with a mother and father who are members of The Church of Jesus Christ of Latter-day Saints (LDS or Mormon); many of my role models and influences came from within the LDS subculture.

I also acknowledge that being a single, never-married female in my early thirties also shapes how I see the world around me and hence my research. Interestingly enough, I don't think I would have been able to conduct this research had I been married. I say this because the degree of relational trauma in the participants' lives would have been more troubling to me if I had my own intimate relationship with which to identify and project onto their experiences. On the other hand, I may have asked different types of questions had I been married and been able to relate more to the participants.

Education

Having been raised in the military, I attended several different schools. From grade seven through twelve I attended a French immersion school in which all of my course work was taught in French except English and Physical Education. My ability to

speak French would later be put to use as a missionary for my church in the south western regions of France, near the border of Spain.

My interests in international law influenced my decision to complete a Bachelors of Art in Communication Studies with an emphasis in Public Relations, as well as a study abroad program in the Middle East (Egypt, Israel, Jordan). I later changed this career path and entered a Masters of Science program in Marriage and Family Therapy because my travels and experience had taught me that strengthening and supporting change within family systems was indeed related to international relations, if not more fundamental on the macro level.

During my initial graduate school experience I had the good fortune of completing an internship at the Family Therapy Program in the Faculty of Medicine at the University of Calgary. It was here that I studied under the well reputed tutelage of Drs. Karl Tomm, Gary Sanders and Alan Parry. These mentors, with backgrounds in psychiatry, theology, psychology and family therapy, turned out to be invaluable to the development of my worldview of change, families, systemic thinking and questioning, human sexuality, post-modernism, and therapy.

Theoretical Lens

Theoretically, I have been most influenced by the post-modern therapies, such as Narrative, Brief Solution Focused and more recently, Systemic Belief Therapy (Wright, Watson & Bell, 1996). Bowenian approaches have also shaped my theoretical lens with Family Systems Theory influencing how I understand many reoccurring family patterns across generations as well as how I interpret and use family genograms with clients. My appreciation for the Bowenian concept of differentiation, for instance, as well as its

current relevance in the field of marital and sex therapy (Schnarch, 1991) have influenced the inclusion of a differentiation of self measure (DSI-R) in this study.

I favor theoretical approaches that respect the client as a collaborator in the solution making process and deemphasize the therapist's role as the expert. Although I understand professional therapists are perceived as having, and in many ways do have positions of authority and areas of expertise, postmodernism has helped me view these roles as informing my ability to collaborate, rather than direct and counsel. I call myself a therapist versus a counselor deliberately because I see therapists creating a context for change wherein clients may arrive at their own conclusions, as opposed to giving direct counsel. The work of Chilean neurobiologist Humberto Maturana has assisted in shaping this perspective. Maturana's biological perspective on people (therapists) not being able to assume another's structure and the need to be therapeutically loving, or in other words, participate in the opening of space for the existence of another, have greatly impacted my stance of curiosity with clients and my understanding of ethics and therapeutic purpose (Maturana & Varela, 1987, pp. 246-247). As stated by Maturana & Varela (1987), "a conflict can go away only if we move to another domain where coexistence takes place. The knowledge of this knowledge constitutes the social imperative for a human-centered ethics" (p. 246).

Interest in Proposed Research

My interest in the proposed research topic grew out of clinical experiences after graduate school. Although I had received training in sexual abuse and human sexuality, I do not recall pornography or sexual addictions ever being mentioned or addressed. Ironically, one of my very first cases within a public school system involved a single-

parent family wherein the children had been used together in the production of child pornography by their biological father. Over the next three years, my exposure to the issues of pornography and sexual compulsive or addictive behavior steadily increased.

It is important to note that I never advertised or claimed a specialty in this area; the cases came to me unsolicited, and I never ceased to be shocked at the degree to which this problem had taken hold and affected individuals and families. I owe a great deal to the clients who came forward and shared their experiences with me, as these stories are what motivate me to pursue answers and effective responses today.

Assumptions about Sexual Addiction and Compulsivities

Currently, my assumptions about sexual addictions and compulsivities are: (a) sexual addictions and compulsivities exist as distinct conditions, (b) the construct of sexual addiction is credible and I support its inclusion in a future edition of the DSM, (c) sexual addictions have psychological, social, spiritual and physical causes and therefore need like solutions, (d) sexual addictions are both similar and different from other addictions, (e) there are similarities between the treatment of eating disorders and sexual addictions, (f) I believe cultural assumptions play a fundamental role in the maintenance and demand for a profitable sex industry and our focus on the Internet as the root cause of this phenomenon distracts us from key undercurrents at play (i.e., the socialization of male and female sexual attitudes, patriarchy, societal media standards, and the economics of unscrupulous business), (g) the concept of differentiation of self has relevant application within the field of sexual addictions.

Assumptions about Wives of Men Struggling with Sexual Addiction and Compulsivities

As a female clinician who has encountered numerous women initiating therapy to deal with a spouse's sexual addiction, my own observations have led me to view this population as: highly motivated for change; having made numerous attempts to encourage their husbands to get help either individually or as a couple; emotionally reactive in their current marital relationship; socially isolated in terms of who they can talk to about this problem; having difficulty separating or differentiating themselves from the problem (i.e., "If I were more attractive or sexier, he would not have this problem"); and struggling with symptoms of depression and anxiety.

It has been my experience both in the U.S. and Canada that many women seek help for this problem individually, either because their own mental health needs are paramount in and of themselves, there are safety issues such as sexual abuse that contraindicate couple therapy, or their husband refuses help. At times, my invitations for a husband to be included in the process have been accepted, and this work has been highly effective; however, many do not accept the invitation, and the needs of the affected spouse remain. As a clinician and researcher, I am curious about how we can effectively support women who come forward on their own. With this study, I wanted to start to explore women's experiences with receiving support and learn about what is perceived to be most helpful for them.

It has also been my experience that males struggling with sexual addictions and compulsivities prefer male therapists, and that referring clinicians, physicians and ecclesiastical leaders tend to support this preference as well. Realistically, this is a pattern I predict will continue throughout my academic and professional career. I am,

therefore, motivated to equip myself with clinical skills that can assist me when encountering wives of sex addicts in therapy. I am not opposed to working with males, and, in fact, I have a great deal of curiosity and concern regarding how to support affected youth, men, couples and families; a curiosity that motivated me to seek out opportunities to co-facilitate a couple's therapy group and a men's therapy group for sexual addictions for a year. I acknowledge the need to be well informed of the dynamics of sex addictions in males and how that impacts the interpersonal dynamics within a couple dyad.

CHAPTER IV: RESULTS

The results of this study will be presented in two parts. First, after describing the researcher's general impressions of the research interviews, an overview of the various categories of support the participants utilized will be provided using the open, axial and selective coding phases as an organizing principle for presenting the data. This section will also include the common factors of support that were identified after taking a meta-perspective of the data and examining the commonalities among responses to problematic sexual behavior. Secondly, the specific properties of what was most and least helpful within each category of support will be outlined.

General Impressions of Research Interviews

Although each participant had a unique personal narrative regarding her husband's problematic sexual behavior and her subsequent response, there are several common characteristics of the participants and the interviews worth mentioning.

First, the majority of participants had experienced some form of isolation while dealing with this problem (e.g., emotional, spiritual, physical or social). It became clear to the researcher that this group of women would not have experienced the same degree of isolation had it been a different kind of problem they were dealing with because they would have been less ashamed to reach out to others and possibly more comfortable about discussing a non-sexual topic. Later analysis validated this observation by revealing that 68.18% (15/22) of the sample referred to being isolated or isolating themselves. The shame, embarrassment, uncertainty and secrecy associated with problematic sexual behavior was a consistent influence regarding who and what the women withdrew from or reached out to for support. It is the researcher's belief that the

participants would have presented a very different narrative of support had another type of problem (e.g., parenting concerns, marital conflict, finances etc.) been the main concern in their lives because it is likely there would have been less shame, embarrassment and social constraints around discussing such topics. In terms of clinical implications, this observation is interpreted to mean that women who are high-functioning and well supported in other areas of life may still be at risk for isolation, delayed help-seeking behavior and/or prolonged psychological struggle due to the nature of the problem and the relative infancy of public awareness and clinical approaches regarding it.

Second, because the participants had experienced isolation, they were highly motivated to share their experiences in a safe environment that was not emotionally attached to the situation they faced. The researcher anticipated having difficulty getting answers to the interview questions, especially in light of the sensitive nature of the problem they were facing, but the women were surprisingly eager to share ideas and experiences. Many women even commented that they had looked forward to the interview because they had had few opportunities to share their story despite a desire or need to share it. This willingness to share may have also been a result of the solution-focused nature of the interview (e.g., "What helped the most?") and may not have been the case had specific questions about more sensitive issues such as marital intimacy been asked. This solution-focused interview process may have also explained why the women were not as emotive as was anticipated.

A common theme among participants was their desire that the interviews and study be able to help clinicians and clergy who encounter this situation, as well as other

women who may be struggling with this issue and feeling alone. Considering the degree of upheaval, trauma, and crisis many of the participants were actively dealing with at the time of the study, this altruistic desire was an admirable and unexpected characteristic of this sample.

Initial Analysis: Open Coding

Approximately 500 pages of interview transcripts were imported into the NVivo program and systematically coded for this study. During this phase of the analysis, each interview was carefully read three times, and in some cases four, to identify the pertinent codes embedded within the data. When a new event or type of support was dissimilar to the existing list of codes, a new code was created within the NVivo program.

The research assistants previously mentioned generated codes during their respective reviews of the interviews, and these codes were integrated into the researcher's master list of open codes during one-on-one research meetings and discussions. The group's combined open coding process generated a total of 58 free nodes (codes not yet associated with a broader category of codes) and 11 tree nodes (preliminary higher-level categories of support) with 70 sub-categories underneath the tree nodes (preliminary sub-categories) (See Appendix H for the open code list).

The NVivo program allowed quotes from the interviews to be automatically coded in a parallel manner to the list of codes. This meant that any word or section of text that was coded was saved under the coded category and could be retrieved in its entirety for future quotations by the creation of coding reports through the NVivo software.

In preparation for the axial coding phase, codes that were redundant, poorly labeled or irrelevant to the research questions were identified, combined, renamed or set aside from the main listing. For example, the codes entitled “advertising”, “advice to caregivers”, “advice to other women” and “community action” were set aside because they did not pertain to the primary research question despite being interesting and useful for other reasons. Codes were set aside by maintaining their status as free nodes and not integrating their data into the main coding structure with trees and sibling nodes.

Higher-Level Categories & Relationships: Axial Coding

The next phase of the research was to identify higher-level categories of supports by analyzing the relationships, similarities and dissimilarities between open codes. Although preliminary higher-level categories had started to form towards the end of the open coding process, this phase of the research took this process to a deeper level and focused on interrelationships between codes that then helped create categories according to their mutual relationship. This phase of the analysis generated the list of codes found in Appendix H.

Over a period of months and after repeatedly asking the question “How are these codes related or unrelated to one another?”, it gradually became apparent that two main categories of support existed under the central category of “Responding to Problematic Sexual Behavior.” These two broad categories included “Coping Supports” and “Change-Oriented Supports.”

Coping Supports

Coping supports emerged as a category of supports that were utilized to maintain the equilibrium of the interpersonal, marital and/or family system but did not cause direct

change. In some cases, the utilization of certain coping supports even made matters worse. Coping supports most often coincided with the period of time leading up to and immediately following the initial discovery or disclosure of the problematic sexual behavior, as well as during periods of denial, confusion or uncertainty regarding the problem. Coping supports were understood to be a necessary phase of support while women identified the changes that were needed, wanted and possible, as well as how to go about enacting them.

The identification of coping supports as a key category is congruent with Schneider's earlier research (2000a, 2003) which identified three stages in the pre-recovery of partners of cybersex addicts: (a) Ignorance/Denial, (b) Shock/Discovery of the Cybersex activities, and (c) Problem-Solving Attempts. Coping Supports may be understood to play a key role in the first two stages of pre-recovery cited by Schneider (2000a, 2003) because they are used most consistently and diligently prior to problem-solving attempts or change-oriented supports being implemented. This isn't to say the use of coping supports ceases once change-oriented supports and problem-solving attempts commence, but rather that coping supports play a more dominant role in this phase of support for this population.

Coping supports included the following codes in alphabetical order. Beside each coping support is a brief definition of what was categorized under this code, as well as an exemplar quote from the interviews.

(1) Avoidance: Strategies used to deflect, postpone or avoid dealing with problematic sexual behavior. For example, "I found myself trying to avoid people, whereas before I was a very outgoing and gregarious and loved to see

people and visit, and I am finding myself just kind of cocooning myself just kind of wanting to lick my wounds quietly and just hoping that I'll disappear to everybody so that I don't have to have them see me in my sadness and my heartache."

(2) Avoidance of Sexual Intimacy: Limiting or refusing to be sexually intimate with one's partner as a way of coping with hurt, mistrust or safety issues. For example, "To this day there has been no sexual intimacy between the two of us, um, I don't feel like I can trust him in that way, and I try not to put myself in that position till he does all that he needs to to become healthy…"

(3) Crying: Using crying to self-soothe or respond to the situation. For example, "In the first probably week or two I would have, I would have cried a lot more."

(4) Distraction: Strategies used to deliberately get one's mind off the problem, while being fully aware of what was going on. For example, "I dove into work a lot to hide, hide feelings…I just didn't deal with it."

(5) Drinking: Using alcohol as a way to cope or to join with husband. For example, "I think some of my unhealthy ways of coping would be um; probably my biggest one would be drinking."

(6) Eating: Self-soothing through the use of food. For example, "Unfortunately with me, I turned to eating…it helped, it almost helped cope. You know, like it was almost like comfort for me."

(7) Enabling: Making excuses for or protecting husband from the consequences of his behavior. For example, "I covered for him in just about everything."

(8) Fantasy: Escaping mentally into fantasies as a way to avoid dealing with reality. For example, “Fantasy was a huge one for me…”

(9) Focusing on Children: Focusing one’s attention on children instead of dealing with the problems in the marriage or one’s own life. For example, “I just dove into their [children’s] life, I mean I was always real, real close with them and what not, but yeah, I turned to them more.”

(10) Humor: Making light of the situation in order to make it easier to cope with. For example, “I use humor a lot...”

(11) Hypervigilance and Monitoring: Policing one’s husband’s activities or computer to find clues about problematic sexual behavior and to manage one’s distrust and anxieties about what he has or has not disclosed. For example, “I still do a lot of, um, spying on him, on the computer to find out where he’d been and I would always find letters, you know, emails, or something back and forth with this other woman…I kind of felt like in a way it became an addiction for me, because I wanted to, what could I find today? And if I didn’t find something I just felt like, oh, he’s still lying…because I had found so much stuff over the last three years.”

(12) Isolation: Either feeling isolated in social context or purposefully isolating oneself from a social context. For example, “I didn’t feel like I had a lot of support for a long time.”

(13) Objectifying Self: Viewing oneself as a sexual or physical object instead of as a whole person. For example, “The physical became all important, that was all that

matters I just thought, 'If I'm just the prettiest girl in the room then he'll want to look at me!'....yeah, I just wasn't a real person…"

(14) Secrecy: Deliberately withholding information from people that desire to help or allowing others to dictate secrecy (e.g., clergy). For example, "I was, by the way, sworn to secrecy and told not to talk to anyone, so I couldn't talk to my parents…"

(15) Self-Blame: Redirecting the blame and responsibility toward oneself versus the husband. For example, "I didn't know who to turn to because I thought it was me that was the problem."

(16) Suicidality: Contemplating or gesturing suicide as a way to cope with the pain or hopelessness of the situation. For example, "I hated myself; I tried suicide. I spent four weeks in the psychiatric ward, um getting help. Just trying to make myself realize that I was still worth it, you know."

(19) Weight Gain: Using food to self-soothe to the point where one's weight is affected. For example, "I gained a lot of weight; I was not happy."

(20) Weight Loss: Experiencing a loss in appetite or deliberately restricting food intake to change one's weight. For example, "I was in the mindset, okay, I need to be the type of person that he wants to be married to, obviously he's not happy being married to me so I need to be the type of person he wants to be married to, um, I basically stopped eating. And, I would exercise all the time…"

(21) Withdrawal: Withdrawal differs from isolation in that one may feel supported and connected but chooses to withdraw from those connections. For example, "Through all the years I've just kind of started withdrawing. Not being as

outgoing, and… (started to cry) I've just kind of inverted into myself. I just haven't, really done anything…I have slowly whittled away."

Further categorization of coping supports occurred after observing that some forms of coping were healthy and adaptive while others had maladaptive, unhealthy or risky qualities to them that complicated the problem further by increasing the symptomology or negative effects. Of course, any coping mechanism can become problematic if taken to an extreme or used rigidly to the exclusion of other strategies, however, most of the above mentioned coping supports were presented by participants as positive and useful until change-oriented supports were employed. The coping supports identified by the researcher and the participants as maladaptive or risky were: (a) suicidality, (b) weight loss and (c) drinking due to their potential to cause death or trigger serious complications to healing such as eating disorders or addiction.

In terms of which coping supports were used most frequently by the research sample, Table 3 outlines each coping support and the percentage of women who used it, with the items listed according to most popular coping supports to least popular. The shading in the table helps the reader view groupings of coping supports with the same percentage of utilization. Table 4, on the other hand, lists which coping supports were used by each participant, and divides the participants into two groups: (a) those that discovered the problem and (b) those that had the problem disclosed to them. The yellow shading further denotes the lowest scores on the DSI-R for this sample (between 2.28 and 3.33), while the unshaded or white sections denote moderate scores on the DSI-R for this sample (between 3.52 and 3.91), and the green shading denotes the highest scores on the DSI-R for this sample (between 4.09 and 4.83). On average, each participant used

between 1 and 7 different coping supports with the mean being 4.18 coping supports per participant.

Table 3. Number of participants who referenced each coping support and the total number of references for each.

Coping Support	Percentage (and Number) of Women Who Used It
Isolation	68.18% (15)
Avoidance	45.45% (10)
Self-Blame	45.45% (10)
Distraction	36.36% (8)
Hypervigilance and Monitoring	36.36% (8)
Crying	36.36% (8)
Avoidance of Sexual Intimacy	27.27% (6)
Secrecy	22.73% (5)
Focusing on Children	22.73% (5)
Withdrawal	22.73% (5)
Enabling	18.18% (4)
Weight Loss	18.18% (4)
Suicidality	13.64% (3)
Weight Gain	9.09% (2)
Drinking	9.09% (2)
Fantasy	4.55% (1)
Objectifying Self	4.55% (1)
Eating	4.55% (1)
Humor	4.55% (1)

Table 4. Coping Supports Used by each Participant

DISCOVERED PROBLEM GROUP (14 participants)
[7 Low Scores (yellow), 4 Moderate Scores (white), 3 High (green)]

Participant	Coping Supports Used	Percentage of Total Coping Supports (Total Number)
UT #1	Avoidance Isolation Self-Blame	15.79% (3)
UT#4	Distraction Isolation Silenced Weight Gain	21.05% (4)
UT#5	Avoidance Distraction Isolation Weight Loss	21.05% (4)
UT#9	Avoidance Isolation Self-Blame Withdrawal	21.05% (4)
UT#10	Avoidance Isolation Self-Blame	15.79% (3)
UT#11	Avoidance Isolation Withdrawal Crying Secrecy Self-Blame Suicidality	36.84% (7)
UT#12	Avoidance of Sex. Intimacy Secrecy Weight Loss	15.79% (3)
AB#3	Crying Humor Hypervigilance and Monitoring Self-Blame	21.05% (4)
AB#5	Hypervigilance and Monitoring and Monitoring	5.26% (1)
AB#6	Avoidance of Sex. Intimacy Eating Isolation	26.32% (5)

	Self-Blame Suicidality	
MN#1	Crying	5.26% (1)
MN#3	Crying Enabling Hypervigilance and Monitoring and Monitoring Isolation Weight Loss	26.32% (5)
MN#5	Distraction Hypervigilance and Monitoring Isolation Self-Blame Suicidality Weight Gain	31.59% (6)
MN#6	Drinking Fantasy	10.53% (2)

PROBLEM DISCLOSED GROUP (8 participants)

[2 Low Scores (yellow), 5 Moderate Scores (white), 1 High Scores (green)]

Participant	Coping Supports Used	Percentage of Total Coping Supports (Total Number)
UT#2	Isolation Distraction Self-Blame Crying Focusing on Children	26.32% (5)
UT#3	Avoidance Avoidance of Sex. Intimacy Isolation Withdrawal	21.05% (4)
UT#6	Avoidance Hypervigilance and Monitoring Self-Blame Weight Loss	21.05% (4)
UT#7	Avoidance Avoidance of Sex. Intimacy Crying Distraction Withdrawal	26.32% (5)
AB#1	Avoidance of Sex. Intimacy Crying Distraction Enabling Focusing on Children Isolation Secrecy	36.84% (7)
AB#2	Avoidance Distraction Enabling Hypervigilance and Monitoring Isolation Secrecy	31.59% (6)
MN#2	Distraction Drinking Enabling Hypervigilance and Monitoring Isolation	26.32% (5)

MN#4	Avoidance Avoidance of Sex. Intimacy Isolation Self-Blame	21.05% (4)

Change-Oriented Supports

In contrast to coping supports, change-oriented supports were identified as strategies and actions used to change, heal or improve the intrapersonal, marital or family system. These supports were also identified as being congruent with Schneider's (2000a, 2003) problem-solving phase of pre-recovery for partners and spouses of cybersex addicts.

Five categories of change-oriented supports were identified through the coding process as being the most common with this sample: (a) Recreational, (b) Relational, (c) Professional, (d) Spiritual, and (e) Conceptual. Descriptors and related quotes are provided for each category below.

Recreational Supports. Recreational supports were identified as activities or pursuits that were not specific to responding to problematic sexual behavior and would not have given an outsider any indication about what the participant was dealing with. For example, someone would not be able to observe a participant running, scrap booking or playing the piano and know the intention or function behind the activity. The recreational activities chosen by each woman were almost always activities previously enjoyed or leaned on prior to the discovery or disclosure of the problem, but the level of involvement became more frequent or intense during the period of seeking change and engaging in problem-solving, and the participants expressed using these supports to find comfort, perspective, increased wellness or healthy breaks that helped them deal with the

problem at hand. Drawing from the interviews, the following exemplar quotes demonstrate how these Recreational Supports were used.

(1) Reading: Turning to books as a source of solace, education, self-help or enjoyment. For example, "I probably have read 15 different books, um; it has definitely been enlightening in changed the way that I've looked at a lot of things. Uh, it's made a huge difference in my perspective and my agenda, actually."

In many of the interviews, participants would cite a specific book as being helpful. Some of these resources included: (a) scriptures and religious books, (b) *Out of the Shadows* by Patrick Carnes, Ph.D. (2001), (c) *Self Matters* by Phil McGraw, Ph.D. (2003), (d) *From Bondage to Bonding* by Nancy Groom (1991) , (e) *Surviving an Affair* by Willard F. Harley, Jr. and Jennifer H. Chalmers (1991), (f) *Love Must be Tough: New Hope for Families in Crisis* by James Dobson, Ph.D. (2004), (g) *Faithful and True* by Mark Laaser, Ph.D. (1996), (h) *Living with Your Husband's Secret Wars* by Marsha Means (1999), (i) *Boundaries* by Henry Cloud and John Townsend (2002), and (j) related newspaper articles (refer to Appendix A for a list of the researcher's preferred books and resources on this subject).

A common complaint about using reading as a form of support was that the case examples often hit too close to home or were too graphic and the participants found them upsetting. For example, one woman stated,

> "It's like a fat book. Either way. That one, the very beginning just like went off on how you get from looking at porn to raping and to killing... And that for me was just not what I needed to hear. It really kind of threw me into despair to think. And dwelling, dwelling on that kind of stuff is just not very smart to

think of what your husband could be capable of if he got caught up in that kind of stuff. Reading the books like that, was for me personally, was not helpful at all."

(2) Exercise: Using physical exercise to release stress, lose weight or improve lifestyle patterns. For example, "I had read somewhere that running released endorphins. I never was depressed and I knew I was in a state of shock and I thought well, I need, I need those endorphins so I would go run [and] my babies would play in the middle [of the track]."

(3) Journaling: Using writing to record, express or explore one's feelings and/or experiences. For example, "It was almost as if my journal became just kind of my outlet for my feelings because I felt so much that oh I can't talk to people about this or about these feelings…"

4) Improving Home Environment: Commencing projects that are intended to improve the organization, appearance and/or feeling of the home environment. For example, "…just trying to make our home environment a positive place."

(5) Music: Either playing or listening to music for enjoyment, inspiration or fulfilling personal goals. For example, "I spent as much time as I could probably playing the piano…that was my therapy."

(6) Sewing: Turning to sewing as a creative release or constructive project. For example, "I made dresses for my little girls and suits for my little boys and I got more involved in that – like I'm a very creative person."

(7) Scrap booking: Creatively displaying photographs in photo albums. For example, "I started doing some scrap booking and things that made me feel better, had a little fun."

(8) Shopping: Making necessary and/or unnecessary purchases as a way to divert attention, deal with stress or positively focus on tasks that needed to be completed. For example, "If you were following me around, I mean you know, I'd go shopping…bargain hunting, because we didn't really have a lot of money, so just looking for bargains everywhere."

(9) Horseback Riding: Turning to equestrian activities as a form of physical activity or constructive focus. For example, "I love to listen to music, and just reading the scriptures, and riding my horses…"

Table 5 shows the list of supports categorized under "Recreational Supports," as well as the percentage of women who used them. The shading in the table helps the reader view groupings of coping supports with the same percentage of utilization. Table 6 shows which supports each participant used, as well as the percentage and number of supports used. Like Table 4, Table 6 is divided and colored according to how the participant learned of the problem and her DSI-R score. On average, participants used between 0 and 4 recreational supports each with the mean number being 1.59 recreational supports per participant.

Table 5. List of Recreational Supports and the percentage of participants who used them.

Recreational Supports	Percentage (and Number) of Recreational Supports Used
Reading (e.g., self-help books)	77.27% (17)
Exercise (e.g., running, water aerobics)	18.18% (4)
Journaling	13.64% (3)
Improving Home Environment	9.09% (2)
Music (e.g., listening to or playing)	9.09% (2)
Sewing	4.55% (1)
Scrap booking	4.55% (1)
Shopping	4.55% (1)
Horseback Riding	4.55% (1)

Table 6. Recreational Supports Used by each Participant

DISCOVERED PROBLEM GROUP (14 participants)
[7 Low Scores (yellow), 4 Moderate Scores (white), 3 High (green)]

Participant	Recreational Supports Used	Percentage of Total Recreational Supports (Total Number)
UT #1	Horseback Riding Music Reading	33.33% (3)
UT#4	Exercise Reading Scrap booking	33.33% (3)
UT#5	Journaling Exercise	22.22% (2)
UT#9	Reading	11.11% (1)
UT#10	Music Reading	22.22% (2)
UT#11	Exercise Reading	22.22% (2)
UT#12	Reading	11.11% (1)
AB#3	Exercise	11.11% (1)
AB#5	Reading	11.11% (1)
AB#6	None Cited	0
MN#1	Journaling Reading	22.22% (2)
MN#3	Reading	11.11% (1)
MN#5	Reading	11.11% (1)
MN#6	Drinking Reading	22.22% (2)

PROBLEM DISCLOSED GROUP (8 participants)
[2 Low Scores (yellow), 5 Moderate Scores (white), 1 High Scores (green)]

Participant	Recreational Supports Used	Percentage of Total Recreational Supports (Total Number)
UT#2	None Cited	0
UT#3	Reading	11.11% (1)
UT#6	Improving Home Enviro. Reading	22.22% (2)
UT#7	None Cited	0
AB#1	Improving Home Enviro. Journaling Reading Sewing	44.44% (4)
AB#2	Reading Music	22.22% (2)
MN#2	Drinking Reading Shopping	33.33% (3)
MN#4	Reading	11.11% (1)

Relational Supports. Relational supports included turning to a significant relationship as a source of advice, comfort, and emotional, temporal, and/or social support. Because the majority of the women (90.91% or 20/22) went through a process phase of "shielding," which entailed actively protecting one's husband, friends, family, faith community and self from the ramifications of open discussion regarding the problem, reaching out to relational supports was understood to be a significant turning point in the healing process and support network for this sample. The word "shielding" came from [AB#2]'s interview and struck the researcher as an appropriate descriptor of the process of actively protecting oneself by protecting others from knowledge of a

problem. While shielding may have been considered a coping support at first glance, closer examination of the interviews revealed that this was more of a process phase than a coping support. For example, when someone is grieving and experiences anger over the death, the anger is viewed as a natural process phase as opposed to something they deliberately choose as a way to cope. Similarly, shielding came to be seen as a natural process of handling problematic sexual behavior because of how pervasive it was for the research sample (90.91% or 20/21 women). Furthermore, a process phase is distinguished from supports because supports can be used to deal with a process phase, but rarely the other way around – someone does not choose anger as a way to cope with their reading or praying, but can choose reading or prayer as a way to cope with the process of anger. Shielding was understood to give the women safe emotional space wherein they could assess who was trustworthy to tell, who could help, as well as make up their own mind about the direction of the marriage before getting others' input. After a period of shielding, the following relational supports were used.

(1) Immediate Family: Turning to parents or siblings for support. For example, "I turned to my family. Number one I turned to my family. My family has always been a huge support."

(2) Friends: Turning to friends (non-family, yet close relationships) for support. For example, "The things that were most helpful um, back, back, um, in 1986, um, was my friends. I had some real close friends that I was able to call and talk to a lot. They were, really were there for me."

(3) Spouse: Turning to one's spouse for support. For example, "I know this sounds funny but even my husband. You know just helping me understand exactly what's going on, being as open and as honest and helpful to help me understand as he could."

(4) Extended Family: Reaching out to in-laws, aunts, grandparents etc. for support. For example, "After seven years I finally um told his mom, actually, but then at least a year or two went by and I never told anybody else."

(5) Women in Similar Marriages: Finding support in speaking with other women who were dealing with a similar problem, or who had done so in the past. For example, "Just being able to be around women that feel the same, have the same feelings and that I can talk to and that I can relate to."

(6) Children: Turning to one's children directly or indirectly for support. For example, "I really turned to them [my children]…"

Table 7 identifies the Relational Supports used by this sample and the percentage of women who used them. The shading in the table helps the reader view groupings of coping supports with the same percentage of utilization. It is important to note that the percentages represent the number who cited a particular support as helpful and not the total number who used it – a focus intended to enhance the answering of the primary research question. The ways in which specific supports were used and deemed unhelpful will be addressed in the preferences section. Table 8 shows which supports each participant used, as well as the percentage and number of supports used and is divided and colored according to how the participant learned of the problem and her DSI-R score.

On average, the participants used between and relational supports each with the mean number being 2.36 relational supports per participant.

Table 7. List of Relational Supports and the percentage of participants who used them.

Relational Supports	Percentage (and Number) of Relational Supports Used
Immediate Family (i.e., , parents, siblings)	68.18% (15)
Friends	59.09% (13)
Spouse	54.55% (12)
Extended Family (e.g., in-laws, aunts)	22.73% (5)
Women in Similar Marriages	22.73% (5)
Children	13.64% (3)

Table 8. Relational Supports Used by each Participant

DISCOVERED PROBLEM GROUP (14 participants)
[7 Low Scores (yellow), 4 Moderate Scores (white), 3 High (green)]

Participant	Relational Supports Used	Percentage of Total Relational Supports Used (Total Number Used)
UT #1	Friends Immediate Family	33.33% (2)
UT#4	Extended Family Friends Immediate Family Spouse	66.66% (4)
UT#5	Friends Immediate Family	33.33% (2)
UT#9	Friends Immediate Family Spouse Women in Similar Marr.	66.66% (4)
UT#10	Spouse Children	33.33% (2)
UT#11	Friends Immediate Family	33.33% (2)
UT#12	Immediate Family	16.66% (1)
AB#3	Extended Family Friends Immediate Family Women in Similar Marr.	66.66% (4)
AB#5	Spouse	16.66% (1)
AB#6	Extended Family Immediate Family	33.33% (2)
MN#1	Friends Immediate Family Spouse Women in Similar Marr.	66.66% (4)
MN#3	Friends Immediate Family	33.33% (2)
MN#5	Friends	16.66% (1)
MN#6	Friends	16.66% (1)

PROBLEM DISCLOSED GROUP (8 participants)
[2 Low Scores (yellow), 5 Moderate Scores (white), 1 High Scores (green)]

Participant	Relational Supports Used	Percentage of Relational Supports Used (Total Number Used)
UT#2	Immediate Family Spouse Children	50.00% (3)
UT#3	Friends Immediate Family Spouse	50.00% (3)
UT#6	Spouse	16.66% (1)
UT#7	Immediate Family Spouse	33.33% (2)
AB#1	Spouse	16.66% (1)
AB#2	Extended Family Immediate Family Children Women in Similar Marr.	66.66% (4)
MN#2	Extended Family Immediate Family Spouse	66.66% (4)
MN#4	Friends Spouse	33.33% (2)

It is important to highlight that the women whose husbands disclosed the problem to them were more likely than those who discovered the problem to turn to their spouse for support and find him helpful. Only 5 out of 14 (35.71%) women who discovered the problem found their spouse a source of helpful support whereas 7 out of 8 (87.5%) women who had the problem disclosed to them found their spouse a source of support.

Professional Supports. Professional supports such as therapy and medical attention were defined as supports that required specific training and licensing on the part of the supporter (i.e., therapist, physician or nurse practitioner), as well as a fee for the

support used (i.e., session fee, co-pay and/or health insurance). The following definitions and quotes from the research interviews are intended to clarify what was categorized under each support.

(1) Combination of Professional Supports. Using more than one type of professional support concurrently or at different phases of healing. For example, "I made the hugest strides in individual therapy. And then, maintained and grew more through group therapy."

(2) Group Therapy for the Wives: Psycho-educational or process group therapy specifically for spouses of individuals struggling with problematic sexual behavior. For example, "I think the most helpful thing almost like the only thing that's really helped is coming to group [spouses' group] and hearing that I'm not alone and other people are handling it and hearing the ways that they've handled it too I think that's helped the most."

(3) Individual Therapy: Meeting with a mental health professional individually. For example, "I think the individual and the support group have been tremendous. I don't know that I could have gotten through…to me it's like a life preserver."

(4) Couple Therapy: Meeting with a mental health professional as a couple. For example, "Being in a couples' situation where…we figured out how to communicate better so that when he had something to disclose, I reacted appropriately and not just reacted. That was very helpful."

(5) Group Therapy for Couples: Participating in group therapy that consisted of psycho-educational and therapeutic components for couples. For example, "The number one help was the psycho educational class [for couples]. That was the

number one because, we learned about what was going on, and having knowledge is power."

(6) Family Physician: Seeking out support or medical attention from a medical physician who specializes in family medicine. For example, "We went to our family doctor"

(7) Hospital: Being admitted to or voluntarily going to a hospital for immediate medical attention. For example, "Oh, it was devastating. The first time when I found out that it had been my friend that he was having an affair with, I actually ended up in a hospital…"

(8) Nurse Practitioner: Consulting with a nurse practitioner for support. For example, "I'm actually going to a nurse practitioner on Friday because I took a, I went to this website called hurried women dot com and I took the mood assessment like three times because I didn't like my results and I kept, like, I'm like oh it's because I took it at work and then I took it at home and I got the same results."

(9) Psycho-Educational Seminars: Attending workshops that focus on problematic sexual behavior or related topics. For example, "The seminar. It was just kind of a mini um, Friday night Saturday morning I think thing...I remember feeling much more hopeful at the end of that session [Saturday morning] then I did the night before…"

(10) Family Therapy: Meeting with a mental health professional as a family unit. For example, "I was most concerned about my children, and how to help them with all this… But um, I you know that's not something normally that you would talk

to your children about and certainly not a nine year old. But my children had to be told all of it and um, I think that's a pretty bitter pill for them to swallow, at young ages. And um, you know maybe the one thing I would have done differently with the family counseling, I'm not sure that it was okay for my nine year old."

(11) ObGyn: Seeking out support or medical attention from a physician who specializes in obstetrics and gynecology. For example, "My ObGyn…the best I've ever had…I felt like I could trust her and talk to her about it, and that was very helpful…"

Table 9 outlines the Professional Supports deemed helpful by this sample as well as the percentage and number of women who used each one. The shading in the table helps the reader view groupings of coping supports with the same percentage of utilization. Table 10 shows which professional supports each participant used, as well as the percentage and number of professional supports used individually and is divided and colored according to how the participant learned of the problem and DSI-R scores. On average, the participants used between 0 and 4 professional supports each, with the mean number being 1.95 professional supports per participant.

Table 9. List of Professional Supports and the percentage of participants who used them.

Professional Supports	Percentage (and Number) of Professional Supports Used
Combination of Professional Supports	45.45% (10), however 95.45% (21) checked off a combination of professional supports on the demographics form just prior to the interview commencing.
Group Therapy for the Wives	45.45% (10)
Individual Therapy	36.36% (8)
Couple Therapy	31.82% (7)
Group Therapy for Couples	13.64% (3)
Family Physician	9.09% (2)
Hospital	9.09% (2)
Nurse Practitioner	9.09% (2)
Psycho-Educational Seminars	4.55% (1)
Family Therapy	4.55% (1)
ObGyn	4.55% (1)

Table 10. Professional Supports Used by each Participant

DISCOVERED PROBLEM GROUP (14 participants)
[7 Low Scores (yellow), 4 Moderate Scores (white), 3 High (green)]

Participant	Professional Supports Used	Percentage of Total Professional Supports Used (Total Number Used)
UT #1	Group Couple Therapy Couple Therapy Women's Group	30.00% (3)
UT#4	Couple Therapy Women's Group	20.00% (2)
UT#5	No professional supports were cited as helpful. Although this participant used couple therapy, it was a negative experience and therefore not cited here as a helpful support.	0% (0)
UT#9	Individual Therapy Women's Group	30.00% (3)
UT#10	Group Couple Therapy Couple Therapy Women's Group	30.00% (3)
UT#11	Women's Group Individual Therapy	20.00% (2)
UT#12	Family Therapy	10.00% (1)
AB#3	Individual Therapy	10.00% (1)
AB#5	Individual Therapy Couple Therapy	20.00% (2)
AB#6	Individual Therapy Hospital	20.00% (2)
MN#1	Psycho-Ed. Seminars Nurse Practitioner Women's Group	30.00% (3)
MN#3	ObGyn Women's Group	20.00% (2)
MN#5	Hospital Women's Group	20.00% (2)
MN#6	Individual Therapy Couple Therapy	30.00% (3)

	Women's Group	

PROBLEM DISCLOSED GROUP (8 participants)
[2 Low Scores (yellow), 5 Moderate Scores (white), 1 High Scores (green)]

Participant	Professional Supports Used	Percentage of Professional Supports Used (Total Number Used)
UT#2	Group Couple Therapy Couple Therapy	20.00% (2)
UT#3	Women's Group Couple Therapy	20.00% (2)
UT#6	Women's Group	10.00% (1)
UT#7	Women's Group	10.00% (1)
AB#1	Family Physician Couple Therapy	20.00% (2)
AB#2	Individual Therapy	10.00% (1)
MN#2	Women's Group	10.00% (1)
MN#4	Family Physician Individual Therapy Nurse Practitioner Women's Group	40.00% (4)

When reading tables 9 and 10 it is important to keep in mind that the figures do not reflect the total number of supports used but rather those cited as helpful to participants during the interview. Women were not probed about the discrepancies between answers regarding supports on the demographics form and supports mentioned or neglected in the interview. The reason this was not done was because the researcher wanted to understand what these women, on their own volition, would cite as the most helpful, as opposed to merely used.

It is also interesting that none of the women in Utah accessed medical supports while a number of women in Alberta and Minnesota had done so. Why this regional difference exists is not understood. Medical facilities were available to all participants, and a range of income ranges were represented in each area. To better understand this difference, future research would need to incorporate information regarding health insurance coverage and employee benefits available to participants.

Additionally, if we examine the medical supports closely, we notice that women who had the lowest DSI-R scores were among those who were treated for suicidality in a hospital or were seen by a doctor for physical symptoms (e.g., anxiety, stress, depression, lack of appetite, or possible STD's). Two women who had moderate scores also received medical attention while women with the highest DSI-R scores did not require or seek out medical supports.

Spiritual Supports. Spiritual supports included all aspects of turning to a higher power, religion, faith, clergy, scriptural texts and one's faith community for support. Although many clergy are professionally trained in theology, counseling or ministry, ecclesiastical services were differentiated from professional supports because a fee for the support was not required. The following codes were categorized under spiritual supports:

(1) Clergy: Turning to an ecclesiastical leader in one's faith community for guidance, comfort, spiritual practices and/or support. For example, "I don't know what I would have done without his [ecclesiastical leader's] phone calls saying 'How are you doing?' He was the only one doing that."

(2) Specific Spiritual or Doctrinal Beliefs: Relying on a religious belief or doctrine to gain strength, perspective and comfort. For example, "The beliefs that um, that that there is a plan and the plan is for us to be happy and there is always and there are always avenues to find that happiness and Heavenly Father desires for us to become strong and rise above these kinds of things."

(3) God: Turning to God, Heavenly Father or a Higher Power for strength and comfort. For example, "I would say the most important thing would be my relationship with Him [God] - knowing that that's my source of strength, and that's the only place I get true answers because people let you down."

(4) Prayer: Engaging in the practice of prayer to seek strength and blessings. For example, "I would say prayer is the most helpful."

(5) Scripture Reading: Reading holy, religious texts for understanding, instruction and guidance. For example, "A scripture that's helped me a lot is in Timothy and…it just talks about how you know, God doesn't give us the spirit of fear and how cause I, I feel myself being so afraid so much, so afraid that um, that it will happen again…"

(6) Religious Meetings or Services: Attending Church services as a way to find spiritual comfort or social connection with one's faith community. For example, "Having a support like just going to church and seeing people and feeling normal around people, it was good."

(7) Jesus Christ: Relying on one's relationship with Jesus Christ (Savior, Messiah) to find strength and comfort. For example, "I keep going back to the Savior. I don't think you can underestimate the power of the Savior's love in helping a person to

deal with it when you're in the middle of it or the aftermath, um, because there is healing and it does come."

(8) Spiritual Promptings: Listening to and acting on spiritual impressions. For example, "I just finally, I don't know, I really just kind of feel like it was something else prompting me to just say you know, 'I know this is going to sound, just ridiculous, but I just kind of, do you have anything you need to tell me?'"

(9) Service: Engaging in volunteer commitments or charitable service to others as a way of finding comfort and/or fulfilling one's volunteer commitments. For example, "Being really involved in what I do in my callings [voluntary church service], you know, but I think that benefits me across the board, not just specifically in this, so I guess that's probably why I don't separate it, when I, when I speak about this struggle in our lives specifically, because it's, it's kind of just a part of me."

Table 11 outlines the Spiritual Supports deemed helpful by this sample as well as the percentage and number of women who used each one. The shading in the table helps the reader view groupings of coping supports with the same percentage of utilization. Table 12 shows which spiritual supports each participant used as well as the percentage and number of spiritual supports used individually and is divided and colored according to how the participant learned of the problem and DSI-R scores. On average, the participants used between 0 and 8 spiritual supports each, with the mean number being 3.91 spiritual supports per participant.

Table 11. List of Spiritual Supports and the percentage of participants who used them.

Spiritual Supports	Percentage (and Number) of Women Who Used It
Clergy	72.73% (16)
Specific Spiritual or Doctrinal Belief	59.09% (13)
God	50.00% (11)
Prayer	50.00% (11)
Scripture Reading	50.00% (11)
Religious Meetings or Services	50.00% (11)
Jesus Christ	31.82% (7)
Spiritual Promptings	22.73% (5)
Service to Others	4.55% (1)

Table 12. Spiritual Supports Used by each Participant

DISCOVERED PROBLEM GROUP (14 participants)
[7 Low Scores (yellow), 4 Moderate Scores (white), 3 High (green)]

Participant	Spiritual Supports Used	Percentage of Total Spiritual Supports (Total Number)
UT #1	Scripture Reading Clergy Jesus Christ	33.33% (3)
UT#4	Specific Beliefs Clergy God Jesus Christ Prayer	55.56% (5)
UT#5	Specific Beliefs Scripture Reading Clergy Religious Meetings God Prayer	66.67% (6)
UT#9	Specific Beliefs Clergy God Promptings	44.44% (4)
UT#10	Specific Beliefs Scripture Reading Religious Meetings	33.33% (3)
UT#11	Specific Beliefs Scripture Reading Clergy Religious Meetings God Jesus Christ Prayer Promptings	88.89% (8)
UT#12	Specific Beliefs Scripture Reading Religious Meetings Jesus Christ Prayer Promptings	66.67% (6)

AB#3	Clergy Religious Meetings	22.22% (2)
AB#5	None Cited	0% (0)
AB#6	Clergy	11.11% (1)
MN#1	Specific Beliefs Clergy Religious Meetings God Prayer	55.56% (5)
MN#3	Scripture Reading Clergy	22.22% (2)
MN#5	Clergy Religious Meetings God	33.33% (3)
MN#6	Specific Beliefs God Prayer	33.33% (3)

PROBLEM DISCLOSED GROUP (8 participants)
[2 Low Scores (yellow), 5 Moderate Scores (white), 1 High Scores (green)]

Participant	Spiritual Supports Used	Percentage of Spiritual Supports (Total Number)
UT#2	Specific Beliefs Clergy God Jesus Christ Prayer	55.56% (5)
UT#3	Scripture Reading Clergy Religious Meetings God Jesus Christ Prayer	66.67% (6)
UT#6	Scripture Reading	11.11% (1)
UT#7	Specific Beliefs Scripture Reading Clergy God Prayer	55.56% (5)
AB#1	Specific Beliefs Scripture Reading Religious Meetings Jesus Christ Prayer Promptings	66.67% (6)
AB#2	Specific Beliefs Clergy God Jesus Christ	44.44% (4)
MN#2	Specific Beliefs Scripture Reading Clergy Religious Meetings God Prayer	66.67% (6)
MN#4	Clergy Promptings	22.22% (2)

Conceptual Supports. Conceptual supports included ideas, metaphors or perspectives that were helpful or the catalyst for change in this sample. How the conceptual supports were encountered varied for each person. Out of 22 participants, 81.82% (18) cited some kind of conceptual support as being helpful to them. Examples of what this meant include: "My number one thing right now is boundaries. I never knew anything about boundaries at all except for life and limb, just knowing if someone is going to hurt you then I think that's probably the only boundary I knew. Um, just uh, taking care of myself, trying to have a sense of my own self. Instead of giving, giving, giving to other people I actually have to know who I am to be able to give to other people." Or, "Concepts about feelings…the iceberg model. That's been an interesting concept to give a picture to your feelings..."

Clarifying a Core Category: Selective Coding

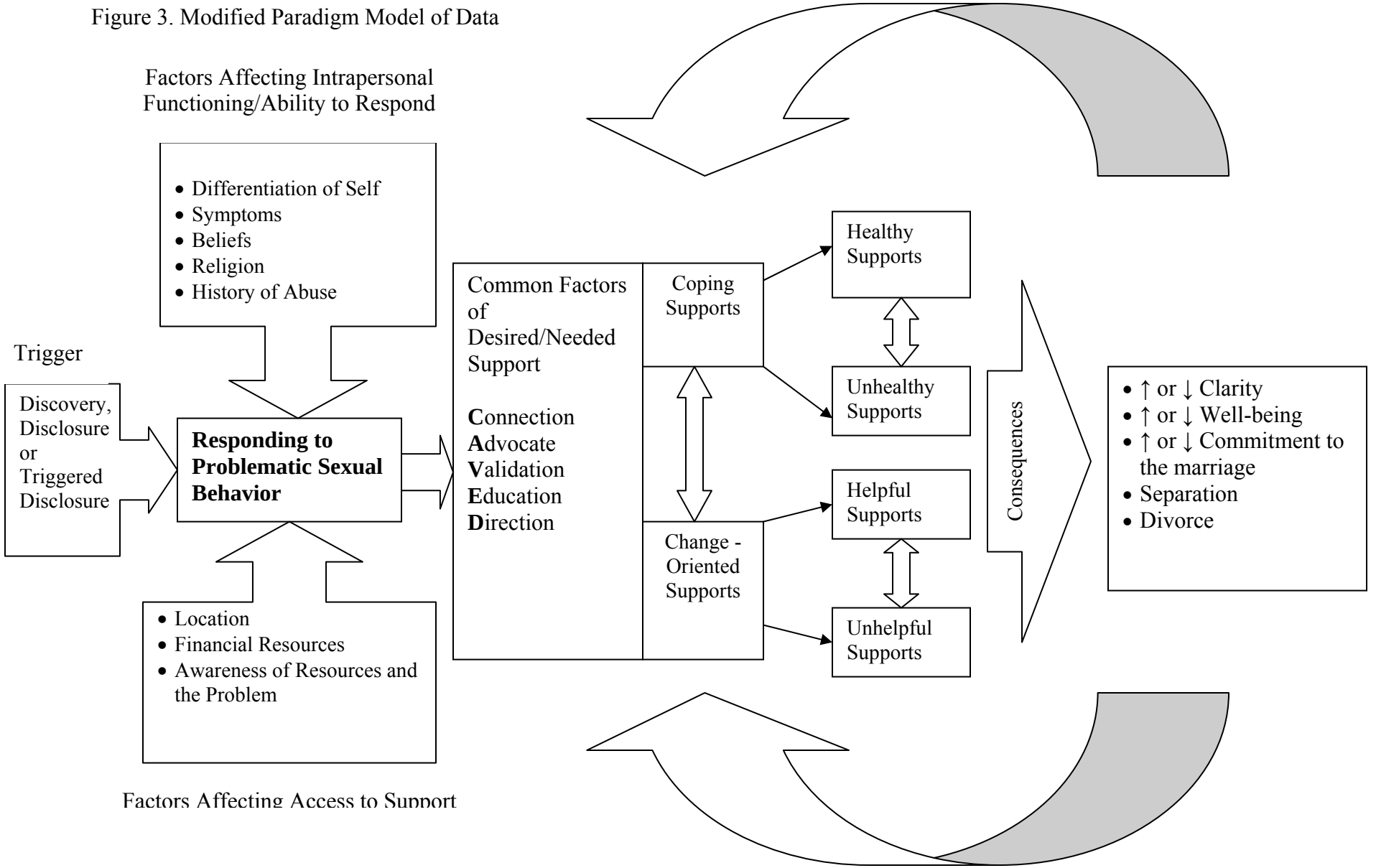
The final stage of analysis involves identifying a central theme or category that emerges from the data and then developing a theory as to how the open and axial codes relate or interact with this central category. This phase of the analysis was heavily influenced by the paradigm model proposed by Strauss and Corbin (1990), and this helped further ground the selection of a central category into the data.

The core category was selected after repeatedly asking, "What do all of these narratives have in common?" and "How are all of the codes related, if at all?" While each participant brought to light different responses to a similar type of problem in their marriage, and each of the codes represented different ways in which these responses took shape and were enacted.

Selecting a core category was, in many ways, the most difficult task in the analysis. The difficulty lay in shifting mental gears from dissecting over 500 pages of text for months and organizing it into more than a 100 different categories or sub-categories, to then thinking about the data in a holistic, unified way. In looking for the core category, the researcher was seeking to find the one unifying theme that all the codes had in common, or in other words, the hub within the data from which all codes originated from.

The core category for this sample was identified as "Responding to Problematic Sexual Behavior." At first, this theme seemed too obvious and too simplistic and was dismissed several times as not 'it'. However, once this central category was tested against the data and put into a research paradigm, the once simplistic category took on new depth and complexity. More importantly, this central theme unified seemingly unrelated pieces of data. The original Strauss and Corbin paradigm, however, became limiting to what was emerging out of this particular set of data, and the paradigm was therefore modified in structure, not content, to accurately portray the interrelationships between codes and the central category. The following figure illustrates the modified paradigm model for this study.

Figure 3. Modified Paradigm Model of Data



The axial coding flow chart as shown in Figure 1 provided the preliminary structure for Figure 3. Figure 3 was developed, in part, by dissecting Figure 1 and exploring what was influencing each phase of support seeking, as well as what happened after each phase. Returning to the data each time a question was posed ensured Figure 3 was grounded in the data and not imposed by the researcher.

Trigger

The trigger for responding to problematic sexual behavior entailed one of three types of revelation: (a) discovery of the problem (e.g., discovering a stash of pornographic magazines, love letters or receipts for sex-related purchases), (b) having one's spouse initiate a partial or full disclosure of the problem, or (c) a triggered disclosure (e.g., a wife senses something is wrong and starts asking questions of her husband, and this subsequently brings the problem to light). Although "discovery" and "disclosure" were the only options listed on the demographics form, the term "triggered disclosure" was created after an assistant coder noticed there were further distinctions to be made within these two types of revelation. From the participants' own reports, 14 women had discovered the problem, and 8 said it had been disclosed to them. After adding the category of triggered disclosure, 12 women had discovered the problem, 7 had it disclosed to them, and 3 had triggered a disclosure by their spouse by asking questions or confronting a particular behavior.

An example of each type of trigger is exemplified by the following quotes:

Discovered. "We had gone grocery shopping and we found a little kitty cat by the garbage dumps, and we took it home, and it was scared and it ran off and hid. And we started searching the house for the cat, and I went downstairs and opened up the water

heater closet and [my husband] ran down and shut it, and I said, 'He could be in here.' and he said, 'No, he's too little. He couldn't climb up there.' I was like, 'Why are you being so weird?' And I got the flashlight and I'm looking around, and I looked up and there just was there whole library of [pornographic] videos and magazines up stuck in the ceiling of our house."

Disclosed. "Well when I was dating my husband um, he told me that he liked Playboy magazines, and I didn't really know too much about them other than they had women in them."

Triggered Disclosure. "I had been feeling that something was amiss, something was wrong in my first marriage and so I um, went to go to the temple to pray about it and when I was there a very strong, very profound, very clear impression I was to leave my current husband, and I cried because I didn't want to, I didn't want to be a single mother and we went home and then I knew that's what I had to do and so when I got home I called him up and I said, something's amiss, something's wrong and if you don't want to tell me what it is then I'll leave it at that, but I will not be here when you get back, and he dismissed it but he knew that I was serious and so fifteen minutes later he called up and started to confess, and I got the tip of the iceberg. Of course, other things continued to come out. I found out that he had a problem with pornography since he was maybe fourteen or sixteen…"

Factors Affecting Intrapersonal Functioning and Ability to Respond

After coding the data, there were several categories of intrapersonal functioning that did not pertain to the subject of supports directly, but which had a significant impact on the types and timing of support received. The following intrapersonal factors had the

most bearing on the process of seeking, accessing and applying supports with this sample: (a) Differentiation of Self, (b) Symptoms, (c) Beliefs, (d) Religion, and (e) History of Abuse. The following quotes illustrate how these factors affected support-seeking.

Differentiation of Self. The concept of differentiation of self was hypothesized to affect one's pathway of support. The following two quotes contrast a lower level of differentiation with a higher one. While both women had participated in group therapy, it is interesting to consider how their level of differentiation affected how long they had waited to seek help and how they integrated concepts taught in therapy differently:

[Lower Level of Differentiation (DSI-R Score = 2.65)]: "I completely lost myself, cause I went for ten years without talking about that this hurts and even letting myself feel that it hurt…I didn't feel like I could be a real person…I just feel like I lost at least 5 years of my life."

[Higher Level of Differentiation (DSI-R Score = 4.17)]: "I feel like I really drastically changed the dance in our relationship, and it was hard to do and it was real uncomfortable because I didn't know the steps and my husband had no idea what was coming up next and what his part was or what his, so he desperately tried to pull me back into the old dance. Sometimes he was successful, but overall um, it has definitely changed, and um even without his cooperation it has changed and my perspective has changed a lot for the better…he doesn't appreciate the new dance he likes the old one."

As previously mentioned, low DSI-R scores were associated with increased physical symptomology and the use of medical supports. In contrast, none of the women who had separated or divorced their spouse as a result of problematic sexual behavior had

low DSI-R scores. Participants such as [UT#5], [UT#11], [AB#2], and [AB#3] who divorced their husbands as a direct results of problematic sexual behavior all had moderate overall DSI-R scores but had the highest "I Position" subscale scores within the sample.

Symptoms. The presence of physical symptoms in the wake of a discovery, disclosure or triggered disclosure expedited the access and pathway of support, especially if the emotional or physical symptoms were severe (e.g., suicidality). The women who did not experience symptoms tended to be the ones who would (or could) wait extended periods of time before reaching out for help. The following quote reveals the expedited nature of help-seeking in the wake of symptoms appearing: "It was devastating. I mean, I kind of felt like I was in an out of body experience because I just couldn't believe that it was happening. It affected me physically, as well as emotionally, because I just felt I had so much going on that literally for the first two to three weeks, I felt like my body was shaking and I couldn't control it, and um, just that quivering sense that I just couldn't stop, so that was kind of scary, and I did go to my doctor."

Beliefs. Aside from religious beliefs, some participants held beliefs or worldviews that were adaptive in certain areas of life, but which constrained seeking support for this particular problem. For example, one woman explained: "We had a family folklore story that as children we referred to. I was the youngest of [number of children cited], but they all talked about mom and dad saying like after you get married and go away your gonna have disagreements with your spouse, but, you work it out because don't come running home to us because you've made a commitment and you can work through it and you can solve it and so that was kind of the mind set I had…And so I

didn't want to bother other people with my problem, and especially when it was just such a sensitive one."

Religion. As previously mentioned, religious beliefs were a source of support for many participants. For some women, however, one's religious culture, doctrine and faith community also shaped a participant's worldview of the problem and subsequent help-seeking behaviors or lack thereof. For example, one woman alluded to a religious lesson framing her perceptions and subsequent responses to the problem, thereby making religion a shaper of response as well as a source of support: "I can specifically remember a Relief Society lesson [a Sunday lesson specifically for LDS women] that we had on Heavenly Father wanting everyone to have joy. And I remember, just being like… (Sigh)…it just knocked me out. Like, I was four or five months into the struggle probably, and I was not happy; I was miserable. I think that's what kind of started the whole hard times for me was just that Heavenly Father wants everyone to have joy, and I was not experiencing joy at all. I guess maybe that triggered the whole personal, like should I be in this marriage, should I not?"

History of Abuse. In some cases, a history of being abused as a child affected the response to problematic sexual behavior in adulthood. As one woman explained: "I had to put up with this and the reason I did it, and did it silently, was because I was used to abuse. My mom used to beat the pulp out of me when I was younger…so I was used to being abused and I was used to not saying anything or telling anyone when it happened in my marriage."

Factors Affecting Access to Support

Circumstantial factors commonly affect the access and implementation of supports. The sample for this study confirmed that despite one's desire or need for support, there are moderating factors that affect one's access to supports. In this sample, three such factors were identified: (a) Location and Availability, (b) Financial Resources, and (c) Awareness of Available Resources and the Problem. The following quotes help clarify what each of these factors entail.

Location & Availability of Resources. When one woman was asked if she would have participated in a women's support group if it had been available in her area, she responded: "Oh yeah, definitely, definitely."

Financial Resources. One woman explained, "I was a single mother so I didn't have a lot of money. I finally got a job at the hospital that had insurance…"

Awareness of Resources and the Problem. When asked why it took several years for her and her husband to connect with help, she replied: "it took so long [to get help] because I didn't know where to go for the help…"

Common Factors of Desired/Needed Supports

This study has focused on the specific types and properties of supports used and preferred by a particular sample of women. Closer examination, however, revealed common factors among the coping and change-oriented supports that influenced help-seeking behavior in response to problematic sexual behavior. This part of the analysis was undertaken once the researcher was very familiar with the interview transcripts and understood the specific supports well enough to step back from them and identify the common denominators among the various pathways of support - a thematic analysis of

sorts. The primary question asked during this part of the analysis was "What do all of the coping and change-oriented supports have in common and what do the women get from all of these?" Five common factors were subsequently identified: (a) Connection, (b) Advocacy, (c) Validation, (d) Education, and (e) Direction – a collection of needs that interestingly form the acronym CAVED, an apt description for the 'caved-in', isolating and devastating experience problematic sexual behavior in a marriage evokes. These five common factors were understood to be the foundation of all supports sought. For this reason, the common factors are situated in the model before any support pathways or delineations branch off and why the common factors touch both the coping supports and change-oriented supports.

The first common factor amongst this sample is the need for connection. As previously described, the isolation experienced by the majority of women responding to problematic sexual behavior in a marriage can be intense and enduring due to shame, embarrassment, fear and being unsure who can be trusted with sensitive information. In light of the cut-off this population experiences from the world around them, it makes sense that a common need in their narratives of support and healing is reconnecting with the world around them. Connection to self, to God, to other people, to one's spouse and in some cases to life itself were ways this need for connection manifested itself. The need for connection is summarized well by the following woman: "Probably the thing that helped me to keep going and doing what I needed to was my connection with my Heavenly Father and with my family, and my extended family... I looked to them for a lot of support as far as doing things, staying connected with them." Another woman

expressed how connection with others helped her to not feel so alone: "I think the only thing that's really helped is coming to group and learning that I'm not alone."

Secondly, the women needed someone who would advocate for their needs and have a degree of authority with which to positively influence the husband and hold him accountable in ways she couldn't (e.g., loss of employment or altered church standing). The term 'advocate' is not intended to convey helplessness on the part of the women, but rather describe a common *role* fulfilled by many of the people these women sought out when looking for support. Many women expressed relief when someone they had turned to advocated a plan of action and gave voice to her pain, her needs, and invited her husband to take responsibility for this problem. For example, one woman, who had been dissatisfied with the passive, non-directive stance previous clergy had taken with her husband's chronic pornography use expressed her relief when clergy finally took the issue seriously and did what she was not in a position to do. For example, she states, "...this one bishop in particular, took it very seriously and said [to my husband] 'You have a very serious problem and you need to get help,' and I was like, 'Thank you! Finally' because nobody else did that, and I wouldn't have known where to go…"

Due to the prevalence of self-blame and isolation, many women became immobilized in the wake of a disclosure or discovery of problematic sexual behavior, and, therefore, did perceive they have the strength, authority or clarity of mind with which to act decisively and effectively. When someone can take on an advocate role and link arms with these women, it helps them remobilize their resources and empower them to eventually make decisions or deliver an ultimatum with confidence – a decision they

may know they need to make or want to make, but do not feel they are in a frame of mind to enact. One woman exemplified this idea when she stated,

> I needed to have someone just say to him, 'This is what you're doing, this is what you're becoming, and this is where you're going to end up if it doesn't stop' and then to also have someone tell me that, 'Yes you can live without that, you can, it may hurt to leave him but if you have to do it that's what you have to do'. And to give me the confidence to say, 'Yeah I can do it!'

Thirdly, an important common factor for these women is the need for validation. Validation includes being affirmed as a human and reassured that one's feelings and experiences are understandable and legitimate. For example, one woman said, "What a Bishop could have done for me is just to listen to what I have to say and validate that…" Another woman expressed the need for validation from her spouse when asked what support from her husband would mean: "That he was acknowledging that he has a problem, and respecting me, and how it affects me when he doesn't tell me and when he would tell me I would feel, fell more affirmed of my feelings, that what I was feeling was right."

Fourth, women tended to find education about problematic sexual behavior a critical ingredient in depersonalizing their husband's problem and becoming clearer about what needed to happen now that the issue was out in the open. Education about the issue included obtaining information about (a) the problem itself, (b) treatment options, and (c) learning how others have dealt with this in their marriages. As one woman described: "I was really naïve and maybe I still am, but I think all the information I just sucked in. I'm very into education and very into reading. The facts were very important because I didn't

know anything and it helped me to understand the past as well as hopefully to fix some of the future." Another woman referred to an educational seminar on sexual addictions as a source of hope and direction. She stated, "I don't remember the details um, of what they presented but I remember feeling much more hopeful at the end of that session then I did before…it was really eye opening and prepared you for what lies ahead…"

When women were asked about the supports they desired but did not receive, education about sexual addictions was something that was frequently brought up. For example, one woman explained: "I think I would have liked to know more about maybe recovery time, or you know what his chances are of really getting over this problem…I didn't know very much of anything about this addiction. I would like to know more about how I can help him in a positive way but still not lose track of me and the kids, our family I think those are two things."

Lastly, the need for direction was a common factor in the supports and desired supports for this population. As the need for education highlights, many of these women are at a loss as to what to do, where to go and how to cope with this kind of problem. This uncertainty is due, in part, by the fact that the problem and solutions are foreign and this issue is not openly discussed in our society. Moreover, this uncertainty combined with shock and emotional distress; make this population particularly needy for informed direction and counsel. As one woman explained, "It's just emotional chaos - you just can't think clearly so it even at that point I wasn't trying to learn about it or read about it yet I was just blown over." Another woman stated, "I didn't know who to turn to."

Many women understood that some clergy and professionals may not know enough about the problem to give direction themselves, but as one woman explained, it is

helpful for such individuals to offer direction about where to go for specific help and counsel: "I think Bishops are more beneficial for spirituality, but I think that they need to turn this over to people that are doing this on a daily basis….They may not be the ones to have the in depth knowledge about these things but at least to have something they could give someone, a piece of paper that says these are some places [that could help]."

While this study did not examine outcomes related to specific pathways of support, it is the researcher's observation that women who acquired connection, an advocate, validation, education about sexual addictions and informed direction while responding to problematic sexual behavior in their marriage had better prognoses and shorter periods of duress. Further research is needed to test this observation with a larger sample of women.

Consequences

The outcomes or consequences of different pathways of support were not the focus of this study. The answers to questions about various supports, however, lent themselves to inferring how certain supports affected the problem over time. The most common consequences inferred from the data were: (a) increased or decreased clarity about the problem and appropriately directing blame for the problem (i.e., shifting from a self-blaming stance to seeing one's husband as responsible for the problematic sexual behavior), (b) increased or decreased well-being, (c) increased or decreased commitment to the marriage, (d) separation, and/or (e) divorce. The arrows in the model that move from the consequences box to the beginning of the support pathway denote the circular process of seeking different supports for different, but related problems to problematic sexual behavior in the marriage. For instance, a woman who finally connects with a

therapist or clergy for support but then finds this experience disappointing or unhelpful is left with the choice of either giving up or not furthering her help-seeking behavior or to commence the help-seeking process again. Or, there may be various problems that arise over time or during the process of seeking support for another problem, thereby necessitating the need to engage in multiple cycles of responding to problematic sexual behavior.

Part of the difficulty in drawing conclusions about the consequences of various supports, is that the majority of the sample (81.82% or 18/22), at the time of the study, was still in the process of using supports or responding to problematic sexual behavior, making it premature to determine what the outcomes of supports would be. The women, however, who participated in the study based on past experiences with problematic sexual behavior, meaning they were not actively dealing with this issue at the time of the study, provided insight into the consequences of certain pathways of support. For example, [UT#5], [UT#11], [AB#1] and [AB#3] divorced their husbands after obtaining greater clarity about the situation (e.g., a husband that was in denial and not willing to seek help or change) and/or overcame constraining beliefs about divorce (e.g., divorce is not an option or contrary to my religious beliefs). For example, when one woman's husband stated he was not going to cease consuming pornography for the sake of the marriage, support from her immediate family helped her overcome her religious hesitancies about divorce. For instance, she stated:

> In the LDS culture it makes it hard because divorce is so looked down upon that you just don't get divorced and if you got divorced you're a bad person [because] obviously you couldn't make your marriage work, or you weren't committed to

your marriage um, but it was very helpful when my parents said to me you know whatever you do it's okay. My dad told me the best situation is to be happily married, after that it is to be happily single, then unhappily single then unhappily married and they were just like you know this is a bad situation and they said that it's okay if you get out of it.

Most Helpful and Unhelpful Properties of Change-Oriented Supports

While five categories of change-oriented supports have been identified and defined, the participants' specific likes and dislikes regarding supports have not been delineated. For example, while the figures outlined in the paper reveal that the majority of participants found clergy supportive and helpful, these figures do not reveal the negative experiences women had with clergy prior to or after having a positive experience. The following section and tables will help clarify the most helpful and least helpful properties of (a) Relational, (b) Professional, and (c) Spiritual supports. For some types of support, such as Recreational and Conceptual, the researcher neglected to ask enough follow-up questions to determine the details around what was deemed most or least helpful in these areas; this would need further investigation.

Properties of Relational Supports

Immediate Family.

Table 13. The Most and Least Helpful Properties of Support from Immediate Family

Most Helpful Properties	Least Helpful Properties
Listening "just the being there listening…"	**Getting Emotional and Upset** "I went to my dad and not my mother [because she] would have gotten all angry and emotional."
Not Giving Advice "…not really advising in any way just being supportive."	**Others' Discomfort with the Problem** "People are so caught off guard they don't know how to react. It makes them uncomfortable."
Level-Headed, Rational Response "I went to my dad [because he] was very level headed."	**Emotionally Abusive** "No support from my husband nor his family. In fact I was receiving even threatening phone calls from his family over this… [threatening] my personal safety along with my children at one point."
Sharing Similar Experiences "It was a realization that a lot of them had the same, or similar, issues they were dealing with…So, it was being able to	**Ignorance about the Problem** "They were supportive of me but they didn't understand what he was going through at all, like they had never dealt

express how I felt and knowing they had dealt with similar things."	with anything that way and … they didn't do much research on it or anything so they kind of, it was more of like a pervert kind of thing so…some of the things they would worry about were things I wasn't worrying about."
Giving Space to Make One's Own Decision "To my parents credit they were not on the next flight down to pick me up and rescue me. They supported me a hundred percent but they knew I needed to make the decision…I really appreciated no one saying here's what you need to do."	**Making Jokes about Pornography or Related Problems** "You know just any references in joking about those things, because they didn't realize what we were dealing with…That was probably the hardest and least supportive thing."
Care packages, Notes, Phone calls "They'll always send little e-mails or call just to make sure I'm doing okay."	**Not Validating Her Situation** "I just wanted someone to tell me I was a strong woman for putting up with all that crap…but it's really not been that way."
Believing Her Story "I didn't need her to tell me how to feel, I just needed someone to believe me."	**Downplaying or Minimizing** "Anyone um, that just says its just a little porn, I don't know what your getting all uptight about, guys do it...relax, it's not that big of a deal it's just a little bit of porn

	- yeah okay $20,000 in porn that's not that much, I mean, whatever."
Supporting Both Partners "We told his parents the same week that I found out…we chose to tell them because we knew that they would be supportive of both of us no matter what happened with the [marriage]."	**Lack of Confidentiality** "I don't think we have families that would necessarily be able to keep it, um, and not talk about it or not, uh. So confidentiality is an issue. Right. I think that my husband's family would be more confidential, because they hide a lot of things…My mom, I would say, would talk a lot about it with her friends, and try to be the victim herself…"
Sharing Similar Belief System "To support us from a biblical sense as well um, just kind of encouraging us to rely on prayer to get us through."	**Blaming the Spouse** "But um with [his] family, um a lot of blame probably would be put on me just because um they have issues with me, um, for whatever reason, it's not really even legit…my husband, is the um baby of the family and has been put on this pedestal and is kind of perfect, and just wonderful."
Reassurance "Just people saying we still love you guys…just reassuring us that there they're	

gonna be supportive if we need anything."	

Extended Family.

Table 14. The Most and Least Helpful Properties of Support from Extended Family

Most Helpful Properties	Least Helpful Properties
Allowing Her to Express Emotions "Just being able to release some of it. Not that I was looking for them to give me advice or help me in any way, just being able to express it."	**None cited for extended family specifically**.
Helping Maintain Normalcy "I looked to them for a lot of support as far as doing things, staying connected with them um, and just carrying on trying to be normal and do those normal things that you that you do."	
Prior Assurance of Support "They've always been, you know, 'Come to us with anything, we'll help you out.' So, I just knew that turning to them was the right thing."	

Friends.

Table 15. The Most and Least Helpful Properties of Support from Friends

Most Helpful Properties	Least Helpful Properties
Being Spiritual In Tune "She's very in tune and I think that's why it turned to her as I knew that I needed to be around people that were in tune."	**Getting Upset and Defensive** "You know she's gonna be like, 'I'm coming down, I'm gonna kick his butt'…like she's right on the defensive and she's gonna take care of it for me."
Understanding Both Sides of the Problem "She was very accepting of his issues and she also in the past was very sexually active…so she kind of understood both sides of the story. She could totally see how he could have gotten to that point. So she really understood both sides of the story, so that was really helpful."	**Promoting Separation and Divorce** "She and her husband were willing to help me pay for a lawyer to go ahead and just get a divorce, and just let him go, you know."
Realizing One's Not Alone "I felt a lot better about myself afterwards and just thinking oh, it really wasn't me and other people deal with this and you know and type of thing but it's not some isolated problem that just my husband	**Not Initiating Enough Contact** "I felt like they kind of dropped the ball over the summer, like people really weren't checking in with me."

had."	
Having Someone Else Know "It's just nice that they know what were facing you know."	
Being Angry for Her "This might sound strange, but some of the best things that helped me were just their anger with my husband. Because I don't think I could emotionally show the anger at that time."	

Spouse.

Table 16. The Most and Least Helpful Properties of Support from a Spouse

Most Helpful Properties	Least Helpful Properties
Offering a Sincere Apology "I think when he finally just gave an extremely sincere apology."	**Downplaying the Problem** "He seemed to be very nonchalant about it - I was devastated."
Helping Her to Understand Problem "You know just helping me understand exactly what's going on being as open and as honest…as he could."	**Not Being Committed to Recovery** "I couldn't quite understand why the hesitancy on his part to do a lot of the things that he needed to do to get himself some help…he'd do the counseling thing until it got tense or started hitting some sore spots, and then um, I guess at first I didn't realize it was an addiction. I should say that, and then gradually I began to realize this is an addiction."
Being a Part of His Therapy "We both found it was better for our relationship if I was there."	**Stonewalling** "Whenever I would bring it up, kind of like, you know, 'How are you doing?' He would just kind of shut me down didn't want to talk about it and a lot of avoidance and also a lot of deception just saying you know he was fine or nothing had happened,

	or whatever, like that, but just kind of knowing in my gut that something was wrong."
Discussing the Problem as a Couple "We've just been able to start discussing it but it helps, I think it helps a lot."	**Repeatedly Not Disclosing Problem** "…but then it's never, ever, ever been disclosed to me ever."
Encouraging Her to Connect with Supports "After awhile, he started to realize that I needed my own support."	**Lying** "I think that's the hardest part for me, is…I know [what] is true and being told that it is a lie. And so I start questioning everything in my life of what I do."
Telling Her When He is Tempted "He's talking to me before it happens, which is really, really good."	**Hiding** "Trying to hide it. He constantly tried to hide it."
Being Open and Living Above Suspicion "He never tried to hide anything and I know he probably knew I would look at certain things just even things that were small that was an issue with me for instance like the sunshine girl in the paper he knows that all goes back down to the same thing and um, I've never seen that around either any, anything that he knows I	**Not Supporting Her Treatment** "I told him what I was doing, um, and why I was doing it, and he doesn't like it that I come."

could be viewing."	
Getting Help "I think the most helpful thing is he is committed to recovery as well it doesn't mean he hasn't had setbacks um, that's been detrimental, but um, the setbacks haven't been to the scale of his previous acting out, um, I the most helpful thing is that he is taking care of himself in that he is going to a men's group he's going to couples group with me he's also in a church um, bible study called every man's battle."	
Disclosing Relapses "Anytime there was disclosure, or something happened, I was just very grateful to have been told that that was my only reaction, was gratefulness."	

Professional

Individual Therapy.

Table 17. The Most and Least Helpful Properties of Support from Individual Therapy

Most Helpful Properties	Least Helpful Properties
Being Given Reading Material "Yes, actually it was very helpful it was very helpful for me I think to read that with [husband]; maybe it was a validation to for me."	**Counseling to Leave Husband** "She just says leave your husband, or um... she doesn't help these women at all. I feel like she's condescending towards them to even be in that situation. Why are you even in this situation? Leave, get yourself out right now. And that's difficult especially when you want to try and make things better, stick it out, you want to, you hope there's ways to heal, move on and. So, it just bothers me that she's so forceful in her opinion..."
Being Able to Express Intense Emotions "Being able to get out my anger. Because when I met with the bishops I always felt like had to, you know, when I just wanted to throw something, you know, I was so mad, and actually being able to get that out."	

Couple Therapy.

Table 18. The Most and Least Helpful Properties of Support from Couple Therapy

Most Helpful Properties	Least Helpful Properties
Validating the Spouse "I didn't feel judged or odd or .... I felt validated in my feelings, and that was the biggest thing."	**Not Addressing the Issue** "I just felt like I did all the talking and he focused more on my past and what I've brought to the marriage and all my baggage and everything I'm feeling and every once in a while he would talk to [husband], but it was more about work and stress from work, and it wasn't an issue."
Specialized Support "Just to be able hear somebody openly talk about what the problem is. I think has hit both of us in the face, not only myself but my husband. It's always been just such a hush, hush thing." Researcher: "It sounds like one thing that was helpful was to have a professional that knew enough about this issue and could really zoom in on it." "Exactly, and, deal with it and to have a name for it, and a pattern for it, to know that you're not a freak."	**Lack of Knowledge about the Problem** "The least helpful are the counselors who have no clue about what it is, what this is about."

Group Therapy.

Table 19. The Most and Least Helpful Properties of Support from Group Therapy

Most Helpful Properties	Least Helpful Properties
Learning New Things "I think I have learned a lot. There hasn't been anything that I've just been bored with or thought was not beneficial."	**Psycho-Education Components Moving Too Quickly or Not Being Adjusted to the Needs of the Entire Group** "At first I didn't understand anything, and now that I'm learning more it's uh, kind of added on top of each other. So even if it's repeated then I actually, I feel like I actually understand those things and then I can move on to the other things I don't understand as much so."
Learning from Other Women in Similar Situations "I think what was the most helpful was hearing other women's stories and hearing you know their struggles and how they triumphed, or just how their working through it and being able to relate and take information from them also that I could take home and just in my own life try to put to practice to see if it would work to	**Covering Too Much Information Over a Short Period of Time** "Group therapy worked but we covered so many things so fast it was hard to really absorb everything. And I think if they could do it for a longer period of time and maybe work on each thing a little more in-depth."

help me or to even to help him, or to help us as a couple."	
Learning One is Not Alone "The only thing that's really helped is coming to group and hearing that I'm not alone…"	
Being Encouraged to Connect "The group always encouraged community and building relationships, and that has been very helpful to me. Um, I didn't quite understand it at first, um, it came very clear to me when he quit therapy, how important that community I'd built and the relationships I had built um were to me."	

Medical Support.

Table 20. The Most and Least Helpful Properties of Support from Medical Supports

Most Helpful Properties	Least Helpful Properties
Having a Relationship to Other Supports "We went to our family doctor because our stake president is a doctor and he was friends with him…"	**Downplaying the Concerns** "So, we're in the doctor's office… and he [the doctor] says 'What's going on?' So, I came out and told him and he said, 'Oh you guys can work this out, look at this lovely man, he's willing to be here and listen to the concerns and he is willing to work this out.'
Being Compassionate with Someone in Crisis "I went in the next day and that was probably the most humiliating experience of calling the doctor's office and this receptionist was just really impatient and I was just a basket case, and started to cry, and she said, you know, why don't I just have the nurse practitioner call you and she can like help you figure out who you need to be seen by. Um, and she called me back probably within the next 15 minutes and I	

said I don't know what I need to be seen for exactly, I just know that I have this sore, and my husband, just found out has been unfaithful, has cheated on me, um, and she was like, well, we'll just get you in, you know she was great."	
A Feeling of Trust "I felt like I could trust her and talk to her about it, and that was very helpful…"	
Straightforward Yet Empathetic and Caring "She was very straightforward, and yet very caring and very sorry for what I was going through and stuff."	
Including Patient in Decisions "The support I got from the nurse practitioner was great. You know, she asked, 'what exactly do you want me to test you for?'	

Spiritual

While the majority of the sample (16/22 or 72.73%) cited clergy as a helpful source of support, it is important to note that 8 out of 22 participants (36.36%) cited

clergy as unhelpful, and in some cases even said that an ecclesiastical leader had made matters worse. Furthermore, as Table 21 outlines, it is worth mentioning that the properties of unhelpful clergy support outnumber the properties for helpful support. There are important training implications for clergy based on this sample's experience of ecclesiastical support.

Table 21. The Most and Least Helpful Properties of Support from Clergy

Most Helpful Properties	Least Helpful Properties
Knowing One's Ecclesiastical Leader Knew about the Problem "It was helpful to have him know what was going on in my life."	**Giving Inappropriate or Harmful Advice** "I remember not saying much but that I wanted to leave [separate from husband] and it would just infuriate him [Bishop] and he would throw the book at me. Had I listened to that bishop I would have lost custody of my children to the state of California and they would have gone to foster homes."
Initiating Contact "I don't know what I would have done without his phone calls saying how are you doing; he was the only one doing that."	**Downplaying or Minimizing** "This has been over ten years - this is obviously a problem…So, it I do believe it was minimized and downplayed." "I did not feel personally like it was being handled well. I thought it was being, you

	know, 'It's okay son, try harder, and you'll do better' and I call it a slap on the wrist. You know, it just was never taken very seriously for many years…"
Being Available "Whenever there was a problem, you can pick up the phone and call anytime day or night. And they were there to listen to pray with you, to keep encouraging you."	**Not Being Directive Enough** "I just think all this time (the husband) was just not being given a guide. Like, "maybe you should see a counselor," or "maybe you should do this," but "no, this is what you need to do and this is what you need to do." Researcher: "So it would have been helpful for them to be a little bit more directive?" "Yeah. And very specific about what helps to gather, where to go."
Seeking Out Wife's Experience of Husband's Recovery "The bishop was about to give him his temple recommend and he asked me first if I felt okay with that, which I though was really nice. He was like, "I don't want to be giving him a temple recommend and you being angry at me thinking that it's too soon or that he's not treating you well."	**Avoiding the Issue Despite Knowledge** "I kept thinking why isn't he going to ask me how are you doing, how are things at home, how is your husband? Nothing. I mean he would give me a recommend interview and it's good to see you sister, you know and off I'd went and I'd so I'd be just dying 'cause he was the only one that knew um, the only person that has any

	knowledge of it um, up until just recently and so you know I'm just dying for an outlet or at least some advice, or just some council…"
Normalizing Her Feelings "Just the support that they gave me, letting me know that I wasn't crazy for being upset by it, then that mad it a little bit easier."	**Procrastinating Action** "He debated for three months over what church action to take, and my husband was one of his counselors in the bishopric and it really should have been a stake matter because of that and it wasn't; his biggest concern was confidentiality and he didn't want to convene a court, but he knew he was supposed to, but didn't want to do that because he was so afraid of the confidentiality thing. And um, so for three months he deliberated about this."
Taking the Problem Seriously "One bishop in particular, took it very seriously and said "You have a very serious problem and you need to get help," and I was like, "Thank you! Finally."	**Basing Advice on One's Own Recovery Process** "He had suffered or dealt with a drug addiction himself and so he was coming at this, you know, looking at this from his experience with narcotics anonymous and all that you know, and had said several

	times kind of like if I would just leave him that that would just shape him up you know, leave to show that I'm serious you know, like pack up things up and go cause that's what finally kicked in for him was that his wife had you know packed the kids up and went to her mother's you know and he had to beg her to come back."
Understanding Needs of Divorced Women "A Bishop in the ward I'm in now has been just very helpful…he's dealt with this type of thing and had so many people in his ward that have been divorced that he, he really knew without me saying. Cause I think I feel pretty o.k. but he'll, he knew what to say to reinforce you know." Researcher: "Can you share with me some of those things?" "Oh, ya he would just talk about, ya know just because your husband had this problem doesn't mean that you're not any less of a person. You know that you are not beautiful. Or that your not you	**Clergy Suffered from the Same Problem** "He had the same look but he was a wonderful man, and so I thought I'm not seeing my own husband, but like I was so confused I would pray…and then what ended up happening is my bishop was released after five years and we found out that he was having affairs with women in the ward and my stake president came to me right away because he wondered if I was one of these [women]."

know, that you can never have a happy marriage again, or you know he just um, I think with the experience that he's had with so much of that that he knew kind of what type of things I might need to hear to help me, so that was really helpful."	
Helping Her Connect with Professional Help "This Bishop has actually been very helpful in helping us find um… a counselor."	**Over-spiritualizing the Problem Despite Serious Symptoms (e.g., marital rape)** "He said but if you two pray about it, we'll work it out and you'll be okay." Researcher: "So there was no referral or direction for professional help." "No."
Being Compassionate "I felt like they've [Bishops] been compassionate towards me and what I'm dealing with."	**Clergy Uncomfortable with Issue** "It was almost like he was more embarrassed because he didn't know how to deal with it… He just didn't know what to do."
Willing to Research the Problem if He/She Didn't Know Enough "He went to the public library and researched it and came up with a research paper that someone had written on the	**Making Matters Worse** "One of the pastors that I tried to talk to tended to be more on the suspicious side and he said, 'You know, I've never said this to anyone before, but I think you might

subject."	want to hire a private detective, find out what he's doing.'…Well, it made me more suspicious, actually. It made me feel worse instead of instead of trying to help me cope with what I had found out… "
Being Believed "I was believed right off the front. I was believed and part of that I think, I think was I was always honest with my bishop, I didn't hide anything from him…So when I came to him and said my husbands into porn big time, hard core, it's disgusting, he totally believed me…I think you've got to believe what the women are saying and even if the women is blowing it out of proportion um, she has to be believed or I think you lose credibility, I think you lose the ability to work through things, and it's bothering her, I mean it's upsetting to her."	**Being Judgmental** "At one point I needed to just get out of there, and I took the kids and I went to visit a friend, and stopped at a community that we had lived in on the way…and I saw our pastor there, our old pastor, and somehow we got into the discussion. You know, he wanted to know what we were doing there, and so I told him. And he scolded me and told me that I needed to go back home, because that that was my place…"
Loving Versus Shaming "There was no shame, no shame whatsoever, but just this embracing um, love and compassion."	**Not Informed About the Issue** "The most unhelpful thing I need to say was our church…just not informed about the issue, and so in not being informed,

	[clergy] give some advice that in some ways in my opinion is harmful and not safe…"
Being Honest About What He/She Can and Can't Do for Support "Like he could be there and listen to us, but as for therapy or something long term, this was not something where he felt…and then within a week we were meeting with [a therapist], and um then my husband started one of his groups right away."	**Not Understanding the Problem** "I had a bishop that didn't appreciate the magnitude, just didn't get it"
Being Included in Meetings with the Husband "I've been in most of the meetings."	**Being Silenced** "I was, by the way, sworn to secrecy and told not to talk to anyone so I couldn't talk to my parents, I couldn't …" Researcher: "Who swore you to secrecy?" "My stake president."
	Overlooking Spouse's Needs "It had been at least five years since I had known about all of this and I went to him and I said I have a problem. And we talked about it and he was aware of it - my ex-

	husband had gone to see him." Researcher: "So the bishop knew what was going on in the marriage but had never brought you in to talk to you?" "No…it had been a confidential issue between them."

While we must be cautious to not over generalize the above-mentioned properties to other populations, this aspect of the study provides a useful foundation for future investigations of supports. It is important to note that in most cases the properties do not represent the views of the entire sample but rather a complete tally of the properties cited by participants.

CHAPTER V: DISCUSSION

The purpose of this study was to identify the kinds of support women find most beneficial when dealing with a spouse's sexually addictive and compulsive behaviors. After carefully reviewing the results of this qualitative study, it was determined that the research questions for this study were answered and the hypotheses validated. As well, a grounded theory of support was identified as women's responses to problematic sexual behavior were analyzed and moderating factors for different pathways of support were considered. Additionally, common factors of support were identified for this population (connection, advocacy, validation, education and direction, or "CAVED"), and this was viewed as one of the most beneficial findings in terms of real-life application. The following section examines the answers to the research questions and hypotheses, summarizes the theory of support, identifies the common factors of support, and outlines the implications for clinicians and future research based on these results.

The first research question for this study was "Which supports do women find most beneficial when dealing with a spouse's sexual addiction or compulsivities?" In response to this question, it was found that all of the participants turned to coping supports while they readied themselves for change and/or decided which supports were available and desired. The most common coping support was Isolation. This finding further supports Matheny's (1998) research and observation that these women tend to experience loneliness and isolation. Some women experienced moderating factors such as a medical emergency that expedited the process of connecting with change-oriented supports (e.g., family physician or hospital). More commonly, however, change-oriented supports were implemented after coping supports had been employed for a period of time

ranging from days to years, and five types of change-oriented supports were used by this population of women. These five categories of change-oriented supports included: (a) Recreational, (b) Relational, (c) Professional, (d) Spiritual, and (e) Conceptual supports. If one were to create a concise profile of the preferred supports from this sample, the data would suggest the following key findings: (a) reading is the most popular Recreational support with 77.27% of the sample citing it as helpful; (b) immediate family members are the most popular source of Relational support with 68.18% of the sample citing parents or siblings as helpful; (c) a combination of therapies is the most common use of Professional supports with 95.45% of the sample citing more than one type of therapy as useful and 45.45% of the sample citing group therapy as the most helpful therapeutic format (a contrary finding to research conducted by Alvidrez and Azocar (1999) and Glover, Novakovic and Hunter (2003) that found women prefer individual therapy over group therapy); (d) Medical supports were used by 31.82% of the women were less utilized than therapeutic interventions in the Professional supports category; (e) 72.73% of the women cited turning to clergy as the most common Spiritual support, and (f) 81.82% of the women cited a Conceptual support as beneficial to them. It is suspected that one reason reading was the most popular support for this population was that it was a safe way to become educated about this issue and involved minimal disruption to one's life and social network. Future research would need to explore outcomes of specific supports more closely in order to expand the current understanding and theory of support for this population.

Taking a more meta-perspective of the data, it was determined that five common factors of support are fundamental to this population having a positive and satisfying

experience with supports. These five common factors were identified as: (a) Connection, (b) an Advocate, (c) Validation, (d) Education and (e) Direction. While all five common factors may not be present in each support sought, it is hypothesized that for a support to be experienced as helpful it would need to include at least one or a combination of these five factors. As mentioned previously, this idea needs to be tested in future research. Meanwhile, the CAVED commonalities provide a valuable framework for clinicians who treat affected women prior to conclusive answers being available.

The second research question was "How can women's experiences and preferences with support inform therapeutic approaches with individuals and couples who are impacted by sexual addictions and compulsivities?" Part of the analysis for this study involved developing a grounded theory of support. This theory, as summarized and illustrated using the modified paradigm model (see page 93), provides clinicians and other types of support networks an understanding of the pathway of support this population typically utilizes, as well as the common factors associated with satisfying support experiences and the moderating factors that can affect individual pathways of support. By being exposed to and understanding this theory of support, support networks will hopefully take into consideration and assess moderating factors such as available resources, level of functioning, or religious beliefs when assisting an affected spouse. The data regarding the sample's preferences of support also provides valuable information to support networks who are committed to making informed recommendations to women in similar situations or who need to prioritize supports in situations where limits in time, money or resources are a reality. Moreover, the helpful

and least helpful properties for each type of support can further assist support networks in being as helpful as possible.

It was hypothesized that women of varying levels of adaptability and well-being would seek out and prefer different supports. As stated earlier, this hypothesis was generated from the researcher's study of the concept of differentiation (Bowen, 1978), as well as clinical observations. The DSI-R measure (see Appendix A), along with other demographic data helped test this hypothesis against this sample. One of the most interesting findings from this study was that women with low to moderate DSI-R scores were the ones that experienced increased symptomology and represented 100% of the women who were hospitalized or treated by medical professionals. What this suggests is that the DSI-R was a valid and reliable measure in identifying women who had problematic emotional reactivity, poor adaptability under stress, were easily being affected by others' emotional reactivity, and had increased psychological and physical symptoms (Skowron & Friedlander, 1998). This finding supports the concept of differentiation of self as an important clinical construct for this population. As stated in Appendix F:

> Low levels of differentiation are associated with problematic emotional reactivity, poor adaptability under stress, easily being affected by others' emotional reactivity, and increased psychological and physical symptoms (e.g., anxiety, somatization, depression, alcoholism and psychoticism) (Skowron & Friedlander, 1998).

The symptomology that is evident in the women with lower and moderate scores highlights the reliability of the DSI-R measure in helping clinicians identify clients who

may need interdisciplinary approaches to care, as well as close monitoring.

The women with low or moderate DSI-R scores were also more likely to be highly suggestible and prone to be "ideological chameleons" in order to gain acceptance from others and to avoid or reduce conflict or societal pressure (Kerr & Bowen, 1998). An example of this comes from a woman who stated she started drinking alcohol and going to bars to be with her husband despite her dislike of bars and history of never-drinking. Women with lower DSI-R scores also confirmed the hypothesized trait of having difficulty setting boundaries with others. This was exemplified by the women who described participating in unsafe sexual practices or pornographic consumption with their spouse in an attempt to please their partner at the expense of their own safety, health, desires or comfort level.

Moderate DSI-R scores, on the other hand, were associated with separation and divorce seeing as none of the women with low or high scores cited leaving a husband due to problematic sexual behavior, whereas four women with moderate scores did (a total of seven women were divorced, but not all of these divorces were directly related to problematic sexual behavior).

Upon closer examination of those who did divorce their husband as a response to problematic sexual behavior, we learn that those who divorced had the highest "I" Position sub-scale scores on the DSI-R, thereby suggesting that women who have a strong sense of self are more likely to divorce than those who have less ability to define themselves as individuals in relation to their spouse. It is not yet understood why women with the highest overall scores did not separate or divorce their spouses, but it could be hypothesized that this group of women were less likely to emotionally cut-off when

anxiety in a relationship got intense, more likely to give their spouse an ultimatum that was a catalyst for him seeking help, or were more likely to engage coping strategies and supports that buffered them and their marital relationship from dissolution.

Additionally, the hypothesis that women who discovered the problem as opposed to having it disclosed to them would have different pathways of support was supported, although not as readily apparent as anticipated. For example, it was hypothesized that the disclosed and discovered groups would be very distinct and different from one another, but within this particular sample, these two groups of women appeared more similar than different. It needs to be acknowledged, however, that rigorous statistical analysis may yet reveal such distinctions in the data and that the qualitative methodology was not well-suited to examining. The distinction that is readily available, however, between women who discovered versus had it disclosed, shows that women who had problematic sexual behavior disclosed to them were more likely to turn to their spouse as a source of support and cite him as a helpful support than women who discovered the problem. This difference suggests that women who discover the problem, as opposed to having had the problem disclosed to them utilize a different relational pathway of support and find less support in their most significant relationship. The reason this is significant is that the marital relationship is the most significant (albeit not always the most helpful) relationship in these women's lives and a woman's experience of this primary relationship will have a major impact on the longevity of the marriage or quality of the marital relationship, and consequently family life, should it stay intact. It is also possible that women find their spouses more helpful when the problem has been disclosed versus discovered because husbands who disclose are typically more ready for help and open to

working with their spouse to overcome this issue. Additionally, it is also possible that husbands who disclose problematic sexual behavior had better relationships with their wives in the first place, thereby facilitating a difficult disclosure and healing process.

The theory of support that emerged from this data set indicates that responding to problematic sexual behavior in a marriage can take multiple pathways and is moderated by various characteristics of intrapersonal functioning, access to supports and the type of revelation about the problem. While two main categories of support emerged (coping supports and change-oriented supports) these were further divided according to the level of risk or adaptability associated with a particular support and how helpful or unhelpful a support was perceived to be. The double-ended arrows that were situated between categories of support were intended to communicate the circular, fluid nature of employing supports and the fact that no linear, stepwise pathway of support could be determined at this time. In some cases, experiencing a risky or unhelpful support was the catalyst for seeking a more adaptive, helpful one, and in some cases, when a chosen support turned out to be unhelpful; some women turned to less constructive supports as a way to cope with their discouragement, frustration or heightened sense of isolation in the face of this problem. One of the challenges in identifying a theory of support was that in the majority of cases, a blend of various supports were used simultaneously and the pathway to and through supports was constantly changing and represented new territory for those seeking help. The group of women who participated in this study are indeed pioneering and carving out the pathway of support for future generations of adults who encounter this issue in their marriage. Future research and larger samples of women (and men) will hopefully refine and add to this initial theory of support.

Implications for Clinical Practice

Implied in the second research question was the hope that this study would inform clinical practice with this population of women, couples and families. Ten clinical implications emerged from the results.

First, women who are high-functioning and well supported in other areas of life may still be at risk for isolation, delayed help-seeking behavior and/or prolonged psychological struggle due to the nature of problematic sexual behavior and the relative infancy of public awareness and clinical approaches regarding it. Consequently, clinicians need to carefully assess a woman's support system prior to the disclosure or discovery of problematic sexual behavior and determine to what degree this network has been recruited since the revelation of the problem.

Second, results from the study validate the use of the DSI-R as a useful measure for detecting increased risk of physical symptomology, including suicidality. Because results identified low DSI-R scores as being associated with physical symptoms and the use of medical supports, clinicians would do well to monitor clients with low DSI-R scores carefully and regularly, and to work closely with a client's medical care provider.

Third, DSI-R scores may also be used to assess the risk for separation and divorce. The results of this study reveal an association between high "I" Position subscale scores on the DSI-R and divorce. Clinicians who are working with individuals who have high "I" Position scores may wish to initiate couple therapy early on in treatment and/or address the couple relationship in individual therapy if contraindications exist for direct couple work.

Fourth, because reading was the most common Recreational Support used amongst this sample, clinicians may enhance the effectiveness of this type of support by offering recommended reading lists and helping clients access books that may not be readily available or known in the general public.

Fifth, based on this sample's experience with therapeutic supports, clinicians working with individuals, couples or families affected by problematic sexual behavior would do well to incorporate the following components or properties into their work: (a) offering reading material, (b) creating a safe environment wherein intense emotions may be expressed, (c) validating the affected spouse's experience, especially in couple therapy, and (d) seeking out specialized clinical training on this issue.

Sixth, the most popular format for therapeutic support for this sample was group therapy. Despite research findings that indicate women prefer individual therapy over group therapy (Alvidrez & Azocar, 1999; Glover, Novakovic & Hunter, 2003), this sample appears to lean towards group therapy. Consequently, clinicians would do well to consider how this type of therapy could be realized for affected women in their respective locales. The women reported preferring this format because it allowed them to learn new things about problematic sexual behavior and learn from other women in similar situations, as well as feel that they were not alone and receive encouragement to connect with others in and out of therapy.

Seventh, the grounded theory of support identified in this study revealed that all of the women turned to a range of coping-supports prior to accessing therapy. Due to the risky nature of some of the coping supports used (i.e., drinking, suicidality, and weight loss), it would be important for clinicians to assess what a client has done to maintain

equilibrium in her life prior to coming to therapy, as well as identify any symptoms or problems associated with the use of coping supports. Additionally, because women can move back and forth between coping supports and change-oriented supports or use diverse supports simultaneously, it is wise to assess the effectiveness of supports and the client's satisfaction with these in order to proactively address frustration or unhelpful supports that could aggravate distress and put her/him at risk for turning to risky coping supports.

Eighth, the grounded theory of support also identified a series of factors that influence a woman's pathway of support. As a result, clinicians should assess factors associated with intrapersonal functioning and access to supports that may hinder consistent and thorough care.

Ninth, because the majority of this sample used Spiritual supports, and specifically clergy, to manage this problem, clinicians should assess how this aspect of support is being used and experienced by affected clients. Also, because many women have negative experiences with their ecclesiastical leaders or faith communities as they respond to problematic sexual behavior in their marriage, consulting with clergy and/or offering training to clergy new to this issue will strengthen the woman's treatment plan and support network.

And lastly, the five common factors of support identified in this study (CAVED) are useful for clinicians to be mindful of when assessing and working with women responding to problematic sexual behavior in their marriage. For example, it would be important to ensure a combination, if not all, of these common factors are realized in the support network associated with treatment.

Implications for Ecclesiastical Leaders

While informing clinical practice was a primary goal of this study, many important implications for ecclesiastical leaders also arose from the data. Although religious affiliation was not a criterion for inclusion in the study, all of the women interviewed were actively involved in a faith community. As the analysis unfolded, it came to light how significant ecclesiastical leaders were to this sample's support network. The following implications were extracted from the findings.

First, it is important that ecclesiastical leaders take problematic sexual behavior seriously and in no way downplay or minimize its potential effect on individuals, marriages or families. Many ecclesiastical leaders are unaware of how addictive Internet pornography can be and therefore unwittingly help perpetuate a destructive cycle due to ignorance. Considering the fact that most ecclesiastical leaders are middle-aged or approaching middle-age, it is understandable that many are not familiar with Internet pornography as a distinct genre of sexually explicit material because this genre did not exist when they were young men or young married men. Many wives in this study, however, referred to how relieved they were when they found a pastor, minister, priest or bishop who understood the seriousness of online sexual behavior and insisted that professional help be sought immediately.

Second, while it is common for support networks to focus on the pornography user or individual who is sexually acting out, the needs of the spouse can be great and at times, even life threatening. Consequently, it is important that ecclesiastical leaders not overlook the needs of spouses when a problematic sexual behavior is disclosed. Additionally, it is imperative that clergy ensure the spouse's physical, emotional and

spiritual safety is not being jeopardized within the marital relationship. As well, it is beneficial to include the spouse in some of the meetings between husband and the ecclesiastical leader; this type of inclusion helps the husband breakdown the secrecy that has fueled the problem and to be accountable to the primary person he has hurt through his actions. Additionally, the wife's needs can be highlighted and addressed during combined meetings and this can help the husband connect with his wife's experience of the problem and the ways he will need to support her during this taxing time.

Third, because most women are devastated by the discovery or disclosure of this problem and consequently blame and isolate themselves, it can be difficult for these women to initiate contact with an authorative male figure. Many women said they feared they would not be believed or would be blamed for the problem, thereby reinforcing their own erroneous views about themselves and the problem. As a result of these dynamics and fears, if clergy become aware of this type of problem in a marriage, it is beneficial for clergy to initiate contact with the affected spouse to ensure her safety, to validate her experience and to help connect her with resources as needed.

Fourth, because many clergy do not have professional training in a mental health field or sexual addictions specifically, it is critical clergy clearly define the scope of what they can and cannot do with regards to this problem and be prepared to refer congregational members to mental health or medical professionals. Many women in this study said how grateful they were for an ecclesiastical leader's referral to a professional source of help. Others who did not receive referrals said how much they desired that kind of direction and support from their ecclesiastical leader because they were at a loss as to where to turn.

It is important to acknowledge that the majority of the ecclesiastical leaders referenced in this study were LDS (Mormon) Bishops and Stake Presidents due to the demographics of the sample. While many LDS women reported having had positive experiences with their ecclesiastical leader, the majority of the women who had had very negative experiences with clergy in this sample were LDS. Unfortunately, even the LDS women who reported positive experiences with ecclesiastical leaders had gone through one or more negative experiences before finding a Bishop who was helpful. When compared to women of other faiths, the LDS women stood out as a population that need more qualified support than is currently available to them. One reason this may be the case is that the LDS faith comprises a lay clergy who work in a variety of careers during the week and have their own marriage and family. Unlike faiths who have professional clergy who are commonly trained as counsellors and well connected to community resources, LDS clergy are not professionally trained to be counsellors nor trained to be a community resource for its membership. As a result, LDS women have a greater chance of encountering an ecclesiastical leader who is not well equipped to neither deal directly with a sexual addiction nor make an appropriate referral to someone who could.

Implications for Women in Affected Marriages

Aside from helping clinicians who encounter problematic sexual behavior in their practices, this study was also intended to help women affected by this issue. This study highlighted five common factors of support that were helpful for this study's sample and are believed to be helpful for this population at large.

The common factors of support (CAVED) are understood to be key factors in effective support for affected women. Connection, advocacy, validation, education and

direction are also factors that can be readily applied to various personal, marital and familial situations, socio-economic statuses and can unfold according to someone's preferences, symptoms or needs. Those who are in a position to offer support or be privy to this issue in a woman's life can also assist in ensuring these common factors are activated in her life. It is hypothesized that these common factors, if activated, would improve a woman's prognosis and possibly the prognosis of the marriage as well. This hypothesis, however, requires further testing and review.

Additionally, this study revealed several types of coping supports and categories of change-oriented supports that were utilized by affected women. A combination of coping and change-oriented supports worked for the women in this study, thereby complicating the process of identifying one effective pathway of support. Sharing the types and combinations of supports, however, that the women in this study found helpful may inspire other affected women to utilize untapped resources or recruit resources into their lives. Support networks may want to inquire about (a) Recreational, (b) Relational, (c) Professional, (d) Spiritual, and (e) Conceptual supports the women have access to or have already activated, in order to assess the breadth of support being used and areas that may need improvement. Sharing examples of healthy coping supports and their associated helpful properties may also inspire affected women who are in crisis and not currently able to think creatively or brainstorm productively due to the degree of hurt and upheaval they are experiencing.

Implications for Future Research

As with any research, the parameters that make a study effective also limit its ability to address a broad range of useful topics. This study served to address a void in

the research literature regarding supports women find most helpful when responding to problematic sexual behavior, but at the same time, there are many questions that still need to be answered or elaborated on. There are seven main implications for future research that arise from this study.

First, this study provides a conceptual and methodological foundation for future studies with (a) larger sample sizes, (b) different demographic profiles, and (b) quantitative methodologies that can examine similar research questions and hypotheses.

Second, because this study focused on the support seeking and utilization phase of healing, it would be important that future research address the consequences and outcomes of certain supports. By determining which supports are associated with positive outcomes for individuals, couples and families, clinicians would be able to guide treatment plans and recommendations for support more effectively. It is also possible that some of the preferred supports do not parallel positive outcomes in terms of individual, marital and familial functioning, thereby raising other research questions about how to reconcile discrepancies.

Third, incorporating the husband's experience of his wife's support pathway would be an important addition to a systemically minded approach to problematic sexual behavior in the future. The current study only examined the spouse's experience of support and while this perspective is a vital component, the husband's perspective would enhance the context of results.

Fourth, additional research is needed to determine why some women wait years before accessing help and others take only a matter of days. Also, it is unclear at this

point in time why some women turn to risky or unhealthy coping supports while others are highly adaptive in their support pathway selection.

Fifth, it will be important to compare the helpful and unhelpful properties of the various supports against larger samples and develop consensus around what is most and least helpful about specific supports.

Sixth, it will be useful to situate the results of this study in the larger body of research findings related to trauma and general social supports in light of the devastating impact sexual addictions has on a spouse and the need for support that ensues. Research within the fields of social psychology, clinical psychology or social work, for example, would lend themselves particularly well to summarizing the trauma and general social support literature and making connections and comparisons between trauma and general social support findings and this qualitative study.

And lastly, testing of the CAVED common factors is needed to determine if these do in fact improve a woman's experience of support and her prognosis. Testing these common factors with a larger sample size is recommended.

CHAPTER VI: LIMITATIONS

In this study, nine limitations were identified. First, the sample was derived from professional contacts, so the women were already connected to some form of therapy, thereby biasing their view of supports generally and likely weighting the role of therapy in their support process. Also, because many of the women were actively involved in group therapy at the time of the study, this may have biased the emphasis and preference placed on this type of therapy. This possible bias in preference was not deemed significant, however, because all of the women had had experience with various forms of professional supports prior to being interviewed and were free to state other preferences if they existed.

Second, although religious involvement was not a criterion for inclusion in the study, all of the women were actively involved in a faith community and the majority (15/22) was LDS (Mormon). Future research would do well to include women who are atheist or agnostic, women who represent non-Christian faiths (e.g., Jewish, Muslim or Sikh), and more Christian women who are not LDS.

Third, not all of the women had equal access to the same kinds of supports in order to be able to fairly comment on the full range. For example, the women in Canada did not have access to group therapy specifically designed for spouses of men who struggle with sexual addictions, and yet this was a form of support regularly cited as the most helpful by women in Utah and Minnesota.

Fourth, hypotheses regarding a correlation between this population and Bowenian concepts of differentiation were imposed on the study, albeit in an educated manner.

This hypothesis and lens, however, did violate the 'pure' qualitative premise of being completely open and unbiased.

Fifth, because the participants were not cued about specific types of supports in the paperwork or interview, it is possible the participants would have identified other supports they used and even preferred had they been allowed to refer to a listing of supports. For example, only eight women mentioned crying; however, it is suspected that the majority would have cried during this highly emotional and stressful time, but that the participants may not have considered that to be a coping support, but rather a response. Being a qualitative study, however, the researcher was careful to not impose a structure or pathway of supports onto participants and respect the participants' own narratives regarding support.

Sixth, the researcher neglected to ask enough follow-up questions to determine the properties of Recreational and Conceptual supports, thereby limited what can be said about why certain supports in those two categories were perceived as helpful or not.

Seventh, the researcher and all but one of coders were women which may give more credence to women's views and therefore bias in the study.

Eighth, coping supports and change-oriented supports were the major focus on the study while other concepts such as emotional experiences and attachment related constructs were left unexplored. This limitation is particularly important because emotional experiences and relational attachment may have shed light on the findings as much or more than differentiation of self.

And lastly, women were not asked specifically about common factors in their desired or positive support experiences, but rather this information was deductively

arrived at by carefully analyzing the common traits of preferred supports and desired support experiences.

CHAPTER VII: CONCLUSION

Women are directly impacted by a spouse's problematic sexual behavior. As a result, women in affected marriages may have diverse needs that require a variety of supports, including coping supports, and change-oriented supports such as Recreational, Relational, Professional, Spiritual and Conceptual. Responding to problematic sexual behavior is also moderated by numerous internal and external factors which can make pathways to support appear both vastly different and strikingly similar to one another. Differences in the types of supports used and preferred are not only determined by personal tastes, but also factors such as financial resources, availability of qualified resources where one lives, awareness of available supports, intrapersonal functioning, history of abuse, personal or religious beliefs and differentiation of self. Similarities in support-seeking and support preferences are moderated by commonalities in emotional, spiritual and physical reactions and the cultural and clinical milieu in which these women live – all of them live in an era where addressing problematic sexual behavior is in its infancy and there is a void of research pertaining to spouses who are impacted directly.

This study also identified five common factors that were fundamental to positive support experiences and increased well-being across the sample. These five common factors were: (a) Connection, (b) an Advocate, (c) Validation, (d) Education, and (e) Direction. These five common factors were organized into the acronym CAVED for easy recall and integration into treatment plans.

This study did not succeed in identifying distinct pathways of support for women who discover this problem versus have it disclosed to them. Additionally, specific treatment models or programs were not identified as being especially helpful to this

population and this was understood to be a reflection of the infancy of the field of sexual addictions. It is hoped that future research will be able to delineate and test specific treatment pathways and that larger samples will be able to demonstrate the differences between women who discover problematic sexual behavior versus have it disclosed to them.

The results of this study provide a useful template for clinicians, support networks and researchers to begin understanding what is helpful and unhelpful when working with this population. Reading, immediate family, husbands who disclose this problem to their spouse, specialized therapists, group therapy, informed clergy and conceptual ideas that heighten understanding or resiliency are considered key components of effectively supporting women responding to problematic sexual behavior at this time. Moreover, ensuring that connection, advocacy, validation, education and direction are incorporated into treatment plans and support networks is understood to be essential ingredients in successful support of women responding to problematic sexual behavior in their marriage. It is anticipated that future research will refine and elaborate on these findings and by so doing will help a population of women and their families heal from the effects of problematic sexual behavior.

REFERENCES

Alvidrez, J., & Azocar, Francisca. (1999). Distressed Women's Clinic Patients: Preferences for mental health treatments and perceived obstacles. *General Hospital Psychiatry,* 21(5), 340-347.

Ashton, W. A., & Fuehrer, A. (1983). Effects of gender and gender role identification of participant and type of social support resource on support seeking. *Sex Roles,* 28, 461-476.

Barbee, A. P., Gulley, M. R., & Cunningham, M. R. (1990). Support Seeking in Personal Relationships. *Journal of Social and Personal Relationships,* 7(4), 531-540.

Bowen, M. (1978). *Family Therapy in Clinical Practice*. New York: Jason Aronson.

Burleson, B. R. (1984). The Development of Comforting Communication Skills in Childhood and Adolescence. *Child Development,* 53, 1578-1588.

Burleson, B. R., Kunkel, A. W., Samter, W., & Werking, K. J. (1996). Men's and Women's Evaluations of Communication Skills in Personal Relationships: When sex differences make a difference – and when they don't. *Journal of Social and Personal Relationships*, 13, 201-224.

Carnes, P. J. (1983). *Out of the Shadows*. Minneapolis, MN: CompCare Publishers.

Carnes, P. J. (1991). *Don't Call it Love*. New York, NY: Bantam Books.

Centers for Disease Control and Prevention. (2005). Retrieved July 5, 2005 from http://www.cdc.gov/diabetes/pubs/estimates.htm#methods & News release dated June 13, 2005 from 2005 National HIV Prevention Conference, Atlanta, GA, accessed through CDC Media Information Line 1-866-584-5030.

Cobb, N. P. G. (2001). *A Grounded Theory of Change for Married Couples in Chronic Conflict from the Couples' Perspective*. Unpublished doctoral dissertation, Brigham Young University, Utah.

Cooper, A. (1998). Sexuality and the Internet: Surfing into the new millennium. *CyberPsychology & Behavior*, 1(2), 181-187.

Cooper, A. (2004). Online Sexual Activity in the New Millennium. *Contemporary Sexuality, 38(3),* pp. i-vii.

Cooper, A., Boies, S., Maheu, M., & Greenfield, D. (1999). Sexuality and the internet: The next sexual revolution. In F. Muscarella & L. Szuchman (Eds.), *The psychological science of sexuality: A research based approach* (pp. 519-545). New York: Wiley.

Cooper, A., Delmonico, D. L., & Burg, R. (2000). Cybersex users, abusers, and compulsives: New findings and implications. *Sexual Addictions & Compulsivities*, 7, 5-29.

Cooper, A. & Griffin-Shelley, E. (2002). A Quick Tour of Online Sexuality: Part 1. *American Psychotherapy*, November/December, 11-13.

Cooper, A., Mcloughlin, I. P, & Campbell, K. M. (2000). Sexuality in Cyberspace: Update for the 21st Century. CyberPsychology & Behavior, 3(4), 521-536.

Cooper, A., Scherer, C., Boies, S. C., & Gordon, B. (1999). Sexuality on the Internet: From sexual exploration to pathological expression. *Professional Psychology: Research and Practice,* 6(2), 23-35.

Corley, M. D., Schneider, J. P., & Irons, R. (1998). *Disclosure: A cornerstone for healing.* Paper presented at the meeting of the National Council on Sexual Addiction and Compulsivity.

Crawford, P., Hueppelsheuer, M., & George, D. (1996). Spouses of incest offenders: Coaddictive tendencies and dysfunctional etiologies. *Sexual Addiction and Compulsivity,* 3, 289-312.

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage Publications.

Delmonico, D. L., Bubenzer, D. L., & West, J. D. (1998). Assessing Sexual Addiction with the Sexual Dependency Inventory – Revised. *Sexual Addiction & Compulsivity*, 5, 179-187.

Delmonico, D. L., & Carnes, P. J. (1999). Virtual Sex Addiction: When cybersex becomes the drug of choice. *CyberPsychology & Behavior*, 2(5), 457-463.

Delmonico, D. L., Griffin, E. J., & Moriarty, J. (2001). *Cybersex Unhooked: A workbook for breaking free from compulsive online sexual behavior*. Center City: MN: Hazelden Educational Press.

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.

Doss, B. D., Atkins, D. C., & Christensen, A. (2003). Who's dragging their feet? Husbands and wives seeking marital therapy. *Journal of Marital & Family Therapy*, 29(2), 165-177.

Engel, M. (2001). Alexa Research Finds 'Sex' Popular on the Web. *Business Wire,* February 14, 2001. Retrieved May 18, 2004, from http://home.businesswire.com & http://www.alexaresearch.com/rd/rd31.php.

Freeman-Longo, R. E., & Blanchard, G. T. (1998). *Sexual abuse in America: Epidemic of the 21st century.* Brandon, VT: Safer Society Press.

Garos, S. (1997). *The Garos Sexual Behavior Index: A measure of addictive sexual behavior*. Unpublished doctoral dissertation, Arizona State University, Arizona.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* San Francisco, CA: University of California.

Glaser, B. G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: IL: Aldine Publishing.

Glover, L., Novakovic, A., Hunter, M. S. (2003). Women's Needs and Preferences for Psychological Help and Support in a Gynecological Outpatient Service. *Journal of Reproductive and Infant Psychology,* 21(3), 195-206.

Guion, L. A. (2002). Triangulation: Establishing the validity of qualitative studies. *University of Florida Extension I.F.A.S.* Retrieved June 7, 2004, from http://edis.ifas.ufl.edu/pdffiles/FY/FY39400.pdf.

Gurman, A. S. (1978). Contemporary marital therapies. A critique and comparative analysis of psychoanalytic, behavioral, and systems theories. In T.J. Paolino & B.S. McCrady (Eds.), *Marriage and Marital Therapy* (pp. 506-518). New York: Brunner/Mazel.

Haber, J. E. (1984). *An investigation of the relationship between differentiation of self, complementary psychological need patterns, and marital conflict.* Unpublished doctoral dissertation, New York University.

Horwitz, A. (1977). The Pathways into Psychiatric Treatment: Some differences between men and women. *Journal of Health and Social Behavior,* 18, 169-178.

Internet World Stats: Usage and Population Statistics. (2004). *Internet Usage Stats for America.* Retrieved May 23, 2005, from http://www.internetworldstats.com/stats2.htm.

Kasl, C. D. (1989). *Women, sex and addiction.* New York: Ticknor & Fields.

Kear, J. S. (1978). *Marital attraction and satisfaction as a function of differentiation of self.* Dissertations Abstracts International, 47, 2505.

Kehoe, C., Pitkow, J., Sutton, K., Aggarwal, G., & Roders, J. (1999). Results of GVU's Tenth World Wide Web User Survey. Retrieved May 23, 2005 from http://www.gvu.gatech.edu/user_surveys/survey-1998-10/tenthreport.html.

Kitchens, J. A. (1991). *Understanding and treating codependency.* Englewood Cliffs, NJ: Prentice Hall.

Krafft-Ebbing, R. (1886). *Psychopathia Sexualis.* Translated by Rebman, F. J. (1927). New York, NY: Physicians and Surgeons Book Co New York.

Kunkel, A. W., & Burleson, B. R. (1999). Assessing Explanations for Sex Differences in Emotional Support: A test of the different cultures and skill specialization accounts. *Human Communication Research,* 25(3), 307-340.

Laaser, M. (1996). *Faithful and True: Sexual integrity in a fallen world (2nd Ed.).* Grand Rapids, MI: Zondervan.

Marshall, C., & Rossman, G. B. (1989). *Designing qualitative research.* Newbury Park, CA: Sage Publications.

Matheny, J. C. H. (1998). Strategies for assessment and early treatment with sexually addicted families. *Sexual Addiction and Compulsivity,* 5(1), 27-48.

Maturana, H. R., & Varela, F. J. (1987). *The Tree of Knowledge: The biological roots of human understanding (revised ed.).* Boston: Shambhala Publications.

McCarthy, B. W. (2002). The Wife's Role in Facilitating Recovery from Male Compulsive Sexual Behavior. *Sexual Addiction & Compulsivity*, 9, 275-284.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach.* San Francisco, CA: Jossey-Bass Inc. Publishers.

Milrad, M. (1999). Coaddictive Recovery: Early recovery issues for spouses of sex addicts. *Sexual Addiction & Compulsivity,* 6, 125-136.

Miller, R. B., Anderson, S. & Kaulana Keala, D. (2004). Is Bowen Theory Valid? A review of basic research. *Journal of Marital & Family Therapy,* 30 (4), 453-466.

Mindel, A. (2005). Wordtracker Report. Personal communication June 21, 2005.

Morais, R. C. (1999, June 14). Porn Goes Public. *Forbes Magazine,* p. 214.

Morse, J. M. (1994). *Designing Funded Qualitative Research.* In N.K. Denzin & Y.S. Lincoln (Eds.), Handbook of Qualitative Research (pp. 220-235). Thousand Oaks, CA: Sage Publications.

Newman, G. (1997). The use of online services to encourage exploration of egodystonic sexual interests. *Journal of Sex Education and Therapy,* 22(1), 45-48.

Nichols, M. P., & Schwartz, R. C. (1998). *Family Therapy: Concepts and methods (Fourth Edition).* Boston: Allyn and Bacon.

Nielsen//NetRatings. (2005). Retrieved directly from Nielsen//NetRatings May 25, 2005.

Orzack, M. H. & Ross, C. J. (2000). Should Virtual Sex be Treated Like Other Sex Addictions? *Sexual Addiction & Compulsivity*, 7, 113-125.

Rafuls, S. E., & Moon, S. E. (1996). Grounded theory methodology in family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy (pp.64-80.* New York: Guilford.

Rao, K., Moudad, S., & Subbakrishna, D. K. (2000). Appraisal of Stress and Coping Behavior in College Students. *Journal of the Indian Academy of Applied Psychology,* 26(1-2), 5-13.

Reid, R. C. & Gray, D. (2002). *Discussing Pornography Problems with a Spouse: Confronting and disclosing secret behaviors.* Murray, UT: Mental Health Publications.

Reisman, J. (2004, May). *The New Brain-Body Paradigm: Pornography & the Free "Speech" Amendment.* Symposium conducted at the meeting of the Lighted Candle Society, Salt Lake City, UT.

Satinover, J. (2004). Senate Hearing on the Brain Science Behind Pornography Addiction and the Effects of Addiction on Families and Communities. November 18, 2004, Russell Senate Office Building, Washington, D.C.

Saunders, S. M. (1996). Applicant's Experience of Social Support in the Process of Seeking Psychotherapy. *Psychotherapy,* 33, 617-627.

Schaef, A. W. (1989). *Escape from Intimacy.* New York: Harper Collins.

Schnarch, D. M. (1991). *Constructing the Sexual Crucible: An integration of sexual and martial therapy*. New York: W.W. Norton & Company, Ltd.

Schneider, J. P. (1988). *Back from Betrayal: A ground breaking guide to recovery for women involved with sex-addicted men.* Center City, MN: Hazelden.

Schneider, J. P. (1989). Rebuilding the Marriage During Recovery from Compulsive Sexual Behavior. *Family Relations, 38(3),* 288-294.

Schneider, J. P. (1991). How to Recognize the Signs of Sexual Addiction. *Postgraduate Medicine, 90(6),* 171-182.

Schneider, J. P. (1994). Sex addiction: Controversy within mainstream addiction medicine, diagnosis based on the DSM-III-R and physician case histories. *Sexual Addiction & Compulsivity: Journal of Treatment and Prevention,* 1, 19-44.

Schneider, J. P. (2000a). Effects of Cybersex Addiction on the Family: Results of a survey. *Sexual Addiction & Compulsivity*, 7, 31-58.

Schneider, J. P. (2000b). A Qualitative Study of Cybersex Participants: Gender differences, recovery issues, and implications for therapists. *Sexual Addiction & Compulsivity*, 7, 249-278.

Schneider, J. P. (2000c). Compulsive and addictive sexual disorders and the family. *CNS Spectrums*, 5 (10), 53-62.

Schneider, J. P. (2003). The impact of compulsive cybersex behaviors on the family. *Sexual and Relationship Therapy, 18*(3), 329-354.

Schneider, J. P. & Irons, R. (1997). Treatment of Gambling, Eating, and Sex Addictions. In N. S. Miller, M. S. Gold, & D. E. Smith (Eds.), Manual of Therapeutics for Addictions (pp. 226-227). New York: Wiley-Liss.

Schneider, J. P., & Schneider, B. H. (1996). Couple recovery from sex addiction/coaddiction: Results of a survey of 88 marriages. *Sexual Addiction & Compulsivity,* 3, 111-126.

Schwartz, M. F., & Brasted, W. S. (1985). Sexual addiction. *Medical Aspects of Human Sexuality,* 19, 103-107.

Skowron, E. A. & Friedlander, M. L. (1998). The Differentiation of Self Inventory: Development and initial validation. *Journal of Counseling Psychology*, 45(3), 235-246.

Spink, A., Jansen, B. J., Wolfram, D., & Saracevic, T. (2002). From E-Sex to E-Commerce: Web search changes. *IEEE Computer, 35,* 133-135.

Spink, A., Ozmutlu, H. C. (2002). Characteristics of question format web queries: an exploratory study. *Information Processing and Management, 38,* 453-471.

Stack, S., Wasserman, I., & Kern, R. (2004). Adult Social Bonds and Use of Internet Pornography. *Social Science Quarterly, 85(1),* 75-88.

Strauss, J. A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications.

Titelman, P. (1998). Clinical Applications of Bowen Family Systems Theory. New York: Haworth Press.

Trobst, K. K., Collins, R. L., & Embree, J. M. (1994). The role of emotion in social support provision: Gender, empathy and expressions of distress. *Journal of Social and Personal Relationships,* 11, 45-62.

Tuason, M. T. & Friedlander, M. L. (2000). Do parents' differentiation levels predict t hose of their adult children? And other tests of Bowen theory in a Philippine sample. *Journal of Counseling Psychology, 47, 27-35.*

U.S. Census Bureau (2005). Retrieved May 25, 2005 from http://www.census.gov/population/www/index.html.

Vessy, J. T., & Howard, K. I. (1993). Who seeks psychotherapy? *Psychotherapy,* 30, 546-553.

Vingerhoets, A. J., & Van Heck, G. L. (1990). Gender, Coping and Psychosomatic Symptoms. *Psychological Medicine,* 20 (1), 125-135.

Wegscheider-Cruse, S. (1985). *Choice-making: For codependency, adult children and spirituality seekers.* Pompano Beach, FL: Health Communications.

Weiss, D., & DeBusk, D. (1993). *Women Who Love Sex Addicts.* Fort Worth, TX: Discovery Press.

Wildmon-White, M. L. (2002). *Validation of the construct of sexual addiction through an analysis of relational attachment and learned helplessness among married conservative Christian women.* Unpublished doctoral dissertation, Mississippi State University.

Wildmon-White, M. L. & Young, J. S. (2002). Family-of-Origin Characteristics among Women Married to Sexually Addicted Men. *Sexual Addiction & Compulsivity*, 9, 263-273.

Woititz, J. G. (1983). *Adult children of alcoholics.* Pompano Beach, FL: Heatlh Communications.

Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Belief: The heart of healing in families and illness.* New York: BasicBooks.

Young, K. S. (1996, August). *Internet addiction: The emergence of a new clinical disorder*. Paper presented at the 104th annual convention of the American Psychological Association, Toronto.

Young, K. S. (1997, August). *Internet addictions: What makes computer-mediated communication habit forming?* Paper presented at the 105th Annual convention of the American Psychological Association, Chicago, IL.

APPENDIX A

Helpful Resources Related to Problematic Sexual Behavior
Compiled & Reviewed by Jill C. Manning

A. For Individuals Struggling with Problematic Sexual Behaviors

1. *Cybersex Unhooked: A Workbook for Breaking Free of Compulsive Online Sexual Behavior* (2001), David L. Delmonico, Elizabeth Griffin & Joseph Moriarity. Gentle Path Press, Wickenburg, AZ.

   This workbook is a companion to *In the Shadows of the Net: Breaking Free of Compulsive Online Sexual Behavior (2001).* The book is well-laid out and has a professional tone throughout. The approach is holistic in that it takes into consideration one's stage of change, level of self-awareness, relapse prevention, triggers, psychological defenses, relationship patterns and lifestyle factors. The workbook also goes into quite a bit of detail as to why sexual behavior online is problematic.

2. *Healing from Sexual Addiction* (2004). Mark Laaser. Zondervan Publishing, Grand Rapids, Michigan.

   This book is written from the perspective of a recovered addict and Christian. It is an excellent resource for clinicians, clergy, and people struggling with sexual addiction alike. The book offers fresh insights into family dynamics that may contribute to one's vulnerability to sexual addictions. Christian principles, aspects of the problem, treatment issues and suggestions for searching for a qualified clinician who treats sexual addictions are well-handled. There is a detailed resource listing at the back, as well as a chapter devoted specifically to clergy who are struggling with this problem themselves.

3. *In the Shadows of the Net: Breaking Free of Compulsive Online Sexual Behavior* (2001), Patrick Carnes, David L. Delmonico & Elizabeth Griffin. Hazelden, Center City, MN.

   The book is authored by well-reputed leaders in the field of sexual addictions. The book provides a good overview of problematic sexual behavior, and although not obvious to a lay reader, is rooted in solid social science research. Although the book is more directed toward those with addictions, there is an excellent

chapter toward the end of the book for spouses of addicts. The book also provides several self-assessments and an excellent resource list at the back.

B. For Spouses

1. *After the Affair: Healing the Pain and Rebuilding Trust When a Partner has been Unfaithful* (1994), Janis Abrams Spring. Harper Collins Publishers.

   Although this book is not written with sexual addictions specifically in mind, it is an excellent resource for couples that have experienced sexual addiction as a form of infidelity and betrayal. Janis Abrams Spring is a nationally renowned expert in the field of infidelity and she offers an excellent blend of case studies, ideas for restoring trust, and hope for affected couples.

2. *Discussing Pornography Problems with a Spouse: Confronting and Disclosing Secret Behaviors* (2002 & 2005), Rory C. Reid & Dan Gray. Mental Health Publications, Salt Lake City, UT.

   This booklet has several advantages: it is very readable, affordable, and addresses an often neglected area of problematic sexual behavior, namely the impact on spouses. This book will help normalize the complex response spouses have to a disclosure or discovery of this problem and offer suggestions for tackling the tough conversations that follow.

3. *How Can I Forgive You? The Courage to Forgive, the Freedom Not To* (2004), Janis Abrams Spring. Harper Collins Publishing, New York, NY.

   This book tackles an abstract subject (forgiveness) in a refreshingly concrete and structured way. The author draws from her 20+ years as a therapist who specializes in infidelity and wades through the complexities of trust, apologies and forgiveness in a refreshing, helpful and applicable way. The book addresses the role of the offender and hurt party in forgiveness. The section on what a good apology looks like has been particularly helpful with couples, and especially men who want to rebuild trust but don't know where to start. Plenty of case examples support each point and the layout of the book helps break down a historically tricky subject that is steeped in religious paradigms.

4. *Infidelity on the Internet: Virtual Relationships and Real Betrayal* (2001), Marlene M. Maheu & Rona B. Subotnik. Sourcebooks Inc., Naperville, Illinois.

This book is ideal for someone who is naïve about problematic sexual behavior and needs an appropriate source of reliable information regarding what the problem can consist of, the technological jargon that riddles 'cybersex' activities, and the effect this type of problem typically has on a relationship. I suspect many of the case examples will be difficult to read for those who are brand new to this issue because they will be tempted to wonder if their partner engaged in the types of behaviors and conversations outlined. The latter part of the book explores aspects of recovery and the role loved ones can play in successful treatment.

5. *Living with Your Husband's Secret Wars* (1999), Marsha Means. Fleming H. Revell, Grand Rapids, MI.

   This book is frequently recommended to me by spouses I interviewed for research purposes, as well as women I work with in group therapy. It is an excellent resource for female clients who are in a marriage where a problem sexual behavior exists. The book normalizes women's responses to this form of infidelity and outlines many concepts that are used in group therapy with this population (codependency, boundaries, self-care, self-esteem, forgiveness and support networks).

6. *The Dance of Intimacy* (1989), Harriet G. Lerner. Harper & Row, New York, NY.

   Dr. Lerner anchors her perspectives in family systems theory and yet makes her work very readable and accessible for the lay reader. This book is catered to female audiences and will assist readers in clarifying their role/position in key relationships and how to communicate 'tough stuff' in non-reactive, assertive ways. The book addresses family of origin issues as they pertain to communication patterns and how anxiety is managed in family systems. For several years this has been a favourite book to recommend to clients.

9. *The Drug of the New Millennium: The Science of How Internet Pornography Radically Alters the Human Brain and Body* (2001), Mark B. Kastleman, Granite Publishing, Orem, UT.

   This book has been very popular with the public and is endorsed by respected clinicians and researchers. This book can assist people in understanding why pornography consumption can be so problematic from a variety of angles. This

book also introduces a biological argument into an arena that is typically dominated by moral, religious, or clinical views on this issue. There is an excellent reading list at the back of the book. The insights into the pornography industry, the steps spouses can take, and the insights and phases of recovery fit with my clinical observations and client learning.

C. For Therapists & Support Networks

1. *Infidelity on the Internet: Virtual Relationships and Real Betrayal* (2001), Marlene M. Maheu & Rona B. Subotnik.

   This book is ideal for someone who knows little about problematic sexual behavior and needs an appropriate source of reliable information regarding what the problem can consist of, the technological jargon that riddles 'cybersex' activities and aspects or recovery that clinicians would do well to cover. The first half of the book is a good resource for clinicians who want to understand this presenting issue better. The latter part of the book explores aspects of recovery and the role loved ones can play in successful treatment. The appendixes are useful for those who are not computer savvy.

2. *Healing from Sexual Addiction* (2004). Mark Laaser. Zondervan Publishing, Grand Rapids, Michigan.

   This book is written from the perspective of a recovering addict, as well as a Christian standpoint. It is an excellent resource for clinicians, ecclesiastical leaders and clients alike. The book offers fresh insights into family dynamics that may contribute to one's vulnerability to sexual addictions, Christian principles, aspects of the problem, treatment issues. There is a detailed resource listing at the back, as well as a chapter devoted specifically to ecclesiastical leaders who are struggling with this problem themselves. This is one of the best books on the subject and integrates current research findings.

3. *In the Shadows of the Net: Breaking Free of Compulsive Online Sexual Behavior* (2001), Patrick Carnes, David L. Delmonico & Elizabeth Griffin. Hazelden, Center City, MN.

   The book is authored by well-reputed leaders in the field of sexual addictions. The book provides a good overview of problematic sexual behavior, and is rooted in solid social science research. Although the book is more directed toward those with

addictions, there is an excellent chapter toward the end of the book for spouses of addicts. The book also provides several self-assessments and an excellent resource list at the back for clinicians.

4. *Out of the Shadows: Understanding Sexual Addiction* (2001), Patrick Carnes. Hazelden, Center City, MN.

   This book blazed the trail for the field of sexual addictions to be recognized and sparked widespread debate and inquiry in the early 1980's. It is considered *the* classic text on sexual addictions. The 2001 version is updated and includes more recent research. The book has an easy to follow chapter lay-out and provides insight into sexual addiction as a clinical construct, beliefs that fuel this cycle, problematic family patterns, twelve-step approaches and the spouse's role in the addictive cycle.

D. Useful Websites

1. www.sexhelp.com
2. www.healthymind.com
3. www.cybersexualaddiction.com
4. www.victoriapoint.com/internetaddiction/
5. www.addictionresearch.com

E. Professional Organizations

Faithful and True Ministries, Inc.
Mark Laaser, Ph.D., Director
P.O. Box 84
Chanhassen, MN 55317
(952) 903-9208
www.faithfulandtrueministries.com

The National Coalition for the Protection of Children and Families
800 Compton Road, Suite 9224
Cincinnati, OH 45231
HelpLine 1-800-583-2964 or (513) 521-6227
www.nationalcoalition.org

Society for the Advancement of Sexual Health (SASH)
SASH/National Office
P.O. Box 725544
Atlanta, GA 31139
(770) 541-9912
www.ncsac.org
Note: This organization was recently renamed. Up until 2004, it was known as The National Council on Sexual Addictions and Compulsivities (NCSAC). The old website address is still in effect.

The Meadows
1655 N. Tegner
Wickenburg, AZ 85390
1-800-MEADOWS or (928) 684-3926
www.themeadows.org

Sexaholics Anonymous (SA)
P.O. Box 11910
Nashville, TN 37222-1910
(615) 331-6230
www.sa.org

Sex Addicts Anonymous (SAA)
P.O. Box 70949
Houston, TX 77270
(713) 869-4902
www.sexaa.org

Co-dependents of Sex Addicts (COSA)
P.O. Box 14537
Minneapolis, MN 55414
(763) 537-6904
www.cosa-recovery.org

Recovering Couples Anonymous (RCA)
P.O. Box 11029
Oakland, CA 94611
(510) 663-2312
www.recovering-couples.org

The San Jose Marital & Sexuality Centre
1022 West Hedding Street
San Jose, CA 95126
(408) 248-9737 telephone
(408) 248-9753 fax
www.sex-centre.com

APPENDIX B

DSI-R

These are questions concerning your thoughts and feelings about yourself and relationships with others. Please read each statement carefully and decide how much the statement is *generally true* of you on a 1 (not at all) to 6 (very) scale. If you believe that an item does not pertain to you (e.g., you are not currently married or in a committed relationship, or one or both of your parents are deceased), please answer the item according to your best guess about what your thoughts and feelings would be in that situation. Be sure to answer every item and try to be as honest and accurate as possible in your responses.

		NOT AT ALL TRUE OF ME					VERY TRUE OF ME
1.	People have remarked that I'm overly emotional.	1	2	3	4	5	6
2.	I have difficulty expressing my feelings to people I care for.	1	2	3	4	5	6
3.	I often feel inhibited around my family.	1	2	3	4	5	6
4.	I tend to remain pretty calm even under stress.	1	2	3	4	5	6
5.	I usually need a lot of encouragement from others when starting a big job or task.	1	2	3	4	5	6
6.	When someone close to me disappoints me, I withdraw from him/her for a time.	1	2	3	4	5	6
7.	No matter what happens in my life, I know that I'll never lose my sense of who I am.	1	2	3	4	5	6
8.	I tend to distance myself when people get too close to me.	1	2	3	4	5	6
9.	I want to live up to my parents' expectations of me.	1	2	3	4	5	6
10.	I wish that I weren't so emotional.	1	2	3	4	5	6
11.	I usually do not change my behavior simply to please another person.	1	2	3	4	5	6
12.	My spouse/partner could not tolerate it if I were to express to him/her my true feelings about some things.	1	2	3	4	5	6
13.	When my spouse/partner criticizes me, it bothers me for days.	1	2	3	4	5	6

		NOT AT ALL TRUE OF ME					VERY TRUE OF ME
14.	At times my feelings get the best of me and I have trouble thinking clearly.	1	2	3	4	5	6
15.	When I am having an argument with someone, I can separate my thoughts about the issue from my feelings about the person.	1	2	3	4	5	6
16.	I'm often uncomfortable when people get too close to me.	1	2	3	4	5	6
17.	I feel a need for approval from virtually everyone in my life.	1	2	3	4	5	6
18.	At times I feel as if I'm riding an emotional roller-coaster.	1	2	3	4	5	6
19.	There's no point in getting upset about things I cannot change.	1	2	3	4	5	6
20.	I'm concerned about losing my independence in intimate relationships.	1	2	3	4	5	6
21.	I'm overly sensitive to criticism.	1	2	3	4	5	6
22.	I try to live up to my parents' expectations.	1	2	3	4	5	6
23.	I'm fairly self-accepting.	1	2	3	4	5	6
24.	I often feel that my spouse/partner wants too much from me.	1	2	3	4	5	6
25.	I often agree with others just to appease them.	1	2	3	4	5	6
26.	If I have had an argument with my spouse/partner, I tend to think about it all day.	1	2	3	4	5	6
27.	I am able to say "no" to others even when I feel pressured by them.	1	2	3	4	5	6
28.	When one of my relationships becomes very intense, I feel the urge to run away from it.	1	2	3	4	5	6
29.	Arguments with my parent(s) or sibling(s) can still make me feel awful.	1	2	3	4	5	6
30.	If someone is upset with me, I can't seem to let it	1	2	3	4	5	6

		NOT AT ALL TRUE OF ME					VERY TRUE OF ME
	go easily.						
31.	I'm less concerned that others approve of me than I am in doing what I think is right.	1	2	3	4	5	6
32.	I would never consider turning to any of my family members for emotional support.	1	2	3	4	5	6
33.	I often feel unsure when others are not around to help me make a decision.	1	2	3	4	5	6
34.	I'm very sensitive to being hurt by others.	1	2	3	4	5	6
35.	My self-esteem really depends on how others think of me.	1	2	3	4	5	6
36.	When I'm with my spouse/partner, I often feel smothered.	1	2	3	4	5	6
37.	When making decisions, I seldom worry about what others will think.	1	2	3	4	5	6
38.	I often wonder about the kind of impression I create.	1	2	3	4	5	6
39.	When things go wrong, talking about them usually makes it worse.	1	2	3	4	5	6
40.	I feel things more intensely than others do.	1	2	3	4	5	6
41.	I usually do what I believe is right regardless of what others say.	1	2	3	4	5	6
42.	Our relationship might be better if my spouse/partner would give me the space I need.	1	2	3	4	5	6
43.	I tend to feel pretty stable under stress	1	2	3	4	5	6
44.	Sometimes I feel sick after arguing with my spouse/partner.	1	2	3	4	5	6
45.	I feel it’s important to hear my parents’ opinions before making decisions.	1	2	3	4	5	6
46.	I worry about people close to me getting sick, hurt, or upset.	1	2	3	4	5	6

NOT AT ALL TRUE OF ME	VERY TRUE OF ME

Scoring & DSI.R Subscale Composition: (underlined means reverse scored)

Emotional Reactivity: 1, 6, 10, 14, 18, 21, 26, 30, 34, 38, 40;

I-Position: 4, 7, 11, 15, 19, 23, 27, 31, 35, 41, 43;

Emotional Cutoff: 2, 3, 8, 12, 16, 20, 24, 28, 32, 36, 39, 42;

Fusion with Others: 5, 9, 13, 17, 22, 25, 29, 33, 37, 44, 45, 46.

APPENDIX C

Demographics Form

Participant ID#: 001 - 0050

Demographics Form				
1.	In which city or town do you currently reside: _____ State/Province: _____			
2.	Age: _____			
3.	Current Occupation: _____			
4.	Please check the income bracket that best describes your combined household income:			
	Under $20,000 ❑	$21,000 - $40,000 ❑	$41,000 - $60,000 ❑	Over $60,000 ❑
5.	Please check the highest level of formal education you have obtained:			
	High School ❑	College Diploma ❑	University Degree ❑	Graduate School ❑	Ph.D. ❑
6.	How many children, if any, do you have: _____			
7.	How many years have you been married: _____			
8.	Have you been married previously? Yes ❑ No ❑		How many times? _____	
9.	Please check which forms of help that you have used in the past: Individual Therapy ❑ Couple Therapy ❑ Group Therapy ❑ Support Groups ❑ Ecclesiastical Guidance ❑ Friends ❑ Family ❑ Self-Help ❑ None ❑ Other ❑			
10.	Were your husband's sexually addictive or compulsive behavior(s) disclosed to you, or did you discover it on your own? Disclosed ❑ Discovered ❑			
11.	How long have you been aware of your husband's sexually addictive or compulsive behavior(s)? Since _____ (approximate date).			

APPENDIX D

Sample Questions for the Qualitative Interviews

1. During the last (years/months), what has been most helpful to you? [Amount of time will be based on their response to how long they have known about their husband's problem on the Demographics Form].

   Why?
   Ask for further detail about specific supports they mention.

2. What has been least helpful?

   Why?
   Ask for further detail about supports they mention.

3. If you worked with a therapist, what did he or she do or say that was most helpful?

   Ask for further detail about therapy.

4. What have you come to understand about your husband, yourself, and this situation that you wished you had known when you first found out about this problem?

5. Looking back, is there anything you wish you had done differently following the disclosure or discovery of this problem in terms of the type of support(s) you would have sought out?

6. What advice would you give other women in similar situations that need support or may not know where to turn?

7. Is there anything that you would want me to know that I haven't asked about?

APPENDIX E

Participant Sign-Up Card

RESEARCH PARTICIPANT SIGN- UP CARD

- If you are:
  - ► Female
  - ► 25 years of age or older
  - ► Married to someone struggling with sexually addictive or compulsive behaviors (i.e., pornography use, Internet cybersex)
- You are invited to participate in an important study that will require filling out some confidential questionnaires (20 minutes) and being interviewed (30 minutes).
- If you are willing to participate, please fill out the contact information below, and return the card to your therapist. If you feel more comfortable contacting the researcher directly, her contact information is on the back of this card.
- Participants will receive a copy of the book *Discussing Pornography Problems with a Spouse* by Rory C. Reid & Dan Gray.

First Name:_____

Phone Number: ( ) Can leave message: Yes / No

Address:

Email address:

(*Back of card)*

- If you prefer to contact the researcher directly, please make contact with her between **September 1, 2004 and November 30, 2004**.

Contact Information:

Jill Manning
Doctoral Student & Researcher
Brigham Young University
Marriage & Family Therapy Department
274 TLRB
Provo, UT, 84602
USA

Phone: (801) 422-7759
Email: jillcmanning@byu.edu

Thank you for your willingness to participate!

APPENDIX F

Consent to be a Research Participant

Introduction
This research study is being conducted by Jill C. Manning at Brigham Young University to determine which supports women find most beneficial when dealing with a spouse's sexually addictive and compulsive behaviors.

Procedures
You will be asked to complete a demographics form and a questionnaire that consists of 46 questions prior to participating in a 45 minute, one-on-one interview with the researcher. It will take approximately 65 minutes to fill out both forms and to be interviewed. Questions will include details about your age, occupation, education, marital status, income range, number of children, education, types of therapy previously sought, the length of time you have known about your husband's sexual problem, how you found out about the problem, the supports you have found useful in coping with this problem, and your emotional responses to this problem.

Risks/Discomforts
There are minimal risks for participation in this study. However, you may feel emotional discomfort when answering questions about your personal life. If this were to happen, the researcher will assist you in alleviating these feelings or connect you with another therapist that could help.

Benefits
There are no direct benefits to participants. However, it is hoped that through your participation the researcher will learn more about the supports women find most helpful when coping with a spouse's sexually addictive and compulsive behaviors, and thereby assist other therapists, researchers, and women dealing with a sexual addiction in their marriage.

Confidentiality
You have the right to confidentiality. Your participation and identity will in no way be disclosed as part of the project, and your completed paperwork (except the consent form) will be assigned an identifying number rather than your name in the project records. Once the study is completed, the paperwork and tape cassettes used to record information will be destroyed. While the study is in progress, research materials and paperwork will be locked in secure office at Brigham Young University.

Compensation
Participants will receive a copy of *Discussing Pornography Problems with a Spouse* (2003) by Rory C. Reid and Dan Gray.

Participation
Participation in this research study is voluntary. You have the right to withdraw at anytime or refuse to participate entirely.

Questions about the Research
If you have questions regarding this study, you may contact Jill C. Manning at 422-7759, jillcmanning@byu.edu or Dr. Wendy L. Watson at 422-2349, wendy_watson@byu.edu.

Questions about your Rights as a Research Participant
If you have questions regarding your rights as a research participant, contact Dr. Renea Beckstrand, Chair of the Institutional Review Board, 422 SWKT, Provo, UT, 84602, (801) 422-3873, renea_beckstrand@byu.edu.

I have read, understood, and received a copy of the above consent and desire of my own free will and volition to participate in this study.

_____ _____

Signature Date

_____

Printed Name

APPENDIX G

Differentiation of Self as a Concept within Bowenian Family Systems Theory and Marital and Sex Therapy

Bowenian theory consists of several constructs. Differentiation of self, however, is considered the hallmark of Family Systems Theory and was considered by Murray Bowen to be the most critical variable to mature development and psychological health (Titelman, 1998; Skowron & Friedlander, 1998). It is this construct that is measured by the DSI-R.

Differentiation of self, in simplistic terms, may be defined as the degree to which one is able to balance a) emotional and intellectual functioning and b) intimacy and autonomy in relationships (Skowron & Friedlander, 1998; Bowen, 1978). Bowen was clear to point out that differentiation is a *process* by which individuality and togetherness are managed by individuals within a relationship system and over the developmental lifespan (Kerr & Bowen, 1998). One's basic level of differentiation was viewed as being determined to a large extent by the process and degree to which an individual was able to define a 'self' within his or her family of origin.

Murray Bowen created a theoretical scale of differentiation that could be broken into four ranges of functioning: 0 to 25, 25 to 50, 50 to 75, and 75 to 100. The 85 to 95 range considered was rare and the upper 95 to 100 range was a hypothetical ideal (Kerr & Bowen, 1998). Bowen intended for the scale to be a general guideline and a theoretical way to interpret functioning. Although Bowen outlined basic characteristics of the functioning in each subcategory, he was vague in how clinicians were to score clients in a systematic way; which, in light of his 'anti-technique' stance seems congruent (Titelman,

1998). This lack of reliable quantifiable methods and lack of structure for technique oriented clinicians may explain, in part, why the construct of differentiation of self has not had more widespread recognition and use both clinically and in research.

Low Levels of Differentiation

Low levels of differentiation are associated with problematic emotional reactivity, poor adaptability under stress, easily being affected by others' emotional reactivity, and increased psychological and physical symptoms (e.g., anxiety, somatization, depression, alcoholism and psychoticism) (Skowron & Friedlander, 1998). People in the lower ranges of differentiation (0 to 50) are highly suggestible and are prone to be "ideological chameleons" in order to gain acceptance from others, and avoid or reduce conflict or societal pressure (Kerr & Bowen, 1998). People in this range also have difficulty setting boundaries with others as they can become easily fused with others and have difficulty distinguishing their needs from others' (Kerr & Bowen, 1998). Furthermore, in the lower ranges of the scale, decisions are based primarily on emotion and 'what feels' right rather than an integration or balance between reason and emotion.

High Levels of Differentiation

High levels of differentiation, on the other hand, are associated with better psychological adjustment and problem solving, lower levels of chronic anxiety, the maintenance of satisfying contact with one's family of origin, the establishment of satisfying long-term relationships, and the management of autonomy and intimacy in healthy, adaptive ways (Skowron & Friedlander, 1998). In the higher ranges (50 to 100) people tend to have more well-defined opinions and beliefs, and will remain true to their needs and beliefs despite differences in opinion they may encounter in others. People in

the higher ranges also are more free to choose whether or not they are governed by emotion or reason, and experience more freedom to "move back and forth between intimate emotional closeness and goal-directed activity" while enjoying pleasure and satisfaction from either (Kerr & Bowen, 1998).

Empirical Support for the Construct of Differentiation

It has only been within the last fifteen years that Family Systems Theory as a whole has been examined empirically, and within the last twenty-six years that the construct of differentiation of self has been tested specifically (Miller, Anderson & Kaulana Keala, 2004). The more recent work of Dr. Elizabeth A. Skowron and Dr. Myrna L. Friedlander (1998), however, represents an important departure from a solely theoretical construct of differentiation into a psychometrically sound method of measuring this aspect of development.

Previous attempts, for example by Dr. Jerry S. Kear (1978) to create a 72-item scale of differentiation, were found to be lacking validity and therefore were not widely used (Miller, Anderson & Kaulana Keala, 2004; Haber, 1984). Skowron and Friedlander's Differentiation of Self Inventory (DSI), however, has been found to be a reliable and valid measure and consistent with Bowen's conceptualization of this construct (Miller, Anderson & Kaulana Keala, 2004; Tuason & Friedlander, 2000). The original (DSI) contained 43 items and was designed for adults (25+) in age. Recently, a revised version of the DSI was released with an additional three questions and re-titled the DSI-R to denote the revisions.

Clinical Applications of the Construct of Differentiation

Many family therapists, and in particular, those dealing with sexual dysfunctions have adopted Bowen's perspectives as a primary theoretical orientation for conducting marital and sex therapy (Miller, Anderson & Kaulana Keala, 2004). For example, well-known marital and sex therapist, Dr. David M. Schnarch bases his therapeutic work on Bowenian theories, and emphasizes differentiation of self as a critical component of marital and sex therapy (Schnarch, 1997). I was introduced to Dr. Schnarch's work five years ago and have been increasingly intrigued by his use of differentiation of self in treating sexual dysfunction in couples, his concept of sexual potential, and his thoughts on sexuality and spirituality being integrated. Dr. Schnarch's view that sexual addictions are the "antithesis of sexual potential" fit with my worldview and clinical experience of sexual addictions and human development.

Another clinician whom I admire and who has based her work on Bowenian concepts is Dr. Harriet Lerner, of the Menninger Clinic. She has successfully made Bowenian concepts widely accessible to the public with her bestselling series of books (i.e., *The Dance of Anger*, *The Dance of Intimacy*, and *The Dance of Deception*) that cater to women interested in making changes in their intimate relationships.

APPENDIX H

Initial List of Open Codes

Coding Structure as of March 10, 2005 (stored in NVivo)

Free Nodes

1. Activities
2. Advertising
3. Advice to caregivers
4. Advice to women
5. Avoidance
6. Being alone
7. Catalyst for seeking help
8. Clergy
9. Community Action
10. Concepts
11. Connection
12. Decision to stay in marriage
13. Desired support
14. Differentiation of self
15. Distraction
16. Drinking
17. Effects
18. Enabling
19. Exercise
20. Extent of the problem
21. Family beliefs
22. Fantasy
23. Friends
24. Helpful
25. History of Abuse
26. Humor
27. Hypervigilance and Monitoring
28. Improving home environment
29. Initial response
30. Initial support
31. Insights
32. Isolation
33. Journaling
34. Lack of trust
35. Medical support
36. Music
37. Normalizing
38. Objectifying self
39. Optimism

40. Perfectionism
41. Physical symptoms
42. Premarital knowledge
43. Reading
44. Retreating
45. Scrap booking
46. Self construction
47. Self-blame
48. Separation
49. Shame
50. Shutting down
51. Silenced
52. Talking
53. Understanding of problem
54. Unhelpful
55. Validation
56. Weight Gain
57. Weight loss
58. Withdrawal

Tree Nodes

1. **Family**
    a. Mother
    b. Unconditional love
    c. Father
    d. Shielding
    e. Children
    f. Siblings
    g. Unhelpful
    h. Desired help
    i. Parents
    j. Helpful

2. **Therapy**
    a. Couple
        i. Unhelpful
        ii. Helpful
        iii. Desired help
        iv. Siding
        v. Weekend seminar

    b. Group
        i. Couples
        ii. Spouses
            1. priority
        iii. Desired help

iv. Men's group

c. Individual
    i. Priority
    ii. Unhelpful
    iii. Workshops
    iv. Helpful
d. Specialized
e. Helpful concepts
f. Combination
g. Hindrances to care
h. Family

3. Clergy
a. Helpful
    i. Inclusion
    ii. Initiation of support
b. Desired help
c. Overlooking
d. Unhelpful
    i. Downplaying
    ii. Lack of information
e. Advice for
f. Primary confidante

4. Spirituality
a. Jesus Christ
b. Scriptures
c. God
d. Facilitating Beliefs
e. Prayer
f. Religion
    i. Services
g. Temple worship
h. Service
i. Promptings

5. Insights
a. Societal
b. Hindsight
c. Marriage
d. Self

6. Unhelpful
a. Lack of hope
b. Ignorance

7. **Husband**
    a. Helpful
    b. Disclose vs. discover
    c. Unhelpful
    d. Desired support
    e. What they need to understand

8. **Community action**
    a. Education

9. **Friends**
    a. Helpful
    b. Shielding
    c. Fear of not being believed
    d. Unhelpful

10. **Individual**
    a. Desired help

11. **Differentiation of Self**
    a. Lack of

APPENDIX I

List of Axial Codes Grouped According to Relationship/Similarity

A. Coping Supports

- Avoidance
- Avoidance of Sexual Intimacy
- Crying
- Distraction
- Eating
- Enabling
- Fantasy
- Focusing on Children
- Humor
- Hypervigilance and Monitoring
- Isolation
- Objectifying Self
- Secrecy
- Self-Blame
- Suicidality
- Weight Gain
- Weight Loss
- Withdrawal

B. Insights

- Hindsight
- Marriage
- Self
- Societal

C. Understanding of problem

D. History of Abuse

- Marital Abuse

E. Process Points

- Focus on Husband
- Matters of Time
- Ultimatum
- Shielding
- Clarity
- Disclose vs. Discovery
- Initial Response
- Cocooning
- Self Construction
- Focus on Children

- Forgiveness
- Hindrances to Support
- Premarital Knowledge
    - Family Knowledge
- Shock
- Initial Support
- Numb
- Catalyst for Seeking Support
- Denial
- Differentiation of Self
    - Lack of
- Symptoms
    - Depression & Anxiety

F. Change-Oriented Supports

Recreational

- Horseback riding
- Sewing
- Music
- Scrap booking
- Exercise
- Journaling
- Reading
    - Unhelpful
- Improving Home Environment

Relational

- Immediate Family
    - Helpful
    - Unhelpful
    - Priority
- Extended Family
    - Helpful
    - Unhelpful
    - Priority
- Friends
    - Helpful
    - Unhelpful
    - Fear of not being believed
- Spouse
    - Helpful
    - Unhelpful
    - Disclose vs. Discovery
    - Desired Support
    - What they need to understand
    - Extent of Problem

- Ultimatum
- Separation
- Decision to stay in marriage
- Triggered Disclosure

Children
- Helpful

General
- Women in Similar Marriages
- Unhelpful
- Talking

Professional

Therapeutic

Individual
- Helpful
- Unhelpful
- Priority
- Workshops
- Desired Help

Couple
- Helpful
- Unhelpful
- Desired Help
- Priority
- Hindrances to Care

Group

Spouse's
- Helpful
- Unhelpful
- Priority
- Desired Help

Men's
- Desired Help for Husbands

Couple’s
- Helpful
- Unhelpful

Workshops
- Helpful

Combination
- Helpful

Specialized

Hindrances to care

Family Therapy

Advice for Therapists

Medical

Hospital

- Family Physician
- OBGyn
- Nurse Practitioner

Spiritual

- Clergy
  - Helpful
  - Inclusion
  - Desired Help
  - Fear of Not Being Believed
  - Unhelpful
    - Downplaying
    - Lack of Information
    - Overlooking
  - Advice for
  - Primary Confidante
- Beliefs
- God
- Jesus Christ
- Spiritual Practices
  - Reading Scriptures
  - Prayer
  - Religious Meetings
  - Charitable Service
- Promptings
- Priority

G. Conceptual

- Helpful
- Unhelpful
- Desired Help

APPENDIX J

Example of Abbreviated Boolean Search Matrix

Boolean Searches can cross matrix hundreds of codes at a time, but the importing the NVivo output into a Word document is difficult. The example below is used to give the reader an idea of the type of searches that were conducted. This search shows the number of times the codes at the top of the matrix and the code shielding appear in the same interview. Boolean codes thereby give the researcher a powerful tool for finding relationships between codes that could be missed otherwise.

Boolean Search Matrix Generated by NVivo:

Matrix Nodes	Immediate Family/Unhelpful	Immediate Family/Helpful
Shielding	4	11