Disclosing Secrets:

Guidelines for Therapists Working with Sex Addicts and Co-addicts

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ABSTRACT

Therapists who treat clients with addictive or compulsive sexual behaviors are often faced with the dilemma of whether a person should disclose to others secrets about the sexual behaviors. If a disclosure is determined, then when, what and how to disclose are issues clients must face. This article discusses issues related to the therapist including transference and counter-transference, disclosure of therapist's personal history and the therapist's values regarding keeping secrets from one member of a couple. Practice guidelines outlined for clinicians include obtaining and gathering history, the importance of establishing goals with clients, timing of disclosure, how much to disclose and how to disclose. Other ethical situations and steps to rebuild relationships are discussed.

Psychologists, addiction counselors, and other mental health workers who treat individuals diagnosed with addictive sexual disorders frequently are told of sexual behaviors that the patient has not disclosed to the spouse or partner. Often the spouse has been suspicious and in some cases has threatened divorce or separation should certain behaviors (e.g. affairs, purchasing sex, participation in cybersex, or sexual involvement by professionals with patients or clients) be revealed. At other times the spouse is totally unaware of the affair, cybersex involvement, or other sexual acting out. Treating professionals are often unclear as to the importance of disclosure, the timing of the disclosure, and its extent.

When a disclosure or discovery of extramarital behavior has already happened, the resultant distress is frequently the catalyst that brings the couple into therapy. At the time of the first visit, the unfaithful partner has already given some information to the spouse. But, especially in the case of sex addicts, the disclosure is usually incomplete (Schneider, Corley & Irons, 1998).

Each member of the couple has his or her own agenda for therapy. For the addict or unfaithful person, items on the agenda may include maintaining the ongoing problematic behavior, preventing the betrayed partner from leaving, limiting further disclosure as "damage control" against multiple losses, and assuaging guilt by revealing everything. The partner's agenda typically includes obtaining information to validate her or his fears and suspicions in hopes of feeling sane again and getting the addict to stop the behavior. Additionally, the partner is hoping to learn every single detail of the acting out in hopes of figuring out *why* it happened to preserve the relationship or to gain ammunition for future

retaliation. Finally, the partner wants to assess the risk of having been exposed to a sexually transmitted disease (STD) or other health risks.

When dealing with the consequences of sexual betrayal, there are many similarities between nonaddicted and addicted couples seeking help to work through the labyrinth of emotions and decisions. However, in the context of addictive sexual disorders, there are two unique factors that significantly impact the disclosure process:

> The sexual acting out has been repetitive and the betrayal and lying egregious. Even when the presenting problem is a single affair, there generally is a hidden history of other affairs or additional sexual acting out.
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> The most widely used model of recovery from addiction, based on the Twelve Steps of Alcoholics Anonymous, is often interpreted as confusing. On one hand, the program requires "rigorous honesty." Yet step nine cautions against disclosure to those we have harmed "when doing so would injure them or others." (Alcoholics Anonymous, 1953)

Consequently, sex addicted couples have many questions and uncertainties regarding the process of disclosure. The therapist's actions can be instrumental in helping both the individual and the couple through a very difficult and complex process.

LITERATURE REVIEW

Although the literature in the marriage and family therapy field was not written specifically for couples dealing with sex addiction problems, it is certainly relevant when the acting out has involved other partners, lies, and betrayal. Some authors stress the importance of honesty and disclosure (Brown, 1991; Pittman, 1989; Subotnik & Harris, 1994 Vaughan, 1989). According to Pittman (1989), for example, the dishonesty may be a greater violation of the rules than the affair or misconduct. He acknowledges that more marriages end in an effort to maintain the secret than do in the wake of telling. Pittman speculates that the partner may be angry about the affair, but will be even angrier if the affair continues and she or he finds out later. Glass (1998), writing about the posttraumatic reactions to the disclosure of infidelity, lists factors that affect the level of traumatization. High on the list is "the extent of the deception and how the infidelity was disclosed (p. 31) Brown (1991) points out that secrecy creates insiders and outsiders. The one who doesn't know the secret becomes the outsider. This person commonly reacts by searching within for what is wrong and then attempting to correct it by trying even harder to please. Learning the truth brings a great sense of relief and brings sense to the person's experience.

Some authors give general advice about what to tell and when to tell (Brown, 1991; Subotnik & Harris, 1994 ; Wallerstein & Blakeslee, 1989; Vaughan, 1989).

Pittman (1989), for example, advises, "Couples need not tell each other every detail of their activity and every thought that goes through their heads, but they do have to tell each other the bad news. . . . The things people must be sure to talk about are those things that are unsettling, guilt-producing, or controversial." Brown (1991) advises that in most circumstances the unfaithful partner must disclose if healing is to occur. In some cases, she notes, behaviors from previous relationships or long ago do not always need to be revealed. She also observes that time and support for the partner is necessary. It often takes longer sessions or more sessions of therapy to help the partner express her or his anger and sadness about the infidelity before actual rebuilding of the relationship can occur. However, these authors' advice is rarely informed by scholarly publications.

Unfortunately, very little has been written in this discipline about disclosure. Specifically absent is information about ethical issues for therapists regarding disclosure, how to effectively counsel clients about the timing, or how to actually carry out the steps of disclosure.

Situations in which there is a significant need to know are when the partner is at risk of acquiring or has been exposed to a sexually transmitted disease. Even in such a well-defined situation, in which life-and-death health issues are involved, disclosure is not consistent. In a study of 203 consecutive patients presenting for primary care for HIV at two urban hospitals (Stein et al, 1998), 129 reported having sexual partners during the previous six months. Sixty percent of this group had disclosed their positive HIV status to all sexual partners. Of the 40% who had not disclosed, half had kept the information from their one and only partner. To make matters worse, 57% of the non-disclosers used condoms less than all the time. The odds that an individual with one sexual partner disclosed were 3.2 times the odds that a person with multiple sexual partners disclosed. The odds that an individual with high spousal support disclosed were 2.8 times the odds of individuals without high support.

The authors call for guidelines for clinicians who wish to help HIV-infected patients disclose their serostatus and protect partners through behavior change, and advised clinicians to take a thorough sexual history that includes questions regarding both current and past sexual partners.

When a client is HIV-positive or has AIDS, and has not disclosed to sexual partners, the therapist may face a difficult ethical dilemma about his or her priority – to maintain client confidentiality or to warn the partner(s) at risk. The Tarasoff v. Regents of the University of California case (1976) mandated therapists "to disclose client confidences to prevent clear and immediate danger to a person or persons," but did not operationally define what constitutes danger. A national survey of marriage and family therapists (Pais et al, 1990) examined what therapists do when their HIV-positive clients disclose that they are engaging in high-risk sexual behaviors. Among 309 respondents to a hypothetical vignette, 59.2% claimed they would report to the client's sexual partners. Interestingly, the likelihood of reporting depended both on the client's

and the therapist's background. Disclosure to partners was more likely when the client was male, young, gay, or African American, and when the therapist was older, female, had less experience with gay/lesbian populations, was Catholic, was very religious or was practicing in an urban area. The authors conclude, "It appears that when there are no clear guidelines, bias and prejudice may determine decision making"(p.469), and they call for more research and training in the area of duty-to-warn with HIV-positive clients.

Persons with addictive sexual disorders are at an increased risk of acquiring STDs, compared with non-sex addicts. At this time, there is not a uniform legal standard regarding the therapist's responsibility when clients are HIV-positive. Guidelines for dealing with such clients were described by Herring (2001) in an article on ethical issues in treating sexual addicts: "Clinicians should discuss the exact nature of their HIV-related confidentiality policies with clients at the onset of treatment, remain current with state laws, educate clients about the seroconversion risks of their specific sex and drug practices, be prepared to speak directly about any concerns that arise during the course of treatment, offer to help communicate information to partners, and consult with colleagues as appropriate." (A recent special issue of the journal *Sexual Addiction & Compulsivity* (2001, #2) is dedicated to helping clinicians who work with HIV-infected sex addicts.)

Within the addiction field, Schneider (1988) interviewed several partners of sex addicts and concluded they have a high need to know. Based on a subsequent larger study of couples in recovery from sex addiction and co-addiction (Schneider & Schneider, 1990), the authors advised couples to be honest about the extramarital sexual behaviors. Their findings confirmed that honesty is considered significant to recovery for both the individual and for the couple relationship.

A more recent study specifically explored couples' perceptions of their disclosure experience. Based on anonymous surveys distributed to recovering sex addicts and partners or former partners of sex addicts, the present authors obtained information on the needs of such clients from therapy (Schneider, Corley, & Irons, 1998; Schneider, Irons, & Corley, 1999). Most respondents emphasized that honesty was the foundation for an improved relationship. Based on their experience, the majority of both sexually compulsive persons (68.3) and partners (81.4%) recommended disclosure. In this population, over half of the partners threatened to leave (60.2%) but less than one-quarter of those that threatened to leave actually left. Threats to leave were seen as part of a process of coping with disclosure by partners rather than a realistic outcome for most couples.

Also noted in the study cited above, some partners complained that in therapy, their needs were considered subservient to those of the addict. What they wished for was validation of their feelings and perceptions, respect for their need to have more information, and more assistance in making appropriate choices for themselves. Several reported traumatic experiences of receiving devastating disclosures by telephone when the addict was away in treatment, or during an

intense family therapy at treatment centers which made no follow-up arrangements for the partner to process the disclosure with assistance.

In this article we describe some specific issues that are relevant to therapists who counsel sex addicts and their partners regarding disclosure. Our views are based on several anonymous surveys done over the past 10 years which included questions about experiences with therapy (Schneider and Schneider, 1990; Schneider et al, 1998; Schneider et al, 1999; Schneider, 2000a, 2000b), and our clinical experience and personal knowledge of hundreds of couples who have experienced disclosure as part of their recovery from sex addiction problems. The areas to be discussed are:

Therapist-specific issues

- Transference and counter-transference
- Sharing personal experiences
- The therapist and secret keeping: ethical considerations
- The therapist with limited knowledge of sex addiction
- The role of the therapist

Practice guidelines for the therapist:

- Crisis intervention and early therapy
- Helping the addict decide about full disclosure
- Timing of disclosure
- Disclosure and safety issues
- How much to disclose
- The formal disclosure
- Ongoing discussions of the impact of addiction and establishing a process for future disclosures

THERAPIST-SPECIFIC ISSUES

Transference and Counter*transference*

In his therapy work, Sigmund Freud thought of himself as a neutral observer, who could reflect back to and interpret his patient's words and emotions. This perspective has been replaced by an understanding that not only does the client project onto the therapist feelings that are based on earlier relationships (*transference)*, but that the therapist's own emotions and experiences inevitably color his or her feelings about the client (counter*transference).*

Given the high percent of primary relationships that have at some point in their history involved affairs, there exists a significant likelihood that the therapist has either had an affair himself or herself, has been the betrayed partner, or has had a close friend or family member who has been affected by an affair and its disclosure. The strong emotions the therapist may have experienced are likely to influence his approach to the client's affairs and the need to disclose. The therapist who has been unfaithful may tend to identify with the addict and to minimize the damage to the partner; the therapist who has been betrayed might overly identify with the coaddict, view the addict as the "bad guy," and push for premature disclosure.

A therapist who is currently involved in an extramarital affair should probably not be working with clients with this issue. Therapists who have had a personal experience with affairs need to obtain supervision about this to clarify its effects on their values, beliefs, and their feelings about disclosing affairs and about keeping secrets. Understanding one's own feelings about disclosure will allow the therapist to counsel the client more objectively and more effectively.

Sharing Personal E*xperiences*

There is a tradition in addiction counseling of sharing some of the counselor's own story. We agree with Herring (2001), in his article on ethical guidelines for counselors treating sexual compulsion, "Although a counselor who discloses a personal recovery experience may offer clients hope and understanding and help reduce shame by modeling an authentic self, unrestrained disclosure has clear risks. If used indiscriminately, such counselor transparency may feel too intrusive, distracting, or unexpected for the client to integrate, and may generate unrealistic expectations or a sense of inadequacy" (p.19).

A young clergyman who only days before had come to the realization that his three years of compulsive cybersex activities represented an addiction, immediately went to see a sex addiction counselor, and reported on his first visit:

> I saw a counselor yesterday. It turns out that he is a sex addict in recovery. He gave me some different perspectives on it to think about. He told me about group meetings that I can go to. But he talked too much, and at times I wondered whether it was me or him who was the counselor. From my training, I know how it should be done. I think it is good for the counselor to share information about himself into the session, but this guy did it a bit

too much. There were things I wanted to talk about, but I couldn't get a word in edgewise.

Intimate personal information should be shared only when it is directly relevant to the treatment goals. Although many therapists in recovery disclose in session some information about their addiction history, it is not advisable for a therapist to share information about his or her own affair or sexual acting out history. This type of personal information is private; unless the therapist and his or her spouse (or former spouse) has gone public with this experience, the professional is betraying the confidentiality of his or her mate. Additionally, some therapists have had unfortunate consequences of such personal disclosures. A client who has had a less than favorable outcome may seek revenge by making public personal information about the therapist. A client with dependent personality disorder may believe that she or he is the therapist's best friend because the therapist shared such intimate information. Our recommendation is that it may be helpful to share less intimate stories that teach skills or demonstrate techniques for resolving problems, but it is more appropriate to use case examples or metaphors than the therapist's personal story.

The Therapist and Secret Keeping: Ethical C*onsiderations*

Whether or not to disclose a secret is a decision clients need to make. The therapist's discussions with the client around the decision can significantly impact the effectiveness of the therapy. The following case is illustrative:

> Martin, a 40-year old radio announcer, had a history of affairs in his first marriage and was now in the midst of the second affair of his second marriage. His wife, Marla, knew about the problems in his previous marriage, but believed that this behavior was ancient history and that Martin was as committed to monogamy as she was. Martin's increasing guilt over this latest affair led him to therapy with Dr. Jim. When Martin had trouble resolving his ambivalence over ending the affair, and with his desire to come clean with Marla about it, Dr. Jim suggested including Marla in a couple of therapy sessions.
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> In session, Dr. Jim explained to Marla that her presence might help Martin as well as their relationship, without specifying exactly how. Instead, he asked Marla how she would feel if she learned that Martin was having an affair. Marla replied (as do many partners asked about such a hypothetical situation), "I'd leave him." Based on this, Dr. Jim counseled Martin not to disclose his affair to Marla. Shortly thereafter, Marla became suspicious and Martin ended the affair and told Marla about it.
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> Marla recalls:

> "In addition to feeling betrayed by Martin and angry with him, I felt betrayed by and angry at Dr. Jim. Dr. Jim got me into therapy under false pretences, in order to dishonestly obtain information for Martin about the likely consequences of disclosing the affair to me, then colluded with Martin in keeping the affair secret from me. He acted like he was trying to help me, but instead he hurt both Martin and me. I would never go back to him again, and Martin now feels the same way."

When a couple seeks conjoint counseling and one of them reveals privately to the therapist a concealed affair or other secret, the situation represents an ethical dilemma for the therapist. Should she or he keep the secret and see the couple? Is it ethical for the therapist to counsel a man who suspects his wife is having an affair, a suspicion that she knows is justified, but not say anything to the man about the affair?

Unlike Dr. Jim, most therapists are uncomfortable holding a secret for one partner that significantly affects the relationship. The reasons they give include "I'm not comfortable with being an accomplice to deceiving one of my clients." "I want to avoid a situation where one partner states she suspects an affair, the other denies it, and I have to act ignorant although I know the affair is indeed going on. If it ultimately comes out that I knew about the affair, it would destroy the trust that the unknowing partner had in me." "I would feel inhibited in the session because I'd have to hold back speaking spontaneously."

Glass and Wright (1992, p. 327) believe "it is inappropriate to conduct conjoint marital therapy when there is a secret alliance between one spouse and an extramarital partner that is being supported by another secret alliance between the involved spouse and the therapist." However, they are willing to see the couple without addressing the affair if the affair is first terminated.

Brown (1991, p. 56) writes "I believe that the integrity of the therapeutic process with couples depends on open and honest communication. Nowhere is this truer than with affairs. The therapist cannot be effective while colluding with one spouse to hide the truth from the other." Instead of getting stuck in this dilemma, Brown proposes referring the couple to separate therapists. She does list a few exceptions in which maintaining the secret with the client is the wiser choice: (1) when there is the potential for physical violence or for destructive litigation in divorce courts, or (2) if the unfaithful client is remaining in the marriage to care for a permanently incapacitated spouse.

Possible solutions proposed by several therapists include:

> Continuing to see both members of the couple, but setting a deadline for the secret to be disclosed in therapy – for example, three sessions – and in

the meantime working individually with the secret holder on reduction of fear and developing a respectful strategy for how to disclose.

Discontinuing couple counseling but working individually with the secret holder to explore his commitment to the primary relationship and motivation for being in counseling.

Some clinicians are less insistent on disclosure and would continue working with the couple while keeping the secret, hoping that they could still assist the couple to improve their relationship. Regarding a request by a client that the therapist not reveal an ongoing affair, Moultrup (1990) argues that if the request comes before the therapist begins couple work and the therapist insists on disclosure and discontinuation of the affair, "it is unlikely that the client will agree to begin therapy. If the demand comes shortly after the treatment has commenced, the probability that the client will bolt from treatment is great."(p.123) In the interest of not losing the client altogether, he will keep the secret from the spouse. Moreover, Moultrup suggests that a therapist who insists on disclosure may be promoting his own emotional agenda: "If a demand for certain action precedes the treatment, it clearly signals the need to re-evaluate the motivation for that action." He writes that his therapeutic strategy clearly anticipates the probability that the therapy will be involved in keeping a secret from one member of some couples. Moultrup's view represents a minority position among therapists who counsel couples.

Although many therapists believe that there is no need, (for non-sex addicts, that is) to disclose a long-past affair which has no bearing on the present relationship, most therapists feel strongly that on-going affairs need to be disclosed. Karpel (1980, quoted in Brown, 1991, p. 58) notes that "a current secret extra-marital affair by one spouse is, in most cases, highly relevant to the other spouse, because it involves major issues of trust and trustworthiness, deception, and a violation of reciprocity" (p.298).

The therapist has a duty to protect the confidentiality of the client, and as much as the therapist may think the partner needs to know, it is the responsibility of the client to decide if he or she will tell. Just because a therapist may think it is morally wrong for a client to be engaging in a particular behavior does not give the therapist the right to disclose for the client. Unless the partner's life is in danger, the therapist cannot disclose information for the client. If you feel that the partner's life is at imminent risk, contact a supervisor and obtain legal counsel before taking any steps to disclose information to a partner.

As a therapist, the most important factor to keep in mind is the context of the case. Each case is individual. However, with addicts, our clinical experience reveals that addicts do get better after disclosure to someone in addition to the therapist. Sometimes this is a sponsor or other group members. Sometimes it is done in the context of 12-step work where an addict reflects on his character flaws and admits this to his or her Higher Power and one other. With this work

comes a reduction in shame and often the addict is then willing to disclose to a partner. Disclosure is a process rather than a single event.

Therapists who Have Limited Knowledge of Sex A*ddiction*

In our research with couples dealing with sexual addiction, the primary complaint was that the therapist was unfamiliar with sex addiction and that the therapist's approach prolonged the addict's denial about the extent of the problem. A therapist who has little or no experience with sex addiction needs to let the couple know this. Express a willingness to refer the couple to a therapist who is familiar with these issues. Some therapists continue working with the couple but find it useful to get peer supervision from someone familiar with sex addiction diagnosis and treatment.

Therapists who have inadequate knowledge of sex addiction may fall prey to the error of premature diagnosis. When a client presents with a sexual problem, ferreting out its cause may require some detective work. An all-too-common therapist mistake is to diagnose without obtaining an adequate sexual history of both the addict and the partner. For example, a client who complains that her husband is not interested in sex with her may indeed be married to someone who has a sexual desire disorder or sexual dysphoric disorder, but alternatively, he may be an active sex addict who is spending hours every night downloading pornography and masturbating. If a client describes her own loss of interest in sex with her husband, she may have sexual anorexia, but alternatively she may be reacting appropriately to living with a spouse who has disclosed that he spends hours masturbating on the computer, and who after 10 years of marriage suddenly wants her to participate in unusual sexual practices with which she is uncomfortable. Therapists need to take the time to ask enough questions to get a full understanding of what is happening in the relationship.

Another type of premature diagnosis is to attribute the cause of any sexual problem to the partner. For example, years ago a woman wrote to Dr. Ruth Westheimer (1987), who had a sex therapy newspaper column, complaining that her husband could hardly wait for her to leave the house so that he could begin watching pornographic videos, and that several times she had returned home early and found him masturbating to a porn movie. Meanwhile, her husband was rarely interested in sex with her. Dr. Ruth's diagnosis was that the wife was sexually boring, and she recommended that the wife work on becoming more exciting sexually by dressing more provocatively and increasing her sexual repertoire and her sexual availability. Another therapist, upon hearing a woman's complaints about her husband's interest in pornography, told her that all she needed was a more enlightened attitude about pornography, including joining her husband in viewing the pictures and films. Meanwhile, her husband's *preferred* sexual outlet, one he spent engaged in for many hours a week, was masturbating to pornography. The wife had, in the past, agreed to experiment with various sexual activities with her husband, but he was not particularly interested in relational sex (Schneider et al., 1998).

In both of the above cases, the underlying problem may have been a compulsive or addictive sexual disorder involving pornography and masturbation. Rather than looking to the partner to change, it is better to obtain a thorough history about addictive or compulsive patterns.

In other cases, the diagnosis may be correct, but the labeling may be premature. Partners are very sensitive to being labeled along with the addict. Labels such as "coaddict" or "codependent," while they may appropriately describe the partner, rarely are the best path for helping the partner begin to see her part in the couple's relational dance. After the chaos begins to subside, it is easier for the partner to see that some of her behaviors have contributed to the situation with the couple. Early on, it is preferable that the partner hear those labels at support group meetings from other partners in similar situations.

The Role of the Therapist

The role of the therapist is not to side with either the partner or the addict. It is tempting to side with the partner because the addict has done the betraying. However, this puts the therapist in a triangulated position and allows the couple to focus on blaming or proving their point through the therapist rather than dealing with their own issues within the context of the relationship. Early in therapy, the couple looks to the therapist as all knowing and the expert. Sharing information about what the counselor has learned through the literature, research and his or her own clinical experience with couples dealing with sex addiction can be useful to give the couple hope and help them be realistic about what to expect.

When concealed affairs or other problematic sexual behaviors are present, the therapist needs to take into consideration the couple's agenda and their commitment to the recovery process. Brown (1991) advises not opening the issue unless the therapist is available to help the couple resolve it, and unless the couple has the commitment to work through the consequences of disclosure.

The therapist helps to interpret what is happening and discuss the differences between how genders view and interpret situations. She/he validates each one's reality and the intensity of their feelings. As a coach, the therapist offers strategies to help the couple communicate more effectively (especially the listening and reflecting part of communication). Another strategy we find useful for addicted couples is the incorporation of cognitive behavioral exercises to correct thinking errors and to develop skills to help build emotional competence. Personal responsibility can be enhanced by teaching skills for holding self and other accountable.

As the couple progresses the therapist will see them able to move from the attack-defend mode of interacting, to productively handling disagreements or difficult issues on a regular basis. Gradually, the problems are addressed without blaming or bringing up past betrayals. Having moved from interventionists in the early crisis phase, to educator and then coach during the rebuilding stage,

near the end of therapy the therapist's role changes to cheerleader, letting the couple practice what they have learned.

CLINICAL GUIDELINES FOR THE THERAPIST

[While the authors are aware that sex addiction is common among males and females, the majority of addicts in our research have been males and the partners have been females. For ease of reading, the following guidelines refer to addicts as he and partners (representing co-addicts/co-dependents) as she. Please take into consideration that the disorder has no preference for gender.]

Crisis Intervention and Early Therapy

A therapist's introduction to a couple often begins with a telephone from the partner, who reports a crisis – the spouse's infidelity. Ask if the betrayal was just discovered and how it was found out, or if there has been an ongoing problem regarding sex in the marriage. If the addict calls, it is usually because the partner has discovered something about his sexual activities, and a major disruption of the marriage has resulted. Ask if the addict thinks he has a serious problem, if he has sought help for the problem, and if so, is he still in therapy. Determine if he is still acting out. If still acting out, an individual session is appropriate to assess the commitment to getting into recovery.

The partner is usually in a state of shock, either full of rage and anger or devastated and hopeless. She may vacillate between both emotional states. She may become anxious and seek relief through several phone calls to you day or night, weekends, and holidays. While listening to her is vital to the process, your ability to model some healthy boundary setting is equally as important. Assure her that some feelings of desperation and chaos are normal for this period and help her develop a plan of coping.. Encourage her to postpone calling you until a designated check-in time. Help her identify a support system by recommending S-Anon or Al-anon meetings and clarifying with her who may be safe to share this information with. Encourage her to journal what she wants to cover with you in the check-in sessions.

In the first few sessions (or in those frantic phone calls) it is helpful to reduce her fear by validating her experience and reassuring her that she is not crazy and that self-care is of the utmost importance. Help her establish obtainable goals in these areas.

In our study, most respondents did see a therapist. In fact, most saw more than one. The partners reported that the most important and useful part of seeing a therapist *was being supported and feeling heard*. The second most valuable type of

advice was to take care of themselves and to recognize that the addict's behavior was not the partner's fault.

In contrast, addicts reported that the most useful early advice was in the area of what and how to tell. Some (60%) thought the advice to be honest and tell everything was the most useful. *Rather than demand the addict disclose, a persistent, gentle coaching to share information with the partner was seen as the most motivating.* The therapists discouraged keeping secrets, warning that secrets are destructive and severely damage trust. Therapists also helped addicts make better choices by considering many options. Most often, the respondents reported that the most useful advice was that honesty is the best way to rebuild the relationship.

Help the addict identify his values and formulate ideas about how honesty can be helpful to the relationship with his partner and his recovery. Have the addict be specific about setting goals for honesty.

While most people in our study reported their experience with advice from therapists to be satisfactory, those who responded to the question about least helpful advice spoke to the impact and seriousness of disclosure for both the addict and the partner. The primary theme identified for both addict and partner was lack of knowledge and skill by the therapist. This included lack of responsiveness to the emotional condition of the partner. Below are some comments by partners that illustrate the serious situation that exists for the partner:

> Another therapist counseled my husband and myself but she didn't know that it was an addiction. Instead, she encouraged me to be a better sexual partner and support his habits.
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> When I found out my husband prefers men or children, I was really devastated. My self-esteem was shaky and that finished it off. I was afraid for my children. I didn't think my husband would stay in our home. Months later my psychiatrist told me he was a pedophile--by then I was so depressed I was planning to kill myself and my children.
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> I was so angry but isolated. I needed to talk about my feelings, but his behavior was all we could see. Maybe disclosure should follow preparation. This was such a dangerous time for me.
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> The first two therapists did not address my need to ask more. I saw a psychologist for a period of time. He was ill prepared to help me. He questioned my aversion to knowing the details. It confused me.
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> I felt I let my children down enormously by dragging them through all the sordid details. Early, I should have been cautioned about who I disclosed to along with connecting up with S-Anon groups. I

acted inappropriately by making several phone calls to those two women he'd been with.

Obviously from these comments, the serious nature of the emotional state of the partners was not enough of a concern for the therapist. Assess the emotional state of the partner before moving forward with further disclosure or before letting the partner leave after a difficult session. Establish a firm goal with her about safety and check for suicidal ideation.

After trust has been broken, couples often struggle with what to do about the marriage. It is common to see the partner beset with fear that she will be hurt again or will not be able to heal from the betrayal. The partner is likely to threaten to leave, want the addict out of the house, actually leave, or become so hypervigilant she becomes obsessed by the addict's every move. Reassure couples that their ambivalence and fear about the future of the relationship is normal at this stage. Early on, establish an agreement to not do anything for 90 days about leaving. We recommend waiting a year, but most couples have a difficult time postponing this decision for what seems like such a lengthy time period, not to mention recognizing that the real recovery takes between two and five years. Couples in early recovery are usually more comfortable agreeing to sit tight for three to six months, and then reassess where they are. At that time, they can recommit to continuing to work on marriage and perhaps increase their level of commitment to each other.

Helping the Addict Decide about Full D*isclosure*

Addict who ask the therapist, "Should I disclose" are expressing ambivalence about keeping the secret either because they want to tell their partner or someone is pressuring them to tell and they are not sure. The therapist's role, then, is to help the addict resolve this ambivalence and prepare him for telling. The following are useful questions to consider during an individual session:

Is the affair over? Is the client still acting out? Does he want to stop?

Does the client still have any contact with the affair partner, or does his or her spouse?

Does the client still have strong emotions about the affair partner? What has been the attempt to resolve those feelings?

How did the affair impact the couple's relationship?

What did the affair solve or seem to make better?

What lies were used to cover up the affair?

Did the partner suspect, and if so, how much energy and additional lying was necessary to disarm the partner's suspicions? (For example, was the

partner accused of imagining things, paranoia, etc. that perhaps contributed to the partner's loss of self-esteem?)

Is this the only affair or behavior the client had, or has this been a recurrent pattern?

Does a past affair or problematic behavior still have an impact on the couple's current relationship?

How comfortable does the client feel about continuing to conceal the affair/behavior?

What is the meaning for the client of continuing not to disclose, and of disclosing?

What does the client believe will be the positive as well as negative consequences of disclosing the affair or problematic behavior (on himself, on the spouse, on the relationship)?

What does the client believe will be the positive and negative consequences of continuing **not** to disclose (on himself, on the spouse, on the relationship?

By clarifying the reasons for the addict's consideration of disclosure, the therapist can help him decide if it would be the right thing to do. By allowing the addict to talk about the positive and negative reasons for disclosing, the addict's motivation for disclosing may increase. However, sometimes the addict may determine disclosure is not right at this time. Determine what will need to change in order for the time to be right for a disclosure.

Timing of disclosure

When there is a need for disclosure, it is best done early. As explained by Brown (1991),

> The earlier in marital therapy that the revelation of an affair occurs, the better once a relationship has been established between the couple and the therapist. Otherwise, any work that has been done is jeopardized, as is the therapy itself, by the fact that it occurred under false pretenses. The spouse's sense of betrayal and outrage is greater and trust is much more difficult to rebuild than when the affair is revealed at the beginning of marital therapy. (p. 60).

Often some type of disclosure has already taken place before the couple shows up for the first therapy session. The addict's initial disclosure most frequently occurs when the partner is about to learn the truth anyway, or when the partner has some incriminating information. Other addicts, however, develop so much guilt that they feel a huge buildup of pressure to disclose. At some point they

may disclose everything precipitously, without considering the consequences for the partner. In both of these cases, the couple typically consults the therapist only after the initial disclosure, in which case the therapist must then support and validate the partner and process the disclosure with the couple. If, however, there is additional material to disclose, doing so in session with a therapist is likely to be most helpful for the partner. If the addict has written a disclosure letter to the partner, process that letter in the session. Discourage the addict from giving a letter to the partner outside the session or without first being reviewed by the therapist, and without responding to recommendations.

If, however, the therapist has the luxury of planning the disclosure, it is best to prepare first. The counselor needs to talk with the partner, be sure she has a support system in place, and determine when she is ready. Similarly, the addict needs preparation to be able to receive the partner's anger, grief, and other emotions without either becoming defensive or fleeing from his discomfort into a relapse of the addictive behaviors.

On the other hand, the process should not be prolonged beyond a few sessions. If there is repeated postponement, then the addict is stuck in fear and it is unfair to keep the partner uninformed. When she eventually learns both the facts and the delay in disclosing them, she will be particularly angry with both the addict and the therapist.

Timing of Disclosure when There is High-risk A*cting* O*ut.*

Sex addicts engage in a variety of behaviors that the partner may or may not view as extramarital – for example, collecting pornography, telephone sex, viewing nude dancers, masturbation while chatting with another person on the computer, and sexual massage. Most sex addicts, however, do engage in behaviors that involve sexual contact with another person, often without protection from sexually transmitted diseases. This was evident in the results of our survey, which found that of the 100 sex addict responses, 91 percent reported engaging in unprotected sexual behavior that included another person.

Involvement with another person presents a different threat or cost to the relationship than solitary sexual activities. For one, it increases the risk that the partner will want to leave the relationship, and therefore makes it more difficult for the addict to disclose the behaviors. For another, involvement with another person risks exposure of the addict – and by extension, the partner -- to sexually transmitted diseases, financial liabilities, and sometimes legal consequences. The risk of infection with a sexually transmitted disease, especially HIV, presents an ethical dilemma for the therapist who learns about a concealed affair. Given the ethical stipulation that therapists report to authorities when a person's life is in danger, an addict might be asked by his therapist to disclose to the partner if he was HIV positive. If the addict has not yet been tested, it is appropriate for the therapist to suggest this to him.

Timing of Disclosure: Long-Distance or Unprepared Disclosure

As reported in our earlier publications (Schneider et al., 1998, 1999), inpatient treatment programs sometimes fail to take into account the needs of family members. In several cases, sex addicts revealed devastating information over long-distance telephone calls to unsuspecting spouses, who were then left to deal with their overwhelming emotions without any support system. Adverse experiences were also reported by partners who received disclosures of significant sexual activities during a therapy session at the inpatient facility and were then left to process the news alone and were not provided with referrals for follow-up back home. We recommend that inpatients be counseled against precipitous long-distance disclosure. If the addict is in treatment elsewhere and if the partner is not able to be present at the center for the initial or for further disclosure, it is best to arrange with the treatment center to have the addict disclose any further information only when the partner is in a therapy session.

Additionally, disclosure during "Family Week" should be planned with careful attention to providing the recipient with onsite support, an opportunity to process the information and her feelings with a counselor, and referral for ongoing counseling and self-help groups in the community.

Disclosure and Safety I*ssues*

If the addict or the partner fears for their physical safety, appropriate steps should be taken to get the couple to separate for a short period of time. If domestic violence has been part of the couple's history, the victim needs to have a back up plan for leaving if the situation increases in volatility. Especially when it is the woman who has acted out sexually outside the marriage, the therapist needs to assess the risk of violence to her before recommending disclosure.

Another area of safety concerns potential victims of sexual offenders. When sex behaviors include victimizing others, the therapist's first priority needs to be to get the client to stop the behaviors. A significant therapist mistake is to focus on getting the addict to understand the sources of the behavior, resolve childhood trauma, and so forth, without directly addressing the behavior itself. For example, in his book *Therapists Who Have Sex with their Patients*, Dr. Herbert Strean describes his treatment of a male therapist who over time had had sexual relations with several female clients. He relates how over a 4-year period, using psychoanalytic psychotherapy, he was finally able to bring the patient to sufficient mental health that he no longer felt compelled to get his emotional needs met through sexual contact with clients. However, the issue of the trauma done to the clients and the need to immediately stop the behavior was reportedly never directly addressed, and the patient apparently continued the behavior for an extended time period while undergoing therapy. (Sexual relations with a therapy client or patient are so potentially damaging to the patient that it is prohibited by professional associations and licensing bodies throughout the United States and Canada, and is a felony in several states.)

Similarly, when a client relates to a helping professional that her partner disclosed to her some potentially victimizing sexual activities, it is a mistake to

underestimate the gravity of the situation. For example, in a survey of partners of cybersex addicts, (Schneider, 2000a) a young woman related that when she was engaged to be married, her fiancÈ admitted he was downloading pornographic images of underage girls from the computer. She went to her minister for counseling, to discuss her options. She reported that the minister dismissed her concern, stating that her fiancÈ was probably "just curious," and that after they were married, his curiosity would undoubtedly be satisfied by having sex with his wife. Unfortunately, the husband's behavior continued long past the marriage, and the wife was now worried about his risk of arrest.

The bottom line is, when disclosure reveals behaviors that are illegal, dangerous, or involve victimizing others, therapists must make it their priority to assure the safety of the addict, spouse, and potential victims.

How Much to Tell: "I am Afraid to T*ell." versus "*I Want to Know E*verything."*

Because disclosure brings shame to the addict and pain to spouse and risks the end of the relationship, addicts initially tend to avoid complete disclosure. In contrast, partners often demand complete disclosure, which is a way for them to make sense of the past, to validate their suspicions and the reality they had experienced, which had often been denied by the addict, to have a sense of control of the situation, to assess their risk of having been exposed to STDs, and establish some hope for the future.

Unfortunately, the belief that knowing "everything" will provide control is an illusion, and the partner who has all the details in her head may ruminate and obsess over them and cause herself endless pain. Disclosure of various details can leave partners with unpleasant memories and associations which are difficult to ignore, serving as triggers for intrusive thoughts and negative feelings. If the partner does not begin a personal recovery program this information can become the source of pathological obsessing that can result in the partner's own acting out behaviors.

For partners who begin a recovery program, later they come to recognize that knowledge is not necessarily power, that no matter how much information they have they are still unable to control the addict. Instead, they develop guidelines for themselves about what information they want (typically, general information such as their risk of STDs and the addict's commitment to recovery and the relationship) and what they do not want (details of sexual activities, locations, and numbers).

The therapist can encourage the partner to consider carefully what information she wants rather than asking for "everything." One helpful therapy technique is to have the client write down every question to which she wants an answer, then give the list to the therapist for safekeeping for an agreed-upon time period, say two months. At the end of that time the therapist and partner review the list and

decide which questions to ask. Frequently, after such a cooling-off period, the partner is no longer interested in painful details.

The therapist can also monitor the intent of the disclosure: moving towards greater intimacy is a positive intent; to obtain ammunition to punish, control, or manipulate the addict is a poor intent.

PARTIAL OR SEQUENTIAL DISCLOSURE

It is tempting for the addict to attempt damage control by initially disclosing only some of the sexual acting out. The adverse effects of staggered disclosure have been described (Schneider et al., 1998). A recurrent theme among partners was the damage of staggered disclosure by the addict. When the addict claimed at the time to reveal all the relevant facts but actually withheld the most difficult information for later disclosure, partners reported great difficulty in restoring trust. One recipient described it as, "His revelations continued to dribble out over weeks as I continued to ask for information. Each new piece of information felt like a scab being ripped off." A man who was sent to prison as a consequence of his sexual behavior disclosed to his wife only some of his activities. She wrote, "Some of his past was reported to the pre-sentence investigator, and I received the report only after he'd been in prison for 3 months. When I read it, I felt immense pain and anger. Part of that was not having been told. I felt lied to and I didn't trust any of the relationship."

Despite the potential adverse consequences of disclosure, most respondents in our surveys recommended disclosure. We advise that the initial disclosure include the broad outlines of *all* the behaviors, while not spelling out the "gory details."

Recipients of disclosure need to be informed by the therapist, however, that disclosure is always a process, and not a one-time event. The reason for staggered disclosure is not always that the addict is deliberately holding back some damaging facts to protect himself or avoid unpleasant consequences. Other reasons (Corley & Schneider) for not having immediately disclosed "everything" includes:

1. The addict has acted out in so many different ways or with so many different people or has told so many lies that he genuinely does not recall some of them until a later time.

2. The addict was in such an altered state at the time of the some of the episodes of acting out – for example, he may have been drinking or using drugs – that he simply does not remember particular events.

3. The addict, although remembering all the details of his acting, does not initially consider particular events or actions significant enough to bother disclosing. With increased

recovery, the addict realizes the need for disclosing additional history.

4. Disclosure of certain actions may be so damaging to the partner or to family relations (for example, an affair with the wife's sister), or may entail significant risk of violence to the addict (for example, a female addict married to a man who has a history of physically abusing her), that a therapist recommends not disclosing these facts initially, until the partner has received counseling and preparation.

5. Certain episodes of acting out occurred only **after** the initial disclosure. That is, they represented slips or relapses of the addiction. (This is the most problematic situation, in that it is likely to cause the most damage to the process of rebuilding trust.)

6. The addict may be so frightened that what he has disclosed may truly be all they were capable of at the time.

A Formal Disclosure

A formal or healing disclosure is appropriate when some disclosure has occurred but the partner continues to voice concern that she does not believe the addict has been honest –- that she believes he is still withholding information -- and she remains stuck in her fear and anger. The couple seems stuck in gridlock and neither can move beyond this stage. The therapist should encourage the couple to have a formal disclosure session – with the goal that this session symbolically stands for beginning the rebuilding process for the couple. It is useful to set aside a two or three hour session for this process. This process is most useful after the addict and partner have had some experience with a 12-step recovery process so each has support and some understanding of unhealthy but common addict and co-addict or codependent styles of responding during highly emotional times.

The partner is invited to write a letter to the addict, outlining how she feels, the impact his behavior and the addiction has had, and is having, on her life and to include all of her unanswered questions. The therapist may want to meet separately with the partner to review her letter, coach her to have personal integrity in her approach, while helping her express emotions that she may be mismanaging. She (the partner) will bring this letter to the session.

The addict is invited to write an amends letter disclosing what he has done in his addiction that has been hurtful and harmful to his partner. The therapist may also want to have an individual session with the addict to review this assignment, and prepare the addict for the presentation of the letter. If he has an opportunity to practice reading the letter to a select group of his peers or in group therapy, he often gains further insight into how he could improve the letter or his presentation. Groups often remind the addict if he is continuing to

try to minimize his behavior or blame others. He should read the letter aloud to gain the full benefit of the process. If the addict does not have a group in which to process this, then the therapist should also serve this purpose. He is cautioned not to blame her or others for his behavior, but to take full responsibility for his actions. He should also be advised to give general details rather than all the particulars of acting out but to state he is willing to answer any questions she may have.

It is important to remind the addict that partial disclosures usually result in further harm to the relationship. Inform him that research clearly states that over half of partners threaten to leave, but of that number, fewer than a quarter actually leave. It can be useful to ask the addict if he wants the partner to stay because she has the information and is informed or stay based on a set of lies.

Sometimes if the addict has been doing individual work on why he turned to addictive behavior, he may want to share what he has learned about himself in the recovery process. It is here that he may chose to talk about the impact of the addiction on his life and the futility of his actions. Be careful to remind the addict not to use this section of the letter to blame others for his behavior.

It is particularly useful for the addict to admit how he has manipulated the partner to think she was in some way to blame for his behavior or that she was imagining things. He should also admit how he has been dishonest about his emotional state. If he has been dishonest about other aspects of their life together, such as putting the children at risk, putting job at risk, spending money on himself when the partner or children did without, the addict should take full responsibility. He should state he was wrong and that he was sorry. Once his letter has been reviewed and often rewritten, the couple is ready for the "formal" disclosure session.

The therapist should have both the addict and partner state their goals for the disclosure. If neither has mentioned a goal is to start the healing process, the therapist should ask if they are ready to make that step for themselves individually if not for the relationship.

The partner is asked to read her letter first. The addict who is encouraged to be attentive and responsive to the partner's emotional state might also ask for permission to take notes if he is prone to forgetting or discounting important points made by the partner. The addict should be instructed to add to his letter any items the partner has brought up that he has yet to address.

After the partner has read her letter, the therapist might ask the addict to describe the emotions he has seen and heard from the partner and to acknowledge those. Although this may seem too directive for some therapists, at this stage the emotional states are so intense that the addict and partner can easily become trapped in anger or fear. The therapist can be instrumental in helping the couple make the most of this session, especially if in prior motivational work either client has been able to generate ideas on his or her own

or make healthy selections of choices from a menu of solution options. The addict should thank the partner for her courage to present her letter and indicate he hopes his letter will respond to some of her questions and concerns. This is a good place for the therapist to suggest a restroom or stretch break and for the addict to make any changes he thinks are needed in his original letter.

The therapist then asks if the partner is ready to hear the addict's response. It is often helpful for the therapist to remark about the level of work the addict has put into the letter writing and how seriously he has taken the process (unless he has not, and in that case the therapist would not be suggesting this process). The therapist should have coached the addict about the strength it takes to do this, that the process represents him being an authentic person and the first steps of regaining his life, and that he should come to the session willing to let his emotional self be vulnerable.

The addict is invited to read his letter to the partner. He is to turn to face her and read the letter to her. Generally, if the addict is sincere, both the addict and partner are tearful. It is common for the partner to begin to respond to the addict's emotional distress by reaching out to him. However, if information comes out that the partner has had no idea about (i.e. exposure to sexually transmitted disease, the existence of another family and children, involvement of a best friend of the partner) the partner may have difficulty completing the process. However, it has been our experience that the partner wants all of the information contained in the letter to be in the open, so is able to tolerate her feelings until the end of the letter. *The key to the success of this process is the addict's ability to take full responsibility for his behaviors, to acknowledge that the partner has every right to be angry,* and *say he was wrong and that he is sorry.* In some cases the addict will ask for forgiveness, but most often the addict does not feel he deserves forgiveness at this stage. When he has finished, a meaningful period of silence is in order for people to gather their thoughts. Often couples will hug and there will be a sense of relief that important progress has been made.

The therapist can ask the partner if she has any questions or anything she wants to say. To close the session, the therapist should go back to the original goals to see what now needs to happen to complete them and to determine where to from here.

Discussing the Impact of Addiction and Establishing a Process for Further D*isclosures*

Addiction is a chronic, relapsing condition that takes time for the addict to learn to manage. The partner needs to understand this, and proactively to create a plan for self-care should a setback take place. If the addict has a slip or relapse, new disclosures should be done as soon as possible. Holding on to the information will only make the partner trust the addict less. Recognize that despite preparation, any further disclosure is a set back for the partner. Nonetheless, if she can avoid punishing the addict for being honest, this will increase his level of emotional confidence and be empowering for her. If he continues to relapse, she

may have to re-evaluate her desire to stay in a marriage in which the person will not use the tools he has been taught to keep himself healthy.

Depending on the outcome of the disclosure, in the follow-up session the therapist encourages the couple to talk about what positive things have come from the disclosure work they have done thus far. Mention that if the partner also wants to disclose any information about her own acting out behaviors (coaddict /codependent) that should also happen, reiterating that this disorder is systemic and everyone needs to do their own work. Point out that the addict may remember more information as his head clears during the recovery process or think of things he had not previously thought important to share and want to share them. There should be an agreed upon process to complete with a therapist in session once per month or on a mutually agreed upon time frame for the first several months of recovery. Then the process can be shifted to support group peers such as another couple from Recovering Couples Anonymous. There also needs to be an agreement of what information the partner wants to have now or what information the addict would find helpful to share if the addict (or partner) has a slip or relapse. The therapist then helps the couple determine how that will happen. In this session, any new disclosure of old information remembered or new slips or relapses should be discussed. More importantly, the addict and partner should discuss the impact, both positive and negative the addiction has had on their lives individually and as a couple. This process allows schedules those difficult conversations that often get postponed. Some couples also want to do this more often.

Most partners want to know why the sex addict did what he did. Rather than focus on the why, it is more beneficial for the couple to talk about the meaning of the addictive behavior to each of them. Once the anger and fear have subsided, discuss what aspects of the relationship are sources of emotional distresses for the partner or addict. Explore with the couple alternative ways of viewing those situations or other ways to interact during those times. Also make plans for dealing with other high risk times such as work difficulties, financial hardships, accidents or illnesses. Be certain the couple recognizes that anniversary dates of the disclosure or discovery or other particularly painful events can be difficult occasions. These anniversaries tend reignite the partner's anger and the addict's shame and need to be planned for appropriately. The couple needs to increase their ability to cope with emotional distress.

Intense flashbacks and other posttraumatic symptoms in the partner can throw the couple into another crisis. Intrusions by a former affair partner, anniversary date, discovery of old acting out paraphernalia, or the exposure of a lieto the partner about an important event can trigger obsessive thoughts for the partner. The addict's best defense is to agree his past behavior was wrong, express sorrow, and then ask if there is anything he can do now to remedy the situation. It is the therapist's task in session to help the partner get unstuck. Ask her to identify any additional unanswered questions and to recognize if she is mismanaging an emotional state. Encourage her to express pain without blaming. Advise her to set aside specific times for obsessing, to use a thoughts

and feelings journal to help her identify thinking errors, and develop plans of action. Meditation and prayer are also helpful for most people. Some therapists have found it helpful to use EMDR (eye movement desensitization and reprocessing) to reprocess and extinguish the power of traumatic memories of the betrayal.

It is common for one or both of the parties to have other addictions, depression, or anxiety. Both partners need to address and begin treatment of any other addictive behavior. If severe depression and anxiety are present, consider referral to a psychiatrist for prescription medication. However, remember that some depression and anxiety is normal; it is important for the client to learn to manage those emotional states rather than medicate them away.

If the couple determines that the marriage is to end, then the goal of therapy is to gain closure and determine what if any relationship they want to have with each other. If they share children, help them to negotiate how to manage the responsibilities of co-parenting.

CONCLUSIONS

Disclosure is the cornerstone of healing and is often what gives the couple hope. Most couples who have experienced disclosure agree with this statement, and recommend the process to other recovering couples. Disclosure brings relief, an end to denial and secrecy, and the gateway to recovery. Disclosure also brings validation to the partner, and hope for a better relationship. Yet disclosure also brings shame to the addict, pain to the partner, and fears to both about the loss of the relationship.

Disclosure is a process rather than a one-time event. The initial disclosure is better done early than late, and should include the broad outline of all the sexual acting out behaviors, while avoiding painful details. The outline can be filled in later, with the help of the therapist in deciding what to ask. Multiple disclosures are unavoidable when due to relapses or forgotten behaviors which are later remembered, but staggered disclosures resulting from efforts to avoid unpleasant consequences are very destructive to the partner and to the relationship.

Therapists who counsel couples about issues of secrets and disclosure need to first examine their own biases and beliefs. A therapist who does couple counseling with sex addicts needs some understanding of addictive sexual disorders, that honesty is vital to addiction recovery, that recovering sex addicts need to disclose affairs and other sexual acting out to their partners, that it is unethical for a couples therapist to collude with one member of the couple in keeping secrets, and that the partner needs validation of her reality, which can come only from knowing the truth.

Therapists are in a unique position to facilitate disclosure for clients, to answer for them questions about the timing of disclosure, about how much to disclose, and to whom, about situations when it might be better *not* to disclose, and about the difference between secrecy and privacy. Therapists need to be educated about disclosure, about its benefits and risks for couples, and about how to best facilitate.

REFERENCES

Alcoholics Anonymous (1953, 1976). New York: Alcoholics Anonymous World Services.

Brown, E. M. (1991). *Patterns of infidelity and their treatment*. New York: Brunner-Mazel.

Carnes, P. J. (1991) *Don't call it love.* New York: Bantam.

Corley, M.D & Schneider, J.P. (2002) *Disclosing secrets: When, to whom, and how to disclose*

addiction secrets. Wickenburg, Ariz: Gentle Path Press.

Glass, S. P., & Wright, T. L. (1992). Justifications for extramarital relationships: The

association between attitudes, behaviors, and gender. *Journal of Sex research,* 29,

361-387.

Glass, S.P. (1998) Beyond betrayal: Post-traumatic reactions to the disclosure of

infidelity. *Professional Counselor*, Feb. 1998, 29—31,52,53.

Herring, B. (2001). Ethical guidelines in the treatment of compulsive sexual behavior.

Sexual Addiction & Compulsivity 8, 13-22.

Moultrup, D. J. (1990). *Husbands, wives, & lovers.* New York: Guilford Press.

Pais, S., Piercy, F, and Miller, J. (1998) Factors related to family therapists' breaking

confidence when clients disclose high-risk-to-HIV/AIDS sexual behaviors.

Journal of Marital and Family Therapy 24, 457-472.

Pittman, F. (1989) *Private lies.* New York: W. W. Norton Co.

Schneider, J. P. (2000a) Cybersex addiction: Effect on the family. *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. (1988) *Back from betrayal: Recovering from his affairs.* Center City, MN: Hazelden. Second edition. Tucson, Ariz.: Recovery Resources press, 2001.

Schneider, J. P., Corley, M. D., & Irons, R. R. (1998). Surviving disclosure of infidelity:

Results of an international survey of 174 recovering sex addicts and partners.

Sexual Addiction & Compulsivity, 5, 189-217.

Schneider, J.P., Irons, R. R., & Corley, M.D. (1999). Disclosure of extramarital sexual

activities by sexually exploitative Professionals and other persons with addictive

or compulsive sexual disorders. *Journal of Sex Education and Therapy, 24,* 277-287.

Schneider, J. P. & Schneider, B.H. (1990). *Sex, lies, and forgiveness: Couples speak on healing*

from sex addiction. Center City, MN: Hazelden. Second edition. Tucson, Ariz:

Recovery Resources Press, 1999.

Spring, Janis Abrahms. (1996). *After the Affair.* New York: Harper Collins.

Stein, M.D., Freedberg, K.A., Sullivan, L. M., Savetsky, J., Levenson, S. M., Hingson, R.,

and Samet, J. H. (1998). Sexual ethics: Disclosure of HIV-positive status to

partners. *Archives of Internal Medicine, 158* ,253-257.

Subotnik, R., & Harris, G. (1994). *Surviving infidelity.* Holbrook, MA: Adams.

Tarasoff v. Regents of the University of California, 17 Cal.3d 425, 551 P.2d 334 (1976)

(Tarasoff II)/

Thompson, A. P. (1983) Extramarital sex: A review of the research literature. *Journal of*

Sex Research, 19, 1-22.