Calming the tempest, bridging the gorge: healing in couples ruptured by “sex addiction”

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Frequently couples seek marital therapy for the painful impact of one partner’s “sex addiction.” Disagreement abounds in both the clinical world and the larger society, about what the designation “sex addiction” actually means. A variety of diagnostic categories are subsumed under it, creating confusion about both its causes and effective treatments. The current paper proposes precise definition and diagnostic language regarding a range of compulsive sexual behaviors. It maps a model for understanding and treating compulsive sexual activity in marital therapy in a stepwise sequence, beginning with careful history taking and diagnostics of both partners, identification of the mutually reinforcing relationship dynamics keeping destructive behaviors in play, processing of underlying psychological and developmental roots of such behaviors, cultivation of empathy and trust, and revitalizing of the couple’s sexual relationship. The method is illustrated with a case history.

Keywords: sex addiction; compulsive sexual behavior; trauma re-enactment; couple’s therapy

This journey began some years ago when a man in a distant coastal town called me inquiring about couples’ therapy. Initially, I thought he was requesting a referral near his home, but he and his wife proceeded to make the 6-hour round trip to my office weekly for the next year and a half. Since then, I have gotten similar calls – one from a man in a treatment program in the Southwest, another from Europe, a third from two hours away in the South Bay Area, a fourth from the East Coast, and more. Usually, the husband in these heterosexual couples has made the call, and the presenting complaint has gone something like this: “I’m a sex addict. Can you help us?”

The geography of desperation

What prompts people to reach out across the miles and traverse great distances for psychotherapy? Initially, I thought it was shame that inspired people to flee their communities to unearth painful problems of compulsive sexual behavior. However, now that I have done a fair amount of work with this population, I have concluded that desperation is the root cause of their long-distance search. They find themselves casting an ever-wider net as they emerge from unhelpful and even damaging treatment experiences closer to home.

I have several objectives for this article, recognizing that space constraints limit my examination of each. Among my goals are myth-busting about, and destigmatizing, a deeply misunderstood affliction; proposing guidelines for precise diagnosis, offering a...
new clinical lens through which to view couples’ dynamics, and mapping an effective course for treatment.

**Does “sex addiction” exist?**

Over the last decade or so, “sex addiction” has become a near-colloquial term in both the popular and clinical literature. It has about the same accuracy of meaning as the old term, “nervous breakdown.” Presumably, everyone knows what they mean by it, but it stands on no nosology, data or uniformly accepted definition. Even the DSM-5 Revision Committee argued vociferously about whether “sex addiction,” in fact, exists, and if so, what to call it and how to treat it. Meanwhile, titillating, menacing, and often incriminating popular depictions abound. Of course, there is a category of incontrovertibly dystonic sexual behaviors that engender great shame and remorse, both on the part of the sufferer and others. However, the confusion surrounding these behaviors only compounds the pain.

Insofar as the there is a self-reinforcing dopamine surge that accompanies many sexual behaviors, particularly those involving orgasm, the addiction model can appear to fit. However, that is probably as far as it goes. By definition, addictive disease involves the following.

- **Tolerance**: meaning that over time, more of the substance is required to get the same result.
- **Withdrawal**: meaning that a distressing physiological reaction accompanies discontinuation of use, which makes stopping difficult and painful. Addiction is also
- **Progressive, chronic, and fatal**: the disease gets worse over time and is incurable.

As we will see, most sexually compulsive behavior simply does not fit the criteria for addiction. Wrongly applying the label “addiction” can demoralize, complicate, deter, or derail recovery efforts.

**What is in a name? The quest for precise diagnosis**

Perhaps the most notable expert on sexual compulsivity is Eli Coleman of the University of Minnesota, who has written extensively and authoritatively on this subject, and has consulted to the DSM revision committee. Says Coleman:

Disagreement exists as to whether compulsive sexual behavior is an addiction, a psychosexual disorder, an impulse control disorder, a mood disorder, or an obsessive compulsive disorder... I now view the behavior as having a multitude of causes and presentations... (Coleman, 2003, p. 12)

While I continue to use the term compulsive sexual behavior, I hope it is understood that it is still a set of symptoms waiting for a better term to replace it. (Coleman, 2003, p. 13)

I have adopted Coleman’s use and rationale for the term, not knowing of anyone with whom I agree more, and also for want of a more exact term.

In his quest to find suitable language and descriptive criteria, he has been one of the strongest proponents of precise and accurate diagnostics. He bemoans the vast variety of behaviors randomly tossed under the “sex addiction” umbrella, as evidenced in my own practice.
My client, Alex, spent over $50,000 a year on exclusive, high-end escorts; another client, Joseph, harbored a secret life of anonymous sex with men during much of his forty-year married life. My client Oscar, meanwhile, carried on a series of sequential “fatal attraction”-like affairs over his 15-year marriage, while Eric escaped into years of fantasy Internet liaisons. All of these men were tagged with, and dogged by, the “sex addict” label. Each had very different problems. Each had his recovery delayed and his life unnecessarily derailed by misdiagnosis and misdirected treatment. All resolved the behavior and healed their marriages once the underlying problems were identified. That is what they had in common.

Just as a “nervous breakdown” could be a psychotic break, a lapse into dysfunctional depression, a series of debilitating panic attacks, a dramatic trauma re-enactment, or a suicidal episode – all calling for vastly different treatment approaches. Therefore, compulsive sexual behaviors can be a manifestation of a wide range of problems. Such behaviors may be an expression of obsessive compulsive disorder (OCD), attention deficit disorder (ADD), social anxiety, post traumatic stress disorder (PTSD) re-enactment, attachment trauma, dissociative behavior, or a host of other named and unnamed diagnoses. By lumping them all together, treatments become generic, cookie-cutter projects that are unlikely to hit the curative mark.

Coleman specifically distinguishes between paraphilic and nonparaphilic compulsive sexual behavior:

Paraphilic behaviors are unconventional sexual behaviors that are obsessive and compulsive. They interfere with love relationships and intimacy.

Nonparaphilic compulsive sexual behavior involves conventional behaviors which, when taken to an extreme, are recurrent, distressing, and interfere with daily functioning. (Coleman, 2003, pp. 13–14)

What I find most destructive about the addiction model is the notion “once an addict, always an addict,” meaning that we cannot cure but at best merely arrest the disease. Although this model may accurately describe alcohol and drug addiction, my experience is that compulsive sexual behavior can, in fact, be healed once and for all. In my experience, the doctrine of incurability often serves as permission for the sexually compulsive person to “continue to fail.” Likewise, it provides permission to the hurt partner to continue to suspect, condemn, and view the partner who practices compulsive sexual behavior through a pathological or “perpetrator” lens. Each of these forms of permission, based on a false premise, can doom the healing process for the individuals and relationships.

So what is compulsive sexual behavior, if not an addiction? I view this behavior through the lens of affect regulation. We will say more about this “new lens” in the next section. For now, it may be useful to consider who it is that determines that there is a “problem.”

If one spouse masturbates multiple times per day and the other spouse has a moral or religious anti-masturbation stance, or simply feels left out, that partner may be the one assigning the label of pathology or addiction. What if the masturbation involves explicit sexual visuals? Or what if one partner has a vastly stronger libido than the other? Does that make him or her a “sex addict” or the other a sufferer of “hypo-sexual desire dysfunction?” We need to ask: who is defining the problem?

In our field, diagnostics can be an unscientific and vaguely defined endeavor, possibly affixing stereotypical labels onto clients and/or becoming a mechanical way to view, assess, and treat them. Yet with compulsive sexual behaviors, the lumping of many varieties into one category – addiction – and assigning the treatment approaches applied to
substance abuse, often misses the mark widely. These behaviors are extremely diverse, encompassing multiple affairs, viewing pornography, e-mail relationships, utilizing sex workers, masturbation with or without visual stimulation, or frequenting clubs and/or other venues where anonymous or recreational forms of sex are available. It may involve wanting — or not wanting — to stop. Rather than automatically labeling this cornucopia of behaviors “addictive,” let us get curious instead.

(i) Individuals may have a conflict with their values and those of their partner, family, or culture. Sometimes the problem is a matter of interpersonal or intercultural conflict. (Coleman, 2003, p. 16)

Applying a new clinical lens

When I first see a couple who present with the problem of “sexual addiction,” my mind comes alive with questions — none of which I ask immediately. But silently, I’m wondering: How often does the behavior occur? Is it a way to manage stress or relieve tension? Is it a way to stimulate a sluggish brain and enliven a hypo-aroused or “flat” nervous system? Might there be autoimmune, adrenal, or nutritional factors, or a biochemically based dysregulation? Is the behavior a “solution” to a sexual dysfunction or a sexless marriage? Is sex an obsession and a variation of a ritualized OCD activity? Thinking this way begins a process of understanding the client, and begins to point toward appropriate treatment.

From the very first session I attempt to establish myself as a neutral party, stressing that mine is a “no-blame” paradigm with no “problem child.” This can be a hard sell. Many treatment approaches view the partner with the compulsive behavior as, in the words of one client, the “bad dog!” And many spouses feel so bitterly and heinously “done to” as to be absolved of any responsibility to help heal the relationship.

A no-blame approach means that although neither partner is responsible for the behavior of the other, each is responsible for his or her own reaction to the other’s behavior. Dynamics between the partners do reinforce and perpetuate the problematic behaviors of both. I assess what each partner views as the problem, and what each desires as the ultimate outcome, while also attempting to discern what I can about their self-perpetuating cycle of suffering.

Next, I obtain a full history of each partner. Depending on the individuals (and the level of antagonism between them) I might see them together, or separately, for history-taking. My preference is to see the couple together as there may already be a fair amount of secrecy or suspicion between them. In addition, often they learn things about each other that they never knew, which can forge vital curiosity, and possibly even empathy and understanding.

Sometimes, however, there is too much rage or defensiveness to make conjoint history-taking workable.

In the sexually compulsive partner, I usually find a desperate attempt to self-regulate or manage intense affects and body states. Beneath that, however, is nearly always some expression of trauma. It may be attachment trauma owing, for example, to a parent who was physically intrusive and emotionally neglectful, a parent whose rage was overwhelming, or a parent who was seductively over-stimulating or sexually abusive. There are countless variations.

Sometimes in dissociated states, sometimes in fits of rage or desperation, the sexually compulsive person re-enacts trauma stories. Invariably, they are unconscious. Identifying trauma as the root of sexual compulsivity can often shift the lens for both partners. I emphasize to clients that “the nature of trauma is to re-enact the trauma.” (van der Kolk,
1980, p. 283.) Often, trauma is logged in memory in a fragmented, incomplete, sensory, emotional, visual, and energetic way, like a broken necklace whose beads roll around chaotically. The task is to restring them into a coherent narrative so that the trauma story can be logged and laid to rest in autobiographical memory, instead of remaining unconscious and perpetually vulnerable to restimulation.

When the behavior is reframed as the desperate urge to give words and meaning to a personal tragedy that has never been consciously recognized, let alone shared with another living soul, it becomes an intimate communication instead of a punishing “acting out.” Both partners may be empathically amazed, moved and deeply saddened by the finally known and understood life events.

Of course, sexually compulsive behavior is not always a manifestation of unhealed trauma. In some cases, the behaviors are an expression of OCD, or a reaction to a sluggish ADD brain. Sometimes symptoms requiring specialized treatment interventions, constellate around trauma, such as extremes of dissociation or depression, and we must address that. My experience most often is that a trauma story is being “told,” as in the example of Marco and Francine, below.

Marco and Francine: the impact of hidden trauma

History
My couples’ treatment approach draws on the work of Harville Hendrix (Hendrix, 1988), which assumes that the dynamics of the couple are shaped by the dynamics of each of their early object relations and childhood experiences. Problems spring from the interplay between the residual emotional vulnerabilities and dysregulation of the two of them. When the past is laid to rest and old fear quieted, they can find calm and restore love and intimacy. I assume that both partners contribute equally to the difficulty, and I routinely say to any designated identified patient, “Don’t be greedy, you can only have half.”

Marco was a child of massive trauma. His father was a fighter pilot who was gone for months at a time, with Marco aware from a very early age that whenever his father left on a mission, or really any time he left home, he might never return. Recurring nightmares of crashing planes are among his earliest memories. His mother, left alone with five children, was alcoholic and erratic, ultimately abandoning the family and moving with a boyfriend to a distant town. Marco, the youngest, was sent to a boarding school, where he was sexually abused by the teacher who was kindest to him. At various points in his childhood, he felt as if his mother’s intent had been to “destroy me and my whole family.”

Marco’s absent father was larger than life. During the rare times he was around, he was authoritarian and difficult to please. He also drank a lot, which made him unpredictable. Nonetheless, Marco idealized and adored him. When his father abruptly died, not in the ever-dreaded plane crash but of a sudden and aggressive cancer, Marco, then 16, was devastated. First, he’d endured his mother’s abandonment, then his abrupt separation from his siblings, and now his worst fear had been realized: his beloved father was gone. It seemed to Marco that all relationships were in one way or another ripped away, that loss was the one constant.

 Shortly after his father’s death, Marco went out for cross-country and spent many hours of his days in intense training. He didn’t know whether he was running from or running to something, just that it brought him some modicum of relief from his chronic internal state of overwhelm.
Later, he found that sex had a similar calming effect on his nervous system, especially when he was free of much consideration of the feelings or idiosyncrasies of a partner. Marco’s sexual compulsivity involved numerous, intense sequential affairs. Invariably, the female partner made the seductive approach. In the last and most dramatic of these affairs, Marco’s lover made repeated, vicious phone calls to Francine, taunting her about her failure as a wife and sexual partner, and threatening to come to their house and make an explosive scene.

As noted earlier, careful and thorough history-taking is a vital first step in our work. Obviously, it is a powerful vehicle for creating an empathetic connection with any individual who comes into therapy, but in this work it may be even more essential and challenging. Many clients arrive demoralized, shame-ridden, and defensive from humiliating prior-therapy experiences. Perhaps the compulsive partner was viewed as the “problem child” or “bad dog.” Perhaps the victimized partner received the message “You’re sick for sticking around with this loser.” One wife I saw was told by a prior therapist, “Your husband is toxic! What are you going to do?” She was horrified, scared and bitterly embarrassed that she still loved him. What did that mean about her? Often, both partners enter my office expecting to be shamed and punished once again. Marco fully expected condemnation and reproach from me.

Second, compulsive sexual behavior routinely involves lying, a challenge at best if it seeps into psychotherapy. So the opportunity to seed the essential therapeutic alliance in the process of history-taking is especially valuable. My aim is to create a space that is safe enough to make honest disclosure possible.

Third, I am listening for the context, the soil from which the behavior patterns sprang. Whether the behavior is some variation of sexual compulsivity, or whether it is the tolerance for a sexually compulsive partner’s betrayals, deceit and absence, there is invariably some foreshadowing or antecedent embedded in the story.

Finally, I am listening for the tenderest vulnerabilities engendered by personal history, which later kindle and inflame the reactivity that will fuel the couple’s core destructive dynamic. I will say more about this later. For now, suffice it to say that the task of history-taking requires great thought, care and attention to what may initially seem to be a mass of extraneous details.

To summarize, the initial interview with each partner, always at least 90 minutes, has the multiple objectives of:

- initiating a safe relationship;
- embarking on diagnosis;
- searching for clues about the roots of the behaviors; and
- gathering information that will shed light on the couple’s relationship dynamic.

Needless to say, this work requires great care, energy, thought, patience and self-regulation on the parts of all three participants.

Marco’s initial call to me had a tone of urgency and fear, a response to Francine’s disgusted anger and exasperation. He scheduled his individual appointment for as soon as I could arrange it. The history-taking was somewhat like witnessing the collapse of a house of cards. On the outside, Marco appeared indomitable, with his Ivy League doctorate, remarkable athletic accomplishments and astonishing accumulation of wealth. Underneath his successful, dignified exterior, however, was an abandoned, rejected, lonely little boy, wracked with fear, shame, and loss.
My initial, impressionistic view of Marco was that he had a wildly dysregulated nervous system, and, like many severely traumatized individuals, had spent his life on a mad quest to calm down. He had endured a cascade of erratic and ruptured attachments, with chronic insecurity and fear beginning early in life, and shocking losses of important attachment figures. His relationship template was “No one takes the time to know you” and “Nobody sticks around.” To him, it made no sense to put all of one’s eggs in a single relationship basket. If called upon to give Marco a diagnostic label, I would have placed him on the spectrum of post-traumatic stress disorder, with the prominent symptoms of hyperarousal, hypervigilance, intrusive memory, and bouts of dissociation.

It took much longer to schedule Francine’s session. She viewed couple’s therapy as something she had to endure because her husband was sick and irresponsible and needed to change – period. She did not think she needed therapy, and resented how much time and effort was required of her to address his problem. Besides, she had spent – in her opinion, wasted – enough time and money on this issue and had no reason to believe this bout of therapy would be any more useful than the others. Angry and deeply skeptical that a therapist recommended by Marco’s analyst could be helpful to her, she was grudging and cool. But she came.

Francine was strikingly attractive and stylish. I have observed that in all the couples I have seen for this problem (all of whom have been heterosexual), the women have been extraordinarily attractive. No excuse about the partner’s physical attributes being a reason for sexual activity outside the marriage, would fly very far in these couples. Francine was petite, exquisitely fit, and dressed with artistic flair. She was also bitter and wary, more interested in talking about Marco’s sordid behavior than about her own history. As is often the case, Francine did not believe she had much of a story of her own. Her childhood, as she described it, was undramatic. “Nothing happened to me.” These words are a flag that the client might in fact be a child of neglect, whose traumatic past is about missing experiences and holes in the fabric of daily life, rather than traumatic occurrences. Francine was the quintessential child of neglect who slipped under the family radar unnoticed, raising her younger siblings and filling in the gaps in the parenting she herself received.

Francine’s parents divorced when she was eight, at which point her father disappeared from her life. “But that happened to many kids,” she said, shrugging. She gave no thought to having to cook and keep house as her mother worked 12-hour shifts as an ER nurse, having to sign herself up for school each fall, or never having a parent present at any performance or athletic event. She had given little thought to the fact that she’d temporarily lost her hearing and ability to speak when she was five and it had been a month before anyone had noticed.

Competent, self-reliant, and proud, Francine had no awareness of how enraged she was about her past. She truly did not believe she had been angry “before Marco gave me something to be angry about.”

The early loss of her father had prepared Francine for Marco’s long and frequent “business trips,” which felt familiar and normal to her. She was accustomed to raising children singlehandedly and thanklessly, having her accomplishments and talents go unnoticed and her pain and ailments ignored. She’d felt proud and safe that she didn’t need anyone’s help. In her mind, Marco continued to increasingly demonstrate that she needed him “like a fish needs a bicycle.” She had little awareness that somewhere deep inside, there lived a little girl who longed to be taken care of, cherished, and spoiled.
Locating the core dynamic

Marco and Francine’s core dynamic emerged early on in our work. By “core dynamic” I mean the primary repetitive cycle or pattern of conflict that imbues almost any topic, and results in ever-increasing disconnection and demoralization. It’s that same tired fight that couples have over and over again on any and every subject, becoming terribly upset, and gridlocked in the process. A thorough and thoughtful history makes it easy to spot. In the usual chicken-and-egg manner, the self-perpetuating destructive cycle re-enacts the worst of each partner’s childhoods (Cohn, 2011, pp. 53–63).

Marco perceived Francine’s confident and unmistakable independence to mean that she had no need for him at all. This belief stirred his fears of rejection, abandonment, and loss, which led him to avoid the house as much as he could. Marco’s absences increased Francine’s imperious and autocratic running of the home, which contributed to more distance and anger and deepened Marco’s wish for warm, vulnerable companionship. The distance continued to widen. Confrontations about each other’s behavior grew ever louder, sharper, and more contemptuous.

To interrupt the seemingly endless volley of blame and accusation, I asked each partner to describe the depth of feeling that each suffered as a result of the pattern. The feelings invariably hearkened back to childhood experiences and we were able to wend our way back to deeply buried stories, some of which Marco and Francine had never shared with each other. In my experience, it is the childhood stories that elicit tears and empathy, the moments of deep emotion that begin to heal both the injured relationship and the addled brain of compulsivity. It is deep and powerful work, not for the faint of heart. Thoughtful and conscientious self-care and support on the part of the therapist are of the essence.

Marco’s most recent affair had a sadistic quality, and Francine was haunted by the violent phone calls of his affair partner. In Francine’s recollections of the traumatic calls, she described feeling as if this woman was “trying to destroy me and our family” – interestingly, using the very words that Marco had used to describe his mother.

As the elements of re-enactment and projective identification fell into place, Marco’s trauma story came into focus. The experience of the “kindly,” exploitative teacher coming on to him in boarding school was repeatedly re-enacted in the opportunistic approaches of powerful, flattering women with their own agendas. With deep pain and shame, he recounted his childhood experiences to Francine in our sessions.

Marco had never before had words for what he felt was his mother’s calculated crushing of his soul. He had never actually talked about her biting, confusing, and insulting verbal abuse, her seeming to take pleasure in making him feel worthless, ugly, and incompetent. By inadvertently creating that experience inside of Francine, he felt that someone, at long last, knew and understood his devastation. In deeply emotional sessions, we were able to link the compulsive adult behaviors to the childhood trauma, with Marco re-experiencing powerful affects, visual and sensory memories. Gradually, as Marco recounted his trauma stories in words, he found that he no longer needed the compulsive behaviors. Their function accomplished, the behaviors were finally laid to rest.

To keep things in perspective, I emphasized to the couple many times that this trauma re-enactment and projective identification were not excuses for the pain and betrayal Marco had visited on Francine. They did not “make it OK”; they simply made it intelligible. At the same time, Francine recognized that she had been entrusted with her husband’s story in a way no one ever had before. She had been worthy of his deepest trust and able
to understand and know him this profoundly, which gave a new and powerful meaning to their terrible and protracted rupture.

By bringing together the present-day stimulus and emotions with the antecedent childhood memory, even asking them to register the body experience, understanding the meaning, and all in the presence of an empathic other – this is how we process trauma. We are integrating fragmented elements, constructing a coherent narrative, and evolving new meaning for both the original experiences and the more recent experience of the couple. As I explained to Marco and Francine, moments of deep empathic feelings are emotional markers or indicators of significance in the brain. This is how we fundamentally change the relationship. With sexually compulsive clients whose compulsivity is rooted in trauma, this process extinguishes the flame that fuels the behaviors.

Francine had been obsessed with details. She wanted to know absolutely every indiscretion that Marco had ever committed. She had read on the Internet that the gold standard for “sex addiction” treatment is when the addict takes a lie detector test. She insisted that if he really loved her, he would do that for her to win back her trust. Marco was appalled at the idea, feeling that he was being treated like a criminal. The most nightmarish of his prior treatment programs had included a lie detector test as part of its protocol, and he viewed the therapist there as a ghoul and a fiend.

As we deepened into Francine’s feelings, we learned of the secrets lurking in the shadows in her family that she did not discover until she was 18. At that time, she found out that her father “all along” had another whole family, and that when he left Francine’s family it was to be with them. She reacted by becoming fiercely distrustful, adamant about keeping the truth transparent and visible at all times. She was terrified and devastated by the depth of the deception in her marriage. Now, Marco understood better why. He could see that the deceit was even more painful to his wife than the infidelity had been. We began to work on how he could reassure her of his honesty, and how she, in turn, could reassure him of his value and his place in her world.

Learning repair

Processing and integration open a channel for true relationship repair, which for many of our clients is an entirely new experience – one never learned in their families-of-origin. What is required is an authentic understanding of how both partners were hurt. Again, it is often a hard sell convincing “victimized” partners that they, too, played a role in the couple’s unhealthy dynamics. Incensed and deeply hurt, they do not want to accept any blame for the heinous behaviors they so despise.

And they are not to blame, much as their compulsive partners may have claimed at times. However, they do, in fact, have a role in keeping the core dynamic in play. Repair is about empathic understanding and ownership of one’s own part of the devastating history of one’s relationship. It is not about who behaved worse and who suffered the most. It is a journey of humility and of learning the elusive art of true apology on both of their parts. It is rarely quick or easy. When undertaken with commitment and perseverance, however, it can be transformative.

Often, couples must build a new sexual relationship from the ground up. Perhaps the sex had never been good between them. In Marco and Francine’s case it had been once, but the lovemaking had stopped years ago when the compulsivity came to light. Francine was haunted by the details of Marco’s affairs that she had insisted upon knowing. She was also worried about being compared with other women, whom she could only
imagine. And it took a while before she could begin to trust that it was really over, and make herself vulnerable to her husband again.

I recommended a tantra workshop in Hawaii, where in a whole new setting with a new set of skills, they could begin to renew their sexual relationship. As calm grew between them, they were ready to deepen their sexual interaction and experience a different and trusting closeness. A new way of starting that focused on connection, presence, and spirituality was appealing to them. During their glorious and successful trip, Marco proposed to Francine again, and they planned a recommitment ceremony to signify the birth of a whole new marriage.

Now, more than a year post-therapy, Marco’s compulsive sexual behavior has not returned. He continues to self-regulate with ultra-athleticism: with Francine’s support, he is currently training for a 100-mile (in one stint!) foot race. And he is supporting and coaching her as she trains for her first marathon. Marco continues to work hard in therapy. Francine, meanwhile, continues to process her own history of profound neglect, and how it prepared her for Marco’s long absences and being left to fend for herself and their children. They celebrated their renewed marriage vows and are actively creating their envisioned new marriage, replete with fun, companionship, satisfying co-parenting and lively, intimate sex. They are happy and hopeful. For me, the measure of a successful outcome is a renewed (or new) and safe closeness, trust, and a measure of joy. Usually that brings with it a rhythm of regular and mutually satisfying sexual and emotional activity.

Mapping a course

Working with couples who struggle with sexual compulsivity is a delicate and difficult challenge. Research states that most unhappy couples have suffered for at least 6 years before seeking therapeutic assistance (Gottman, 2002, p. 35). My own experience is that these couples have struggled a decade or more and have made more than one, often tragic, attempt at treatment. They may be skeptical, resigned, or worse. I warn them that both partners will need to make a big investment of time and energy. Our goals, very briefly, are:

1. to identify the couple’s core dynamic and its expression of each partner’s personal history;
2. to translate the meaning of each partner’s problematic behavior: what is the story that each is attempting to tell?
3. to put language and affect to the trauma stories; building an empathic connection between the partners; linking the unwanted behaviors to the trauma stories;
4. to integrate trauma memory, behavior, affect, and meaning in shared moments;
5. to make a shared commitment to eradicating the unwanted behaviors;
6. to apologize, forgive, and renew trust and commitment;
7. to create a new sexual relationship between the partners.

I warn couples (and remind myself) that it will not be easy or quick. Certainly, my intention is not to imply that all compulsivity is rooted in trauma, or that all couples can effectively process their histories, change behavior, forgive, and live happily ever after. Admittedly, those who have the resources to travel great distances and engage in long-term therapy are a select subgroup. This is the population I know best. My intention here is to encourage exploration, creativity, hope, and dialog about the nature and healing of these complex and painful life dramas.
Notes on contributor

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