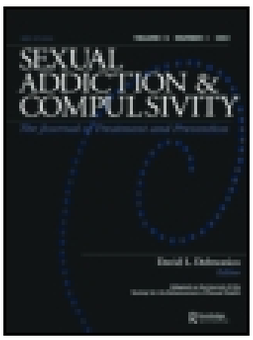

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The Traumatic Nature of Disclosure for Wives of Sexual Addicts

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Wives of sexual addicts experience distressing symptoms in response to the disclosure of their husbands' compulsive sexual behaviors and often describe the disclosure event as traumatic. The results of this study suggest that a majority of wives of sexual addicts respond to disclosure with significant trauma-related distress. The data also reveal that years married at the time of disclosure and number of previous traumatic event exposures best predicted total trauma symptom severity scores. The study concluded with a discussion of the benefits of using a trauma model to understand and treat wives of sexual addicts following disclosure.

Various theories and opinions on the etiology and treatment of problematic sexual behaviors appear in psychological, self-help, and addictions literature, as well as within scholarly writings and texts. Problematic or "out- of- control" sexual behaviors involve driven behaviors an individual and those closest to him or her find troublesome, and which continue despite negative consequences and disturbed levels of functioning (Carnes, 1991, p. 11). Researchers of the phenomenon of out-of-control sexual behaviors do not agree on terminology or an appropriate diagnostic category that sufficiently describes the problem (Finlayson, Sealy, & Martin, 2001; Goodman, 2001; Kafka, 2001; Manley & Koehler, 2001). However, the term sexual addiction/compulsivity (SAC) appears most frequently in the literature and the addiction model is the most widely used to explain the phenomenon. While many may disagree

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on how to term the condition, there appears to be agreement regarding the negative consequences of problematic sexual behaviors. The use of the term sexual addiction or sexual compulsion throughout this article in no way represents tacit approval or agreement of the use of the construct, only of its frequency of use, and is used for purposes of ease of communication and understanding.

For the spouse of the sexual addict, the disclosure of the existence of a sexual addiction and/or related sexual behaviors is described in existing literature as a crisis and a traumatic event (Bergner & Bridges, 2002; Glass, 2003; King, 2003; Matheny, 1998; Schneider, 2001). This period of disclosure, when the reality and extent of the spouse's sexual behaviors outside of the marriage are exposed, is usually highly distressing and merits an informed response from professionals who would provide assistance. (Corley & Schneider, 2002; Schneider, Corley, & Irons, 1998). Spouses of sexual addicts (SSAs) report varied distressing symptoms and behaviors in response to their relationship with a sexual addict/compulsive (King, 2003; Milrad, 1999) and often seek mental health treatment immediately following the disclosure of the addictive behaviors due to significant distress (Corley & Schneider, 2002). Qualitative studies and clinical case reviews describe a collection of symptoms experienced by SSAs, including anxiety, depression, anger, rage, obsessive thoughts and compulsive checking behaviors, difficulty concentrating, increased isolation, and hyper-vigilance (Bergner & Bridges, 2002; Carnes, 1991; Milrad, 1999). In the literature, the behaviors of compulsive checking, emotional numbing, rage or increased isolation are viewed as maladaptive and signs of the SSA's own addictive tendencies and loss of self, and are often labeled as co-addictive behaviors (Carnes, 1991, 1987; Cermak, 1986; Corley & Schneider, 2002; Crawford, Hueppelsheuser, & George, 1996; Ferree, 2002; Matheny, 1998; Milrad, 1999; S-Anon, 2003; Schneider et al., 1998; Schneider, 1991; Weiss & DeBusk, 1993).

It is important to consider that the above symptoms and behaviors are common responses to significant life-altering traumatic events (Horowitz, Wilner, Kaltreider, & Alvarez, 1980; Ozer, Best, Lipsey, & Weiss, 2003). Although researchers such as Bergner and Bridges (2002) and Milrad (1999) state that many partners of sexual addicts display symptoms consistent with posttraumatic stress disorder (PTSD) in response to the discovery of sexual acting out in their partners, neither the presence nor causes of these symptoms have been validated. Additionally, factors specific to the manner in which the spouse becomes aware of the compulsive sexual behaviors may contribute to the traumatic nature of revealed sexual misconduct. This article presents results of a study that explored the effects of disclosure of sexual addiction from the perspective of its resulting traumatic stress response of the spouse.

SPOUSES OF SEXUAL ADDICTS

The spouse or partner of a sexual addict bears a great burden and experiences disruption in response to the out-of-control sexual behaviors of the addict. While both men and women are in committed relationships with sexual addicts, this study focused upon wives of sexual addicts (WSA). WSAs have been described by most sexual addiction professionals as bringing psychological and relational difficulties with them into their primary relationship with a sexual addict. Surveys of those married to sexual addicts have provided information on family of origin issues, past abuse, and relational style (Carnes, 1991; Ferree, 2002; King, 2003; Milrad, 1999; Schneider, 2002; Wildmon-White, 2002; Wildmon-White & Young, 2002). The most frequently reported patterns of dysfunction and personal history include history of sexual abuse, family history of addiction, lack of self-esteem, emotional instability, rigid and disengaged family of origin structure, and restriction of emotional expression (Carnes, 1991; Schneider, 2001).

Milrad (1999) conducted a qualitative study of 35 WSAs to explore the experiences of wives following the disclosure or awareness of their husbands' sexual addiction, and found that the women became involved in what she termed "detective behavior" or checking the husbands' belongings for evidence of hidden sexual behavior (p. 127). According to Milrad, if the wife found evidence and confronted her husband, the addict typically denied any misbehavior. This then led to escalation of her behaviors as she became obsessed with the addict's actions. Milrad stated that wives described their husband's actions and broken trust as "traumatic, painful, and exhausting and said they were significant in destroying their trust in their husbands" (p. 128). Milrad also found that the wives reported feeling anger, sadness, and shame while involved in detective behaviors, with many displaying symptoms consistent with posttraumatic stress disorder (PTSD) when they felt suspicious of their husband's behaviors.

In a qualitative study on the effects of cybersex on the family, Schneider (2000) described the effects of the discovery of sexual addiction upon the spouse as resulting in feelings of "hurt, betrayal, rejection, abandonment, devastation, loneliness, shame, isolation, humiliation, jealousy, and anger, as well as loss of self-esteem" (p. 31). Bergner and Bridges (2002) conducted a qualitative study based upon 100 writing samples of WSAs from four Internet message boards. The authors discovered several common themes of meanings within these writings, including experiencing the discovery of sexual addiction as a traumatic event, experiencing a reappraisal of the relationship, and experiencing the sexually addictive behaviors as betrayal or infidelity. Wildmon-White (2002) measured learned helplessness and relational attachment styles of conservative Christian wives of sexual addicts. In this study, Wildmon-White reported that WSAs exhibited learned

helplessness and insecure relational attachments. Wildmon-White and Young (2002) also conducted research with wives to determine family-of-origin characteristics. The results of this study suggested that significant differences existed between WSAs and a control group in the area of family-of-origin characteristics as measured by the Family Adaptability and Cohesion Scale (FACES II) (Olson, 1992). The authors found that WSAs "are more likely to have encountered abuse, abandonment, chaos, physical punishment, crises, and depression in their families of origin" (Wildmon-White & Young, 2002, p. 269).

RELATIONAL TRAUMA AND INFIDELITY IN SEXUAL ADDICTION

WSAs experience their husband's sexual acting out behaviors as significant and damaging betrayals that threaten the relationship, contributing to the traumatic nature of disclosure. These betrayals come in the form of marital infidelity and deception. However, there is little in the way of discussion in the literature of the WSA's experience of the betrayal that occurs within sexual addiction as infidelity or as traumatic. Betrayal in marriage was defined by Finkel, Rusbult, Kumashiro, and Hannon (2002) as the "violation by a partner of an implicit or explicit relationship-relevant norm" (p. 957). Interpersonal violence and other relationally-based traumatic events and betrayals are among those that result in significant trauma symptom levels (Green, Goodman, Krupnick, Corcoran, Petty, Stockton, & Stern, 2000). Perhaps the greatest trauma occurs in response to a traumatic event involving a person with which the survivor has a close, personal relationship. Finkel et al. (2002) suggested that "betrayal of one's partner constitutes one of the more serious threats to a relationship" (p. 956).

Johnson (2002), a pioneer of Emotionally-Focused Therapy (EFT), identified relational traumas as attachment injuries between those in close relationships. From this perspective, relationally traumatic events involve betrayal, abandonment, or refusal to provide support at times when they are needed the most. Johnson stated, "although these events may be considered small 't' traumas, rather than the life-shaping events to which this term usually refers, they are nevertheless extremely significant . . . they overwhelm coping capacities and define the experience, in this case the relationship, as a source of danger rather than a safe haven in times of stress" (p. 182). Johnson went on to describe the emotional and behavioral responses of the injured partner following a relational trauma. "Following traumatic abandonment, an injured partner's involvement in the relationship often becomes organized around eliciting emotional responsiveness, or defending against the lack of this responsiveness from the other partner. Moreover, the injured partner may exhibit the classic symptoms characteristic of PTSD, such as re-experiencing, numbness, and hyper vigilance" (p. 187).

The betrayal of infidelity is a specific form of relational trauma. Infidelity or extra marital sex is considered by many as "a betrayal of the marital promise . . . a form of deviant or immoral behavior" (Previti & Amato, 2004, p. 218). Lusterman (1998) divided infidelity into three major types: (a) one-night stands, (b) philandering, and (c) affairs. Lusterman also listed varied motivations for marital infidelity, including life crises, entitlement, sexual identity issues, sexual addiction, exploratory affairs, retaliatory affairs, and exit affairs. Lusterman stated that traumatic stress symptoms "are the usual results of the discovery of the infidelity" (p. 15). Glass (2003) stated that the news of a partner's infidelity "sends a jolt of adrenaline into the body that sets off a stress reaction" (p. 89), including symptoms of numbing, obsessing, interrogating, and shifting emotions. Additionally, Glass and Wright (1997) described the intensity or depth of the trauma as dependent upon the way in which the discovery occurred. The clinicians also disagreed with commonly held beliefs by many marriage and family treatment specialists that a betrayed spouse "must have some level of awareness and colludes in an extramarital triangle," with the betrayed spouse capable of total unawareness of the infidelity prior to disclosure (p. 475). According to Glass and Wright, betrayed spouses commonly suspect some form of marital infidelity and may confront their partner, only to receive denials from their betrayer. The clinicians suggested that these denials prior to disclosure of the infidelity add to its traumatic nature. Further, Glass and Wright proposed that the traumatic nature of disclosure of infidelity intensifies when the threat continues, through the continuation of the marital affair or lack of proof of its discontinuation.

Coop-Gordon and Baucom (1998, 1999, 2003) theorized that recovery from infidelity to the place of forgiveness shares many similarities with recovery from a traumatic event. The authors pointed out several similarities in symptoms experienced by the injured party following infidelity, including cognitive responses of a sense of victimization, confusion, intense emotions, and defensiveness. Emotional responses to infidelity mirror those of other traumatic events, including shock, repression, denial, intense mood fluctuation, depression, anxiety, and lowered self-esteem. Behaviorally, victims of infidelity demonstrate the need to question the offender repeatedly, and experience hypervigilance, intrusive thoughts about the event, along with obsessive thoughts of acts of revenge or punishment. Coop-Gordon et al. (2004) conducted a mixed methods design study of a treatment model with 13 couples in recovery from a single act of marital infidelity. The authors found high levels of PTSD symptoms as measured by the Posttraumatic Stress Disorder Symptom Scale-Self Report (PSS-SR) (Foa, Riggs, Dancu, & Rothbaum, 1993) among half of the non-offending partners at intake, with three non-offending partners scoring in the severe range. The authors described this finding as consistent with their "trauma model of affairs" (Coop-Gordon et al., 2004, p. 225). If the disclosure of one episode of marital infidelity is traumatic

to the non-offending spouse, then the disclosure of multiple acts of infidelity within the context of sexual addiction may be experienced as traumatic as well.

DISCLOSURE AND DISCOVERY OF SAC

In addition to being symptomatic of an addiction or compulsive disorder, the behaviors often associated with sexual addiction constitute a breech of a marital promise of fidelity for WSAs (Bergner & Bridges, 2002). Thus, relational trauma is likely to occur with the disclosure of sexual addiction. McCarthy (2002) stated disclosure of the sex addict's behaviors usually occur because of a "dramatic incident" where the addict's previously secret out-of-control sexual behaviors are broken or suddenly uncovered (p. 276). McCarthy went on to describe the potential disclosure has for relational trauma because the male sexual addict "sees this [the addiction] as his secret domain, totally separate from the woman and having no impact of the marriage or family" (p. 275).

Glass (2003) described the intensity of response to disclosure of infidelity, including sexually addictive behaviors, as dependent upon "how the discovery was made, extent of shattered assumptions, individual and situational vulnerabilities, the nature of the betrayal, and whether the threat of betrayal continues" (p. 94). Glass also described the response of the non-involved spouse as "acting crazy . . . they are hypervigilant . . . they have flashbacks . . . they obsess over details" (Glass, 1998, p. 74). Glass (2003) reported that the disclosure of infidelity can occur through confessions, third party informants, or through accidental discovery. Glass also stated that the revelation of sexual addiction is particularly traumatic, in that "the betrayed partner often hears about multiple sexual encounters staggered over time . . . every time the betrayed partners think they have heard it all, they are re-traumatized with additional horror stories" (pp. 100–101).

WSAs experience a variety of distressing symptoms and behaviors, frequently in direct response to the revelation that their husbands have secret lives of hidden and compulsive sexual behaviors outside of norms of a monogamous marital relationship (Steffens, 2005). These repeated episodes of relational betrayal bring about a host of responses. Trauma response or symptoms consistent with PTSD are common among those presented with a significant life-altering event, including relational trauma. The revelation of a husband's hidden sexually addictive behaviors may constitute such a relational trauma. The existing literature also underscores the existence of a population of women who experience significant distress and who can benefit from thorough and informed assessment and mental health treatment.

To assist in determining whether the distress experienced by WSAs could be symptomatic of an exposure to a traumatic event (disclosure of sexual

addiction) the current authors studied WSAs within the initial five years following disclosure to determine the following:

1. Do WSAs experience symptoms consistent with exposure and response to a significant traumatic event?
2. How do factors around the disclosure process affect the severity of reported trauma symptoms?

METHODS

Population and Sampling

Participants appropriate for this study were required to be wives, age 18 or older, currently married and/or separated from self-identified sexual addicts. The authors utilized non-random sampling methods appropriate to special groups by seeking out participants who met the above criteria, due to the specific nature of the research problem (Everatt, 2000). The primary researcher sought to obtain participants from urban and rural areas as well as from diverse racial and ethnic groups. The resulting non-random convenience sample consisted of 63 women. The women came from 26 states within the United States, and from one additional country.

Questionnaire Data

Participants completed a self-report questionnaire created for the study to provide demographic information and information on the following variables related to the disclosure/discovery of the SAC, based upon the literature:

1. Method of disclosure/discovery: intentional, accidental, or third party (Afifi, Falato, & Weiner, 2001; Glass, 2003; Glass & Wright, 1997).
2. Husband's sharing of information in response to the discovery/disclosure: denial, partial information, full disclosure (Corley, 1998).
3. Number of repeated disclosure events, and response at discovery: accepting responsibility, denial, or blaming spouse (Glass & Wright, 1997; Schneider et al., 1998).
4. Suspicion of sexual infidelity prior to disclosure and response of husband to suspicions (Glass & Wright, 1997; Schneider et al., 1998).

Measurements

Each participant completed two self-report instruments, the Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995) and the Impact of Event Scale-Revised (IES) (Weiss & Marmar, 1997).

PDS

The PDS (Foa, 1995) is a 49-item, self-report instrument designed to test for a diagnosis of PTSD along the five *DSM-IV-TR* (American Psychiatric Association; APA, 2000) diagnostic criteria and to measure symptom severity. The PDS report confirms or rules out *DSM-IV-TR* PTSD, as well as quantifies trauma symptom severity from total scores on a symptom severity scale (from 0–51), numbers of symptoms endorsed (from 0–17), and level of functional impairment (0–9) related to the most distressing traumatic event. The PDS was validated on adults, aged 18 to 65, and requires an 8th grade reading level. The instrument takes approximately ten minutes to administer (Foa, 1995).

The PDS demonstrated good test-retest stability following a second administration 10 to 22 days following the initial administration, with a kappa score of .74, and a high degree of reliability regarding diagnosis at 87.3% (Foa, 1995). The Symptom Severity Scores are internally consistent, with a Cronbach alpha of .92. Tests of validity demonstrated that the PDS has a good overall level of diagnostic agreement with the SCID (Structured Clinical Interview for *DSM-III-R*) in correctly identifying individuals with PTSD at 82.0%, and correctly identifying those without PTSD at 76.7%.

The participants followed special instructions for the completion of this assessment and were directed to identify the discovery/disclosure of their husband's sexual addiction as a traumatic event under "Other" in question 12, and to utilize their responses to the disclosure/discovery event to answer the remainder of the assessment's questions. Participants also endorsed any additional traumatic events meeting PTSD diagnostic criteria, enabling the authors to determine the number of exposures to significant traumatic events.

IES-R

The IES-R (Weiss & Marmar, 1997) is a 22-item, self-report instrument that measures levels of trauma symptoms along three subscales (Avoidance, Intrusion, and Hyper arousal) consistent with the diagnostic criteria for PTSD, within the preceding seven days and in response to a specific traumatic event. The instrument is a revision of the original Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) developed prior to the establishment of PTSD as a diagnosis. The revised version added six new items to assess for hyperarousal symptoms to meet the changed *DSM-IV* diagnostic criteria, and changed the scale from frequency of a symptom to level of distress (Weiss, 2004). Assessment respondents rate each item on the instrument on a scale from zero (not at all) to four (extremely) regarding the degree to which a given item's symptom was problematic within the preceding seven days. The instrument is event-specific, in that it asks the respondent to answer items in response to a specified distressing life event. Researchers tested the

parametric properties of the IES-R utilizing two samples from natural disaster survivors and first responders (Marmar, Weiss, Metzler, Ronfeldt, & Foreman, 1996). Results from both samples revealed very high internal consistency. Test-retest data revealed higher consistency from shorter test–re-test intervals, which the authors suggest is due to immediacy of the intervals between the traumatic event and retest. The samples did not contain participants identified as suffering from PTSD; thus warranting further research on clinical samples. The measure takes about 10 to 15 minutes to administer (Weiss & Marmar, 1997). The assessment was scored by calculating the mean scores of items specific to a given scale (intrusion, avoidance, and hyperarousal) and adding the three means for a total score.

Participants answered the questions in response to the event of initial disclosure/discovery of sexually addictive behaviors in their partner as directed. Weiss (2004) warned researchers of the need to provide rationale for use of events not recognized by the *DSM* or how the proposed event meets the *DSM* criteria, and to be cautious in use of a class of events rather than identifying a specific event or incident. The event under study is a specific traumatic incident rather than a class or group of events, given that participants were directed to complete the IES-R and the PDS using the event of initial disclosure/discovery of the sexually addictive behaviors.

Data Collection

The primary researcher contacted treatment professionals who specialize in SAC through the Society for the Advancement of Sexual Health (SASH), contacted additional mental health professional colleagues who specialized in working with sexual addicts/compulsives and their wives, and contacted national organizations who provide online support or education on the issue of compulsive sexual behaviors. Participants were instructed to contact the primary researcher directly by phone or email. The researcher then mailed informed consent forms, questionnaires, and self-report measures to potential participants and requested the materials be returned postage paid. Returned materials were screened for completeness and to determine whether they met the requirements to participate in the study. Resulting information and self-report scores were entered into a database and statistical package. Data collection occurred between November 2004 and February 2005. Applicable Health Information Portability and Accountability Act (HIPAA) standards were reviewed and all necessary steps taken to meet these privacy requirements.

Research Design

The authors utilized quantitative, causal-comparative research design. Multivariate statistical methods were utilized to identify relationships between

factors related to disclosure, trauma and demographic information and trauma symptom severity among WSAs. Multivariate analysis of variance (MANOVA) was utilized to determine the statistical significance of independent variable(s) upon two or more dependent variables (Weinfurt, 1995). In this study, the effects of type of disclosure (intentional or accidental, as measured by the disclosure questionnaire) upon symptom severity scores on the IES-R Avoidance, Intrusions, and Hyperarousal subscales were examined. An additional MANOVA explored the effect of trauma history among WSAs (no prior trauma exposure vs. previous trauma exposure, as measured by the PDS number of prior traumas item) upon total symptom scores on the PDS and IES-R.

Additionally, this study measured trauma symptom severity among wives to determine relationships between these scores and factors identified as significant to and predictive of WSA distress. Licht (1995) stated, "One can gain a better understanding of the nature of a phenomenon by identifying those factors with which it co-occurs. Although not conclusive, it is likely that co-occurring factors either are causally related to one another or have other causative factors in common" (p. 33). Multiple regression and Correlational designs (MRC) assisted in the prediction of a criteria, and "provides a linear formula for combining the predictors to make the prediction" (p. 31). Multiple regression analysis "determines the best combination of the set of predictors for predicting the single criterion" (Licht, 1995, p. 60). Linear multiple regression analysis was used to determine any linear relationship between predictors (factors) and criterion or dependent variable (symptom severity score on the PDS).

RESULTS

Overview of WSAs

The mean age of the WSAs was 40.13 ($SD = 8.732$), mean years married at the time of the study was 13.99 ($SD = 9.845$), mean number of times married was 1.32 ($SD = .692$), and the mean amount of time since the disclosure of the sexual addiction was 1.85 years ($SD = 2.084$). The racial makeup of the study's participants was 93.7% Caucasian, 1.6% African American, and 4.8% Hispanic. The WSAs' current employment status was 63.5% employed out of the home, and 82.5% of the women reported receiving some form of counseling in response to the disclosure of their husband's sexual addiction. The highest percentage of women (42.9%) had completed an undergraduate college degree, followed by 22.2% graduate degrees, 17.5% some college, and 12.7% associate or other two-year degrees or certificates. Approximately 75% ($N = 47$) of the WSAs experienced the disclosure through their own initial discovery of evidence of the addiction and its behaviors. In some of the cases (15.9%, $N = 10$), the disclosure occurred in a planned manner or

TABLE 1 PDS Data Summary, $N = 46$ Valid

	M	Minimum	Maximum	*SD*
Re-experiencing Symptom Score	6.54	1.00	15.00	3.51
Avoidance Symptom Score	8.02	.00	21.00	4.91
Arousal Symptom Score	5.87	.00	13.00	3.55
PDS Total Severity Score	20.24	1.00	42.00	10.74
Symptom Level Score	2.28	1.00	4.00	.86
Functional Impairment Score	2.57	1.00	3.00	.75

Note: Symptom Level Scores are based on a four-point scale, with 1 = mild symptom level, 2 = moderate symptom level, 3 = moderate to severe symptom level, and 4 = severe symptom level. Functional Impairment Scores represent Criteria F for diagnosis of PTSD (American Psychiatric Association, 2000) and are based on a similar scale measuring overall functional impairment, with 0 = no functional impairment, 1 = mild functional impairment, 2 = moderate functional impairment, and 3 = severe functional impairment.

was initiated by the husband, through a planned confession, in response to a confrontation, or in a counseling session setting.

PTSD Consideration

In this current study, 69.6% ($N = 32$) of participants met all but Criteria A1 for a diagnosis of PTSD, including criteria A2, which requires that the individual experience feelings of helplessness and terror in response to the traumatic event. The PDS revealed number of symptoms endorsed and symptom severity scores for criteria B, C, and D. Criteria E, F, and symptom duration scores (Acute or Chronic) also were tallied. PDS scores revealed Symptom Severity Rating scores (no rating to severe) and Level of Impairment in Functioning scores (no impairment to severe impairment). Table 1 summarized the PDS Subscale Scores and Table 2 summarizes the Symptom Severity Scale and Functional Impairment Scores.

The PDS also allowed participants to describe other traumatic event exposure, following *DSM* criteria for PTSD. Roughly seventy-nine percent (79.4%, $N = 50$) of total participants ($N = 63$) endorsed exposure to

TABLE 2 PDS Symptom Level and Functional Impairment Scores ($N = 46$)

	N	*Percent*
Symptom level		
Mild	11	23.9
Moderate	12	26.1
Moderate-Severe	22	47.8
Severe	1	2.2
Functional impairment		
Mild	7	15.2
Moderate	6	13.0
Severe	33	71.7

additional traumatic events. These results compare to survey results regarding lifetime trauma-exposure rates among women at 51.2% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and at 65% for a single traumatic event exposure and 38% for multiple trauma exposure (Green et al., 2000). Interestingly, the current study found that 42.9% ($N = 27$) of the women reported experiencing sexual abuse, compared to Carnes' (1991) much higher study rate of 81%. The study participants also cited experiences of non-stranger sexual assault at a rate of 36.5%. Fifteen of the WSAs who experienced sexual abuse endorsed both non-stranger sexual assault and sexual abuse, and an additional four endorsed experiencing three forms of sexual assault: sexual abuse, non-stranger sexual assault, and stranger sexual assault.

IES-R

The WSAs completed the IES-R (Weiss & Marmar, 1997) and rated how distressing each difficulty or symptom was for them in the prior seven days as they related to the initial event of disclosure/discovery of their husband's SAC. IES-R items provided scores for Avoidance, Intrusion, and Hyperarousal subscales and a total symptom score. These subscales reflect global distress levels on Criteria B, C, and D for PTSD (APA, 2000). WSA scores from the IES-R are summarized in Table 3.

PDS

An analysis using the Pearson product-moment correlation coefficient was conducted to determine relationships between PDS Subscale Scores and factors related to the initial disclosure of SAC. There was a moderate positive correlation between the variable of Years Married at Initial Disclosure and the mean score for the Re-experiencing Symptom Scale Score ($r = .355$, $p = .016$), with an increased symptom score associated with increased length of marriage at disclosure. Additionally, there was a moderate positive relationship between Time since Disclosure and Arousal Symptom Scale ($r = .391$, $p = .030$). The variable Number of Traumatic Event

TABLE 3 IES-R Data Summary, $N = 63$

	M	Minimum	Maximum	*SD*
Avoidance symptom scale	1.24	.00	3.75	.80
Intrusion symptom scale	2.00	.00	3.86	.99
Hypervigilant symptom score	1.59	.00	3.86	1.00
IES-R Total severity score	4.85	.00	9.57	2.39

Note: Symptom scale scores are based on a four point scale describing how much the participant was distressed or bothered by the symptom, with 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely. The total severity score represents the total of the three symptom scale scores.

TABLE 4 Correlational Data for PDS Subscale Scores and Disclosure Variables

Variable	Re-experience	Avoidance	Arousal
Time since disclosure	.171	.117	.319*
Years married at disclosure	.355*	.275	.199
How disclosed	.005	.048	.025
Episodes of disclosure	−.141	−.098	.179
How much information shared	.080	.151	.160
Husband's response	.031	.085	.107
Number traumatic event exposures	.347*	.322*	.287

Note: Values represent Pearson correlation.
*$p < .05$.

Exposures was positively correlated with both the Re-experiencing Symptom Scale Score ($r = .347$, $p = .018$) and Avoidance Symptom Scale Score ($r = .322$, $p = .029$). Table 4 summarizes the PDS Subscale Correlational data.

Highest levels of positive correlation were found for Years Married at Disclosure ($r = .309$, $p = .037$), and Number of Traumatic Event Exposures ($r = .342$, $p = .020$) on the PDS Total Symptom Score. The next highest level of correlation occurred between the PDS Total Symptom Severity score and Time since Disclosure ($r = .223$, $p = .136$). Additional positively correlated items included How Disclosed and Time since Disclosure ($r = .406$, $p = .005$). The variable Husband's Initial Response to Disclosure was negatively correlated with Time since Disclosure ($r = -.343$, $p = .020$).

Multivariate Analysis

The authors conducted analysis utilizing one-way between-groups multivariate analysis (MANOVA) to determine if there was a significant difference on the Avoidance, Intrusions, and Hyperarousal IES-R subscale mean scores between WSAs who experienced an intentional versus accidental disclosures (ACC). One outlier was identified and removed from the sample prior to running the MANOVA ($N = 62$). The MANOVA revealed no significant effects of the independent variable ACC among WSAs on the dependent variables of IES-R Subscale Scores utilizing the Wilks' Lambda value: $F(3, 58) = 1.76$, $p = .165$.

Additionally, the authors conducted analysis utilizing MANOVA statistical methods to determine whether there was a significant difference on the IES-R total scores and PDS Symptom Severity scores between WSAs who have experienced previous traumatic events and those who have not. Tests for assumptions of multivariate normality, linearity, multivariate or univariate outliers, and homogeneity of variance-covariance matrices revealed no serious violations. Utilizing Wilks' Lambda value, there was no significant

effect of the independent variable of Prior Trauma (PT) upon both the PDS Symptom Severity Score and the IES-R total score: $F(2, 43) = 11.77$, $p = .183$. A review of the mean scores revealed that those with Prior Trauma Exposure had higher mean scores for the IES-R total score ($M = 4.66$, $SD2.34$) and PDS Symptom Severity Score ($M = 21.61$, $SD = 9.92$) than those who had no PT (IES-R: $M = 4.06$, $SD = 2.81$; PDS: $M = 15.30$, $SD = 12.62$).

A subsequent linear regression analysis revealed that that among WSAs, there were predictive values from a linear combination of the factors of Number of Prior Traumatic Event Exposures (standardized coefficient .421, $p = .003$) and Years Married at Disclosure (standardized coefficient .393, $p = .005$) upon PDS Total Symptom Severity scores. This result revealed that for this sample of WSAs, factors related to how the disclosure occurred and the husband's response did not predict increased symptom severity, but rather the length of the marriage at disclosure and the WSAs' number of prior traumatic event exposures best predicted increased trauma symptoms severity.

DISCUSSION

The Traumatic Nature of Disclosure

This study provided valuable information on how the WSAs experienced the initial disclosure episode of SAC and described factors related to disclosure that may contribute to its traumatic nature. Perhaps most importantly, this study revealed that 69.6% of valid participants met all but Criteria A1 for a diagnosis of PTSD as measured by the PDS, including the experience of terror or helplessness during the event. Those who did not meet the other criterion for PTSD either had subclinical levels of scores on the subscales, or did not experience terror or helplessness during the disclosure event. Additionally, the PDS revealed that 50% of the WSAs experienced Moderate to Severe ($N = 22$) or Severe ($N = 1$) levels of symptom severity. Although the event of initial disclosure of SAC does not meet the current Criteria A1 for PTSD, the resulting traumatic stress symptoms suggested that the event itself had profound traumatic effects upon many WSAs.

The data also revealed 75% of the women studied uncovered or discovered evidence of compulsive or addictive sexual behaviors themselves, as opposed to a planned disclosure or confession on the part of their husbands. While this was consistent with previous research, this result illustrated the degree of suddenness or surprise surrounding the disclosure episode that may contribute to the traumatic nature of disclosure. The data and women's comments also revealed the level of functional impairment following the initial disclosure of SAC. A full 71.7% of the WSAs demonstrated a severe level of functional impairment in major areas of their lives, as measured by the PDS Functional Impairment Score that reflects the PTSD diagnostic

Criteria F. Criteria F required "significant distress or impairment in social, occupational, or other important areas of functioning" to meet the requirements for PTSD diagnosis (APA, 2000, p. 468). For example, one woman stated, "I was shocked. I threw up, couldn't sleep, couldn't eat, cried constantly, couldn't work." Another stated, "It impacted me severely emotionally and physically. It was devastating."

The data also suggested that, although WSAs experienced accidental disclosure as traumatic, a planned or intentional disclosure produced traumatic-stress response symptoms as well. While the data revealed no significant effect of method of disclosure upon the mean scores on the IES-R, it suggested that initial disclosure, as a significant distressing event, resulted in significant symptoms of traumatic stress regardless of how it occurred. Subsequent analysis sought to uncover what factors related to initial disclosure produced increased trauma symptom severity among WSAs.

In summary, these results suggested the event of initial disclosure is indeed a traumatic event, resulting in significant trauma-related symptoms and functional impairment. In this study, the length of the marriage at disclosure and the number of prior traumatic event exposures experienced by the WSA best predicted severity of trauma symptom levels.

Theoretical and Treatment Implications

Addiction model

The current addiction model views sexual addiction as a family disease. The popular conceptualization of the responses and treatment needs of WSAs centers upon the women's addictive or obsessive relationship with an addict and predisposition to the development of coaddiction due to the WSAs' traumatic and dysfunctional pasts. In the current addiction model, WSAs frequently receive referrals to 12-Step groups and are encouraged to focus upon their own recovery programs. The WSA is "in recovery" when she refrains from attempts to control the husband's sexual acting out and becomes less reactive emotionally to his addictive behaviors. Many writers within the professional sexual addiction treatment community conceptualize the WSA's initial response to disclosure as a crisis and respond accordingly, while working towards encouraging the WSA to enter her own recovery program for her illness. This model has provided help, support, and recovery for hundreds of SSAs.

The current addiction model centers upon the concept of the disease model, whereby individuals with illnesses or diseases such as addictions must engage in recovery behaviors to obtain remission and to prevent relapse. In addiction, there is no cure. For WSAs, this means that, although she is told that her husband's addictive or compulsive behaviors are not about her, she is also told that she carries her own disease that contributes

to the continuation or deepening of the sexual addiction. Her attempts to "fix" the addict are therefore viewed as symptomatic of her own addictive illness, co-addiction. The co-addict in recovery demonstrates health by her ability to focus upon her own life and detach from the addict by reducing her obsession with her spouse's life and behaviors. Her trauma history contributes to her distress as these past traumas are triggered by the act of sexual betrayal.

Trauma model

Trauma theory conceptualizes the responses and needs of the WSA somewhat differently. Rather than conceptualizing her symptomatic responses as arising from her own dysfunction and addiction, the WSA's responses serve as a reaction to a stressor that is traumatic in nature, in predictable emotional, behavioral, and physiological ways as her mind and body attempts to survive and adapt to a dangerous situation. Attempts to avoid painful stimuli and scan the environment for dangers are common reactions among trauma survivors. In the case of SAC, the WSA becomes hypersensitive to any indication that the threat has returned through behaviors she observes in her husband or through emotional reactions in response to a perceived cue or reminder of the threat. Obsessive and intrusive thoughts of the disclosure and of her husband's actions that caused injury occupy her mind and energy, as she seeks what she cannot find: safety in an unsafe situation. One woman described the impact of initial discovery this way: "In one moment, your heart and breathing stops. You have been completely thrown into an alternate universe. Nothing will ever be the same and you know it." Her world has changed.

The husband's behaviors or environmental cues can "trigger" the WSA or bring about flashbacks, whereby she experiences the threat as if it is currently occurring. If her husband continues to act out, dismiss or deny the destruction of his behaviors, or does not take actions to help restore safety in the relationship, the WSA remains in a situation of perpetual threat until she finds ways in which she can develop self-protection skills and adaptive ways of managing the anxiety and stress. Prior traumatic event exposure may contribute to her vulnerability to the development of clinically significant distress, as she once again experiences her world as an unsafe place. The event of disclosure is traumatic and her reactions following disclosure are in response to the current traumatic event, rather than simply a triggering of prior trauma. The event of disclosure, as in any crisis or highly stressful situation, also provides an opportunity for the WSA to learn and develop effective and adaptive methods of managing stress and to put safety measures or boundaries into her life to help protect against further injury.

Attachment model

Attachment theory complements trauma theory in its description of attachment injuries and relational traumas. Individuals bond in significant close relationships and when the bond or connection is threatened, repair attempts on the part of the injured party serve to re-establish the connection. These repair attempts can include behaviors such as clinging, obsession, pursuit, angry outbursts, and detective behaviors (Bowlby, 1988; Kobak, Cassidy, & Zir, 2004). Attachment injuries, whereby one partner betrays the trust or injures the other through intentional behaviors, evoke significant anxiety and are traumatic in nature (Johnson et al., 2001; Kobak et al., 2004; Rholes & Simpson, 2004). The discovery of deception and multiple acts of marital infidelity such as those that occur with sexual addiction can certainly be a threat to the integrity of the relationship and trigger significant attachment injuries. One woman's statement illustrated this kind of attachment injury: "I was in total shock. I went from a good marriage to one on the brink of divorce in the flash of an eye." Another stated, "[My] initial reaction was to shake uncontrollably—I've had this kind of reaction before to death. This was death."

Comparison of trauma and addiction models

Addiction theory views the WSA as carrying an illness into a relationship from which she must recover, while trauma theory views her as someone who had a bad thing happen to her. Trauma theory also posits that the survivor can find healthy ways to cope and adapt to the trauma exposure. Both models promote recovery and growth. However, the trauma model acknowledges the significant destructive event of disclosure of repeated infidelities and betrayals and conceptualizes her reaction as typical and expected response to an extreme stressor, and given the danger she perceives. As one woman described the disclosure event, "These events rocked me to the core of my soul." Another stated, "It left me shell shocked. I'm hypervigilant and skeptical of everything, even when I try not to be." A trauma model respects the devastation in the life of the WSA, through no action of her own.

Treatment from the trauma perspective shares common goals and interventions with the addiction model, but also suggests some important differences. Rather than addicted and pathological, the WSAs' most disruptive behaviors are framed as attempts to adapt to a serious threat and thus she can be encouraged to try new adaptive strategies that can provide what she is seeking: an increased sense of empowerment and safety.

As summarized previously, no factors around how the disclosure occurred contributed significantly to trauma-related symptoms among this sample of WSAs. However, it is important to note that the study did not measure other symptomatic distress and therefore the study results do not suggest

that staggered disclosures were not damaging. Further research would assist treatment professionals in understanding the relationship between disclosure and resulting distress among WSAs.

Additionally, the study's results revealed a very strong relationship between trauma symptom severity and years married at the time of disclosure. This offers important and valuable implications for those treating the person with SAC. Early identification of problematic sexual behaviors and subsequent treatment assists not only the addict, but also contributes to lessening the traumatic damage of disclosure, if the disclosure can occur earlier in the marital relationship. Perhaps this increased damage is due to the length of time deception was a large part of the relationship, or due to the possible progression of the behaviors as the addiction flourished. Clearly, disclosure is traumatic regardless of when disclosed; however, this result suggested that the longer the problematic behavior continues unaddressed, the greater damage done to the addict and specifically his spouse.

In summary, this study revealed the existence of a trauma-related response among WSAs that deserves attention and consideration. This data supports the previous descriptions of the WSA and the disclosure process, while providing an alternate conceptualization for fully understanding the impact of disclosure and the traumatic nature of learning of a husband's SAC beyond the construct of co-addiction. Responding to the trauma-related distress of WSAs will enable her to begin a recovery process based upon empowerment and adaptive strategies for responding to a significant betrayal and traumatic threat. Additionally, early intervention in SAC positively affects not only the person struggling with compulsive sexual behaviors, but also may reduce the severity of traumatic distress within WSAs.

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