Common Factors in Christian Women’s Preferences for Support When Dealing with a Spouse’s Sexually Addictive or Compulsive Behaviors: The C.A.V.E.D. Theory

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While research exists on many issues relating to wives of sex addicts, there is a void in the literature regarding the kinds of support women find most beneficial when dealing with a spouse’s sexually addictive or compulsive behavior. Using a qualitative, grounded theory methodology, 22 Christian women from Canada and the United States were interviewed to identify the types of support they found most beneficial when dealing with this multifaceted problem in a marriage. Additionally, the common factors of support which are summarized by the acronym C.A.V.E.D. (Connection, Advocacy, Validation, Education and Direction) emerged from the analysis of the interviews.

Research shows the majority of people struggling with sexual addictions and compulsivities involving the Internet are married, heterosexual males (Cooper, Delmonico, & Burg, 2000). Consequently, women who are married to these men are directly impacted by this problem (Schneider, 2000b). Additionally, marriages in which a sexual addiction or sexual compulsivity exist are commonly pervaded with diminished intimacy, anxiety, secrecy, mistrust, isolation, relationship dysfunction, sexual dysfunction, and decreased temporal security due to the risk of job loss or related debts (Carnes, 1991; Schneider, 2000a; Schneider & Schneider, 1996; Wildmon-White & Young, 2002).
Although there is a growing body of research pertaining to wives of sex addicts, there is a void in the research literature regarding the specific kinds of support women find most beneficial when dealing with a spouse’s sexual addiction or sexually compulsive behaviors (Manning, 2006). Twelve-Step groups such as S-Anon and Codependents of Sex Addicts (COSA), as well as individual and couple therapy have been cited as helpful in several studies (Laaser, 1996; Salmon, 1995; Schneider, 1989; Schneider & Schneider, 1996), however, most of this work focuses on couple recovery and does not specifically query the women’s experience of support as it pertains to her own well-being or sense of self. Numerous studies (Corley, Schneider, & Irons, 1998; McCarthy, 2002; Schneider & Schneider, 1996; Wildmon-White, 2002; Wildmon-White & Young, 2002) refer to the lack of empirical research that focuses exclusively on the wives of sexually addicted and compulsive men or the lack of resources available to these women, and have subsequently encouraged a breadth of studies focusing on this population. 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; Schneider & Schneider, 1996), understanding how this population may best be supported is not only beneficial for augmenting the wife’s well-being, but also the treatment course and prognosis of the sex addict if she has chosen to remain married.

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. Additionally, identifying the common factors of support for this population was a priority.

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.

The secondary purpose of this study was for the women’s experiences to inform clinical work with this population. By clarifying common factors of support, this study contributes to targeting evidenced-based practices and narrows the scope of supports needing empirical investigation.

RESEARCH QUESTIONS

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) What are the common factors of support amongst this population, if any? and (c) How can women’s experiences and preferences with support inform therapeutic approaches with individuals and couples who are affected by sexual addictions and compulsivities?

METHODS

Research Design

A qualitative, grounded theory methodology was employed for this study. This methodology was selected because qualitative research is recommended in fields where the research objective is to reveal the nature of peoples’ experiences or understand an area in which little is known (Strauss & Corbin, 1990).

Participants & Data Collection

A diverse sample was recruited through the 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 e-mail were employed to reach mental health professionals 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. The criteria for participation included: (a) being female, (b) being a minimum of 25 years of age, (c) being married, and (d) presenting a spouse’s sexually addictive or compulsive behavior as the primary presenting problem in therapy (past or present). Although religiosity was not a criterion for participating in the study, all of the participants turned out to be actively involved in a Christian faith. The reference to research participants as “Christian women” was subsequently added post de facto.

Once participants had been identified and each had consented to be contacted, they were asked if they would meet with the researcher in person for approximately one hour and fifteen minutes to have the study and limits of confidentiality explained in detail, complete the paperwork and participate in a 45 minute interview.

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.

Women were excluded from the study if they were under the age of 25, single, suicidal, currently abusing substances, psychotic, or if problems related to problematic sexual behaviors were not their primary presenting problem in therapy. The professionals involved in recruitment were made aware of these criteria and assisted in selecting women who were an appropriate fit.
TABLE 1 Demographic Profiles: Continuous Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>25 to 56</td>
<td>35.40</td>
<td>9.28</td>
</tr>
<tr>
<td>Number of children</td>
<td>0 to 8</td>
<td>2.86</td>
<td>2.55</td>
</tr>
<tr>
<td>Years married</td>
<td>1 to 28</td>
<td>11.64</td>
<td>7.83</td>
</tr>
<tr>
<td>Years aware of addiction</td>
<td>0.33 to 28</td>
<td>7.07</td>
<td>6.94</td>
</tr>
</tbody>
</table>

Three participants were excluded from the study after the fact, because it was not realized until afterward that they were either not legally married or not yet 25 years of age. Consequently, the total number of participants was reduced from 25 women 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 conducted in-person by the researcher. Additionally, each participant was given a copy of *Discussing Pornography with a Spouse* (Reid & Gray, 2002) as a form of compensation for their time. Tables 1 and 2 summarize the demographic data collected from participants.

Data Analysis and Interpretation

The initial phase of data analysis involved transcribing the interviews. Once completed, 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. 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 common factors 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). As part of the open coding phase, each transcript was carefully read and coded on three separate occasions, sometimes four, to ensure the codes were congruent with what the data contained and were appropriately labeled. A total of four people participated in this phase of the analysis, with each of the coders reading between three and 22 interviews and participating in discussions with the researcher to further tease out the relevant codes and labels. All of the codes were entered directly into the NVivo program by the researcher.
TABLE 2  Demographic Profiles: Discrete (Categorical) Variables

<table>
<thead>
<tr>
<th>Discrete Variable</th>
<th>Number of Women</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>6</td>
<td>27.27%</td>
</tr>
<tr>
<td>College diploma</td>
<td>5</td>
<td>22.73%</td>
</tr>
<tr>
<td>University degree</td>
<td>10</td>
<td>45.45%</td>
</tr>
<tr>
<td>Graduate school</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Current occupation*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business</td>
<td>2</td>
<td>9.10%</td>
</tr>
<tr>
<td>Childcare</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Computers</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Event director</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Genealogist</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>12</td>
<td>54.55%</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Piano teacher</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Self-Employed</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>9.10%</td>
</tr>
<tr>
<td>Teacher</td>
<td>3</td>
<td>13.64%</td>
</tr>
<tr>
<td>Writer</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Annual income bracket</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $21,000</td>
<td>3</td>
<td>13.64%</td>
</tr>
<tr>
<td>$21,000 to 40,000</td>
<td>6</td>
<td>27.27%</td>
</tr>
<tr>
<td>$41,000 to 60,000</td>
<td>6</td>
<td>27.27%</td>
</tr>
<tr>
<td>Over $60,000</td>
<td>7</td>
<td>31.82%</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Baptist</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Evangelical</td>
<td>3</td>
<td>13.64%</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>United</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>LDS (Mormon)</td>
<td>15</td>
<td>68.16%</td>
</tr>
<tr>
<td>Current marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First marriage</td>
<td>15</td>
<td>68.18%</td>
</tr>
<tr>
<td>Second marriage</td>
<td>4</td>
<td>18.18%</td>
</tr>
<tr>
<td>Divorced &amp; single</td>
<td>2</td>
<td>9.09%</td>
</tr>
<tr>
<td>Twice divorced &amp; single</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Manner of sexual addiction disclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discovered</td>
<td>12</td>
<td>54.55%</td>
</tr>
<tr>
<td>Disclosed</td>
<td>7</td>
<td>31.82%</td>
</tr>
<tr>
<td>Triggered disclosure</td>
<td>3</td>
<td>13.64%</td>
</tr>
</tbody>
</table>

*4 women cited two professions, i.e., Homemaker/Teacher, making the total percentage 122.79% versus 100%

Axial Coding

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?”

**Selective Coding**

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.1 Additionally, this phase of the analysis clarified the common factors of support this population relied on, desired and/or preferred. The theory and common factors were identified gradually during the coding process and were continually tested against the data to ensure they were grounded in the data.

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 and common factors (Rafuls & Moon, 1996).

**RESULTS**

This study was successful in identifying specific supports, as well as common factors of support for the sample it examined. The common factors of support, however, will be highlighted and examined in depth here, with a brief overview of the specific supports2 and general impressions of the research interviews provided to give context to the common factors.

**An Overview of Specific Supports**

Over a period of months and after repeatedly asking the question “How are the open codes related or unrelated to one another?” it gradually became apparent that two main categories of support existed for this population. These two broad categories were identified as “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

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1 The theory of support is outlined in Manning (2006).
2 The specific supports are addressed thoroughly in Manning (2006).
coping supports even made matters worse. Coping supports most often co-
incided 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 or possible, as well
as how to go about enacting them.

Table 3 outlines the coping supports identified in this study as being the
most helpful, as well as the percentage of women who used them.

**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. Five categories of change-oriented supports were
identified as being the most common with this sample: (a) recreational, (b)
relational, (c) professional, (d) spiritual, and (e) conceptual. Table 4 out-
lines each category of change-oriented support, along with specific kinds of
activities, behaviors, services or beliefs that were included in each category.

**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 likely more comfortable about
Supports Women Find Most Beneficial

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 because there would have likely 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 context 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 have been different had specific questions about more sensitive issues such as marital intimacy or trust 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.

Common Factors of Supports

Examining the common factors of support 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. The primary questions asked during this part of the analysis were “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. This collection of needs interestingly formed the acronym C.A.V.E.D., a term deemed appropriate by the researcher to describe the “caved-in,” isolating and devastating experience problematic sexual behavior evokes in a marriage. These five common factors were understood to be the foundation of all supports sought, although further research is needed to support this finding.

**Connection**

The first common factor amongst this sample was the need for connection. 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, not to mention sexual, information. Within this sample alone, 68% of the women experienced some type of isolation in the wake of the disclosure or discovery of problematic sexual behavior in their marriage. 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 were reconnecting with the world around them. Connection to self, to God, to others, to one’s spouse, and in some cases to life itself were ways this need for connection manifested itself.

The need for connection was 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.”

Interestingly enough, sometimes the connection didn’t even require direct admission or acknowledgement of the problematic sexual behavior to be considered supportive. For example, one woman said, “Being with friends and family helped. Even though they don’t know, just reaching out to other people, just to feel like a normal person helped a lot.”

Based upon the experiences of these two women, connection also had a normalizing effect and as a result enabled them to function in the roles they fulfilled. This normalization effect indirectly spoke to how abnormal, disorienting and traumatic the disclosure or discovery of this problem feels for spouses.

**Advocacy**

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., regarding his loss of
employment or altered church or community 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 the 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 stated, “... 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 not perceive they had 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!’

VALIDATION

Thirdly, an important common factor for these women was the need for validation. Validation included 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, felt more affirmed of my feelings, that what I was feeling was right.”
This common factor makes sense when one considers how diminishing the disclosure or discovery of a sexually addictive or compulsive problem can be for a spouse. To have someone who can help her re-enter the realm of being okay and counterweight the tide of self-doubt, insecurity, and self-blame she feels in the wake of this problem is enormously helpful to this population. Moreover, validating her experience assists in the process of depersonalizing the problem and appropriately assigning responsibility for the problem.

EDUCATION

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.”

DIRECTION

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, to 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, makes 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 many 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 [clergy] 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, and 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.

**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. While taking a more meta-perspective of the data, however, it was determined that five common factors of support were fundamental to this population having a positive and satisfying experience with supports. These five common factors were identified as: (a) Connection, (b) Advocacy, (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, the C.A.V.E.D. theory needs to be researched further to solidify its applicability and validity. Meanwhile, C.A.V.E.D. provides a valuable framework for clinicians and clergy who treat affected women prior to conclusive answers being available.

**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. Several clinical implications emerged from the results.

First, the C.A.V.E.D. theory provides timely insight into the properties and factors of support that are perceived as most helpful to this population. This acronym provides a checklist of sorts that is easy to remember when designing treatment plans or consulting with affected women. While it is not clear which factors carry the most weight, or if there is an order to which they
are most useful, implementing all or most of these common factors serves as a valuable framework for working with this population. When it is not possible to implement all of these common factors, clinicians would do well to ensure these needs are met through other means or sources.

Second, 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.

Third, 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 by the public at large.

Fourth, 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 toward 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 about problematic sexual behavior, as well as feel that they were not alone. What proved interesting with this sample was that none of the women cited 12-Step group meetings (e.g., S-Anon and Codependents of Sex Addicts or COSA) as a type of group therapy they had participated in even though previous research (Laaser, 1996; Salmon, 1995; Schneider & Schneider, 1996) had emphasized this format of support as beneficial. It is the researcher’s view that this difference likely signals an increase in the number of issue-specific treatment options now available to women as opposed to a direct comment on the 12-Step modality. For example, the women’s groups and couples groups this sample was participating in at the time of the study were not running or available in the mid-1990’s when prior 12-Step research was conducted. Additionally, because the 12-Step format was not directly queried, it is possible that some of the women had attended 12-Step groups in the past and had just not mentioned it, or had viewed the 12-Step format as a form of support versus professional treatment. Further investigation would be needed to clarify this incongruence within the research.

Fifth, 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 secondary symptoms or problems associated with the use of coping supports.

Lastly, 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. Furthermore, 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.

LIMITATIONS

In this study, five 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) were LDS (Mormon). Future research would do well to include women who: (a) are atheist or agnostic, (b) represent non-Christian faiths, and/or (c) represent a greater range of Christian faiths.

Third, not all of the women had equal access to the same kinds of supports 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, 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.
Lastly, the researcher and all but one of the coders were women which may give more credence to women’s views and therefore bias in the study.

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. More importantly, this study highlighted five common factors (C.A.V.E.D.) which contribute to positive experiences of support. Incorporating the principles of connection, advocacy, validation, education, and direction into support for this population is hypothesized to enhance the effectiveness and positive experience of support by affected women. 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, as well as what heightens resiliency and well-being. 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


