SEEKING HELP FOR INTIMATE BETRAYAL TRAUMA: THE LIVED EXPERIENCE OF UNSUSPECTING WIVES RECEIVING COUNSELING MESSAGES FROM MENTAL HEALTH PROFESSIONALS AFTER DISCOVERING THEIR SEXUALLY ADDICTED SPOUSE'S OUT OF-CONTROL BEHAVIOR

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Johanna B. Dillenbeck

Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirement for the Degree

Doctor of Philosophy

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APPROVED BY

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Abstract

After unsuspecting wives (UWs) discover their sexually addicted spouse's (SAS's) out-of-control behavior (OCB) outside of their committed relationship, they may seek support from mental health professionals. Depending on a mental health professional's theoretical framework for treating sexual addiction (SA) and partner betrayal, women may receive messages based on a family systems approach for addiction counseling or from a trauma model that prioritizes the client's need for safety, stabilization, and grief work, with the goal of reconnecting the UW to a redefined sense of reality. Components of trauma work along with validation of an UW's experience offers UWs the safety to cope with the nature of an intimate betrayal trauma (IBT) and experience growth as part of the process. This transcendental phenomenological study explored the experience of UWs who sought counseling after discovering their SAS's OCB, and how messages they received from their mental health professionals impacted their recovery. Semi-structured interviews were used for data collection, and data were analyzed and coded based on conceptualizations from the Multidimensional Partner Trauma Model (MPTM), transcendental phenomenological approach required the researcher to suspend bias and work intentionally to honor participants' narratives with objectivity and curiosity. Phenomenological data analysis revealed three themes and eight subthemes. A subsequent discussion included an expansion of the literature, its application in practice, implications, recommendations for actions, and recommendations for further study.

Keywords: unsuspecting wives, sexually addicted spouses, out-of-control behavior, MPTM, intimate betrayal trauma, counseling messages

Dedication

I want to thank my faithful LORD, my protector and wise figure, who has been with me despite my lack of strength and courage (Joshua 1: 6-8). I thank you for your faithfulness from the start of this doctoral journey to its completion.

This dissertation is dedicated to my husband who continues to keep me on track as we "finish well" together. Thank you for never wavering in your belief that we would accomplish this important milestone. You have adjusted to a chaotic lifestyle for a while, and now I look forward to sunset walks, dinner on the water, and fulfilling some of our plans that have been in the que for some time. Thanks to Barbara, my youngest sister of many! You, your husband Pat, your son Vincent, and your daughter Emily have been an inspiration to me, and Ken, for your sacrificial love to us and to many!

Thank you to my courageous women friends who continue to love their families well and make time to reconnect and celebrate the many gifts that come with being a "seasoned" woman. Thank you for being there when I came up for air! I look forward to spending more time with you.

To my SRC family for encouraging me, providing nourishment for my soul, mind, and body, and for praying for me through this challenging journey. Thanks to my small group for listening patiently as I shared my successes and setbacks along the journey. By God's good grace, we did it! PTL!

Finally, I dedicate this work to the women participants who embody courage. Despite your painful discovery, you have navigated your experience of betrayal trauma, and have become beacons to many hurting women through your tenacity and compassion. Throughout the

challenges of a life you would not have chosen, you dare to envision better and more beautiful tomorrows! Thank you for graciously navigating the process with me.

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Thank you to my committee for making sacrifices to ensure this part of my doctoral journey would be completed in 2023. Thank you, Dr. Thomas, for agreeing to be my chairperson and for the work you do in this important field. During every step of this dissertation process, I stood in agreement with you and was amazed by His grace! Thank you to my committee, Dr. Mwendwa and Dr. Hinkley. Thank you to Dr. Joy Mwendwa who spoke powerfully into my life throughout the doctoral journey. I have felt your prayers! Thank you, Dr. Hinkley for investing your time and skills to ensure that mental health professionals make their therapeutic spaces safe for women.

Thank you, Dr. Sosin, for advocating for me as there were some obstacles for me to overcome in the program. Thank you, Dr. Volk, for encouraging me to go deep in my investigation of shame, sexuality, and spirituality. When I discovered betrayal trauma in your first class it changed the way I counsel women. Thank you, Dr. Roaten, for your encouragement and genuine interest in my progress. I look forward to more in-person meetings at professional conferences. Thank you, Dr. Spellman, for your hard work that was instrumental in getting our article published with Dr. Nivischi and Dr. Bohecker. What an honor it is to present our work and conference and reconnect. Finally, thank you Dr. Nivischi for raising the bar for my preparation as a counselor educator and supervisor and for providing multiple ways for me to experience leadership and advocacy. I am so grateful for Dr. Joy's e-mail that connected us. I am grateful for the **many** ways you supported me along this journey! Thank you, Linje, for sharing your amazing wife with me.

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List of Abbreviations

Unsuspecting wives (UW)

Sexually Addicted Spouses (SAS)

Out-of-control behavior (OCB)

Intimate Betrayal Trauma (IBT)

Multidimensional Partner Trauma Model (MPTM)

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CHAPTER ONE: INTRODUCTION

Counselor messages towards unsuspecting wives (UWs) of sexually addicted spouses (SAS) struggling with out-of-control behavior (OCB) reveal their conceptualization of addiction, the partner's role, and the relational dynamics among the couples. Despite growing research on sexual addiction and its effects on normative functioning (Carnes, 2020; Grubbs et al., 2020), the dearth of research that better understands the UWs' experience and divergent conceptualizations among scholars (Seyed Aghamiri et al., 2022; Stokes, 2020) has impacted treatment for SASs and UWs. Similarly, although limited in comparison, studies on the UW's experience have revealed that the discovery of a SAS/OCB is painful and traumatic (Keffer, 2018; Laaser et al., 2017; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2007) because the revelation violates the assumptions of relational trust, connection, and emotional safety (Herman, 1997). Although evidence supports the traumatic nature of UWs discovering a sexually addicted spouse's (SAS) out-of-control behavior (OCB) and, in many cases experiencing his chronic relapses and deceptions (Minwalla, 2021; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2007; Vogeler, 2018), insufficient research may perpetuate misrepresentation and confusion when UWs seek support from mental health professionals. While there has been a developing acceptance among specialists working with SASs and their UWs of the pain caused by the discovery of an intimate betrayal, scholars and practitioners differ on the partner's role, responsibility, and recovery (Black, 2019; Corley et al., 2013; Daniels & Farley, 2022; Hall, 2016; Hentsch-Cowles & Brock, 2013; Laltrello, 2020; Manning & Watson, 2007; Minwalla, 2021; Pollard et al., 2013; Reid et al., 2001; Schneider et al., 2012; Seyed Aghamiri et al., 2022; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Stokes et al., 2020). An UW's

therapeutic experience is contingent on the professional's aptitude and attitude about her condition.

This chapter introduces a transcendental phenomenological study that explored the lived experiences of UWs who discovered the OCB of their SASs and the messages they received from mental health professionals pre- and post-discovery. First, the study's background of the problem, the problem statement, the purpose statement, and the significance of the study are discussed. Next, the study's research questions are presented, followed by the conceptual frameworks. Key terms associated with the primary concepts significant to the study are operationally defined. Lastly, the study's assumptions and limitations are examined before summarizing and transitioning to Chapter 2.

Background of the Problem

When UWs discover their SASs' OCB and seek professional counseling, they receive messages from mental health counselors that reflect the professionals' training and value systems related to sexual addiction and the relational dynamics among family members, especially intimate partners (Carnes & Lee, 2014; Baird, 2011; Daniels & Farley, 2022; Laaser, 2018; Minwalla, 2021; Reddick et al, 2016; Reid et al., 2010; Schneider et al., 2012; Seyed Aghamiri et al., 2022; Steffens & Caudill, 2021; Steffens & Rennie, 2007; Stokes et al., 2020; Vogeler et al. 2018). Some UWs experience messages as "confusing, retraumatizing, and disorienting" (Vogeler et al., 2018, p. 49), which undermines their need for safety and stability after their discovery of their spouse's intimate betrayal (APSATS, 2022; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2011, 2021; Steffens & Rennie, 2007). Psychological trauma, such as intimate betrayal trauma (Steffens & Caudill, 2021), has become conceptualized as a deleterious human experience that overwhelms one's ability to function due

to a loss of stability, relational connection, and personal meaning (Herman, 2015; Kress et al., 2017). Although symptoms observed in UWs of SASs were once thought to be indicative of "codependence" (Black, 2019; Cermak 1991; Hentsch-Cowels & Brock, 2013) or "coaddiction" (Baird, 2011; Carnes, 2001; Milrad, 1999; Tripodi, 2006), trauma specialists and counselors who are trained in sex addiction partner work argue that dysregulated emotions and hypervigilience post-discovery are better explained as the UW's reaction to discovering that she has been the target of an intimate betrayal in the form of chronic infidelity, ruptured trust, deception and gaslighting (APSATS, 2022; Collins, 2017; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2007; Stokes et al., 2020). When Reid et al. (2010) compared the mental health of women married to SASs to a control group, they refuted previous notions that charaterized UWs as psychopathological. Instead they found that distress associated with their marriage to SASs differentiated their presenting symptoms from their counterparts. While a growing body of research shows evidence for the traumatic nature of discovering a SAS's OCSB, contemporary scholars argue for maintaining labels previously embedded in family systems treatment models that addressed chemical addiction recovery (Hentsch-Cowels & Brock, 2013), failing to distinguish the often imperceptable nature of sexual addiction from chemical dependence (Hall, 2016; Vogeler et al., 2018). Some scholars recognize the complexities of being in a relationship with SASs (APSATS, 2022; Minwalla, 2021; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2011, 2021), and others question the injustice of pathologizing family members who care about individuals with addictions (Weiss, 2018). The lack of research on the experience of UWs who receive messages from mental health professionals may perpetuate a professional's naivete or disregard for how

UWs respond to treatment that feels incongruent with their reality. Consequently, mental health treatment for UWs seeking support post-discovery may be inappropriate and traumatic.

For example, Hall's (2016) recent findings countered what was once conceptualized as the UW's propensity to collude with the behaviors of her SAS (Carnes, 1991) or choose to deny that a problem exists (Black, 2019). When she surveyed 126 UWs, only 30% were cognizant of the notion of sexual addiction prior to their traumatic discovery or mate's diagnosis. Within this same population, she found that 70% of UWs surveyed may have initially confused their mate's behavior with infidelity, suggesting that they may have sought counseling for issues unrelated to the chronic nature of sexual addiction, but hoped counseling would remedy their spouse's behavior. Other findings suggest that while UWs may have suspected their SAS's engagement in OCB, a myriad of factors associated with contemporary lifestyles (Daniels & Farley, 2022; Hall, 2016), protective self- and relationship appraisals (Gomez et al., 2016; Hall, 2016), and repeated dishonesty by the SASs (Keffer, 2018; Minwalla, 2021; Steffens & Means, 2021) may prevent UWs from confronting the reality of their SASs' OCB. Groundbreaking work on the traumatic nature of an actual discovery found that 70% of UWs who confronted the reality of their SASs' behavior experienced symptoms of trauma (Steffens, 2005) and that reactions post-discovery were attempts to find safety after their trust and intimacy attachments had been ruptured (Skinner, 2017; Steffens, 2005; Steffens & Rennie, 2006). These findings explained reactions commonly observed among individuals who are targets of psychological trauma inflicted by those entrusted to protect their psycholgical, physical, and spiritual well-being (Gomez et al., 2016; Herman, 1997). Another study revealed when partners including UWs were asked about their role in their SASs' OCB, 41.3% accepted their role as "co-addicted" or "codependent," despite 76.9% of participants from this study recounting the traumatic nature of confronting the

reality of their SAS's OCB (Corley et al., 2012). Surprisingly, 30.8% of the participants concurrently identified with the role of victim and coaddict, while 29.7% perceived themselves as victims but failed to identify as coaddicts (Corely et al., 2012). These findings reveal that labels such as "coaddicted" or "codependent" maintain a stronghold in counseling language associated with SASs and their UWs, and mental health professionals send messages to UWs based on outdated information regardless of their appropriateness or efficacy in treatment. Some mental health professionals who lack training or awareness may perpetuate labels entrenched in earlier frameworks without considering the traumatic nature of their messages. Consequently, mental health professionals may currently conduct treatment plans based on the family systems model for chemical addiction and use labels conveying messages to UWs that they are "coaddicted," "codependent," (Baird, 2011; Carnes, 2011; Cermak, 1991; Hentsch-Cowels & Brock, 2013; Stokes et al., 2020) and somehow culpable for their SAS's OCB. However, lack of research leaves the mental health community with limited evidence to indicate their usefulness or detriment to the UW's recovery.

Evidence supports that relational trauma (Herman, 2015), such as that experienced by UWs who learn of their SASs' OCB, has negative effects on psychological, emotional, and cognitive functioning, similar to what is typically observed in survivors seeking safety from an event that is out of their control (Herman 2015; Kress et al., 2017; Steffens, 2005). While UWs experience infidelity as a rupture in relational trust (Lonergan et al., 2021), UWs in relationship with SASs who have patterned OCB are more vulnerable to the effects of their SAS's chronic and risky behavior placing them in emotional, physical, psychological, and financial harm (Daniels & Farley, 2022; Steffens & Rennie, 2007). Adaptations from the family systems framework originally used to treat individuals with chemical addiction perpetuated the

stigmatization of women (Weiss, 2018) in committed relationships with SASs with OCB (Steffens, 2005). UWs may receive implicit or explicit messages that they are angry, controlling, manipulative, obsessed, and detrimental to their own recovery with insinuations that they take responsibility for their role and responsibility in their SAS's OCB (Black, 2019; Carnes, 2011; Hentch-Cowles & Brock, 2013).

Although scholars agree on the traumatic nature of discovering an intimate betrayal (Black, 2011; Carnes, 2011; Corely et al., 2013; Daniels & Farley, 2022; Hetsch-Cowels & Brock, 2013; Laaser et al., 2017; Laltrello, 2020; Manning & Watson, 2007; Pollard et al., 2013; Reid et al., 2010; Schneider et al., 2012; Seyed Aghamiri et al., 2022; Skinner, 2017; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2006; Stokes et al., 2020; Tripodi, 2006; Vogeler et al., 2018), differing beliefs about the UW's role and responsibility may leave them vulnerable to treatments that may be ineffective and revictimizing. Until further research explores the experience of UWs seeking treatment for their SAS's OCB, the mental health community remains uninformed about the messages women receive characterizing them as coaddicted (Carnes, 2001; Hentsch-Cowels & Brock, 2013; Schneider & Irons, 2001), codependent (Cermak, 1991; Weiss, 2018), pathological (Reid et al., 2010) or one seeking to recover from IBT (Lonegran et al., 2019; Minwalla, 2014, 2021; Schneider et al., 2012; Skinner, 2017; Steffens, 2006; Steffens & Caudill, 2021; Steffens & Means, 2021; Stokes et al., 2020). Laaser et al, 2017; Skinner, 2017; Sperry & Sperry, 2012; Steffens & Caudill, 2021; Steffens & Means, 2021).

Problem Statement

When compared to the abundance of literature on distress caused by excessive sexual behavior, the lack of research on UWs of SASs with OCB avails mental health practitioners with only limited approaches for conceptualizing partners' symptoms and providing effective counseling treatment plans (Seyed Aghamiri et al., 2022; Stokes, 2020). While studies refuted that UWs were not only unaware of their SASs' OCB (Hall, 2016; Minwalla, 2021; Skinner, 2017; Steffens, 2006; Steffens & Means, 2021; Steffens & Rennie, 2007) but traumatized by the discovery (Laaser et al., 2017; Minwalla, 2021; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2011, 2021; Steffens & Rennie, 2007), scholars and practitioners still debate about the appropriateness of conceptualizing the UW's discovery experience as traumatic (Daniels & Farley, 2022), suggesting instead that she confront her role and responsibility for her mate's addictive behavior and seek help for her "disease," or pathology (Baird, 2011; Carnes, 2001; Hentsch-Cowles & Brock, 2013; Stokes, 2020; Tripodi, 2006, Vogeler, 2018). Once conceived as a psychological form of abuse primarily against marginalized groups including women, mind manipulation brought on by using terms or conveying messages that seem incongruent to the client's reality is considered a sociological injustice brought about by an imbalance of power and control (Minwalla, 2021; Stark, 2019; Sweet, 2019). In their contributions to counseling women, Tyre et al. (2021) warn against the professional prescription, or social acceptablility, of 'sick roles' for women (Tyre et al., 2021, p. 22), while Gomez et al. (2016) called to question contextual factors that may be overlooked when treating women who have experienced trauma. While ostensibly unintentional, the confusion among scholars regarding recovery treatments forcing the UW's acceptance of her role and responsibility

perpetuates the SAS's gaslighting tactics (Tormoen, 2019) when UWs are manipulated into adapting to messages that seem incongruent with their experience.

Purpose Statement

This transcendental phenomenological study explored and described the lived experience of UWs seeking professional support after discovering their SASs' OCB and the messages they received from mental health professionals suggesting they were pathological rather than considering their need to recover from IBT. Additionally, this study sought to understand how the messages UWs received from their mental health professionals positively or negatively impacted UWs' recovery from the traumatic experience of their discovery.

Significance of the Study

Through interviews with UWs who sought professional counseling after discovering their SAS's OCB, this study applied a transcendental phenomenological framework to explore their experience with mental health treatments. While developing theories about a client's presenting issues and therapeutic needs post-interpersonal trauma (Herman, 2015, Steffens & Caudill, 2021), confusion among practitioners about the UW's role, responsibility, and recovery may subject her to confusing and retraumatizing interventions. Consequently, the mental health community would benefit from understanding how messages conveyed to UWs after discovering their SASs' OCB positively or negatively impact their recovery from Intimate Betrayal Trauma (IBT) (Steffens & Caudill, 2021). Specialists who study sexual addiction estimate that between 3% to 6% of the North American population struggle with a form of sexually uncontrolled behaivor identified by Carnes (1989) as compulsive masturbation, multiple sexual affairs outside the committed relationship, unrestrained viewing of pornography, as well as sexual behaviors that may be risky to themselves or others (Chaney & Burns-Wortham, 2015; Deneke et al., 2015,

Weinstein, 2014). Between 40% to nearly 70% of individuals seeking professional help for problematic sexual behavior are in relationships (Bothe et al., 2020a, 2020b, 2021; Kraus et al., 2016; Reid et al., 2012a; Wery et al., 2016). Approximately 25% of marital relationships are ruptured by betrayal, and evidence shows a rate three times higher in non-married relationships (Fincham & May, 2017; Londegran et al., 2019; Maddox Shaw et al., 2013). Between 30% and 70% of betrayed partners experince clinical symptoms which later develop into post-traumatic stress disorder (Laaser et al., 2017; Skinner, 2017; Steffens, 2006; Steffens & Means, 2021). Like individuals struggling with "rock-bottom moments" forcing them into treatment, both the SASs and the UWs enter therapy or counseling after the OCB is exposed (Collins, 2017). Although experts who work with SASs and their UWs may initially validate the traumatic nature of the discovery, the divergent beliefs about sexual addiction and the UW's role and responsibility may be conveyed in messages that confuse and pathologize them because they are in relationship with their SAS (Gomez et al., 2016; Schneider et al., 2012; Vogeler et al., 2018). Their confusion, perpetrated by professionals entrusted to provide a safe space for recovery from IBT, may compound the gaslighting UWs experienced from their SASs (Sweet, 2019). Alternatively, an adaptation of Herman's model (1992) called the Multidimentional Partner Trauma Model (MPTM) (APSATS, 2022) may provide a more effective framework for treatment (Steffens & Caudill, 2021).

This study sought to elucidate how UWs experience recovery frameworks through messages conveyed by mental health professionals. Due to the nature of exploring the experience of UWs with curiosity, UWs can not only inform the mental health community of their recovery journey, but benefit from the empowerment of sharing their narrative to help other women. Although limited research provides guidance to professionals counseling UWs, the findings of

this research potentially could impact training programs for related mental health professionals by bringing awareness of potential retraumatization and revictimization that women experience when they seek professional support post-discovery. This knowledge could change how counselors assess partners' experiences, conceptualize their therapeutic needs, and form collaborative relationships conducive to treatment. This awareness may improve counseling conceptualizations and practices when working with UWs of SASs with OCB, especially as researchers continue investigating relational dynamics between sexually addicted individuals and their partners. Accurate messages about UWs' experiences post-discovery will be necessary for couples counseling as a framework to build empathy between UWs and their SASs.

Empirical Significance

Exploration of the lived experience of UWs of SASs with OCB seeking counseling has empirical significance because it contributes to the literature on how women integrate and respond to professional messages which convey that they are pathological, or validate their desire to heal from IBT (APSATS, 2022; Minwalla, 2021; Steffens & Caudill, 2021; Tyre et al., 2021; Vogeler et al., 2018). Additionally, scholars and practitioners can learn to what extent labels support or detract from the UW's growth post-descovery as well as her process to recover from the effects of IBT. Through the exploration of UWs' narratives and descriptive experiences about their professional mental health counseling, this study elucidates the reality of counselor labels and messages that have their basis in individual and societal values, beliefs, (Reddick et al., 2016; Rosenberg et al., 2014) and theoretical frameworks (Sperry & Sperry, 2016). The existing power differential between therapist and client (Tyre et al., 2021) demands that consideration be given to prevent pathologizing UWs for their relationship with SASs and presenting issues associated with IBT (Gomez et al., 2016; Laaser et al. 2017; Steffens &

Caudill, 2021; Steffens & Means, 2021). In learning from the lived expeience of UWs seeking support from mental health counselors after discovering their SAS's OCB, the findings provide evidence on how vulnerable women integrate counselor messages based on congruence with their reality. In contrast to the extant research on the nature of sexual addiction and out-of-control sexual behavior, this research informs stakeholders in professional mental health on the power dynamics conveyed in counseling messages to women recovering from IBT (Gomez et al., 2016; Schneider et al. 2012; Steffens & Caudill, 2021; Vogeler et al., 2018) and how these messages positively or negatively impact recovery (APSATS, 2022; Seyed-Aghamiri et al., 2022; Vogeler et al., 2018). The data from this study reveal UWs' experiences with labels and messages from both traditional or contemporary models that UWs interpret as their role, responsibility, and plan for recovery.

Because this study explores the UWs expereince of receiving messages from mental health professionals it adds to the literature by revealing current-day mental health practices as they relate to treatment for SAS and UWs. Finally, this study provides guidance for training mental health professionals working with UWs and SASs in clinical mental health programs and continuing education offerings. Contributions from this study's outcomes could inspire future qualitative and quantitative studies.

Theoretical Significance

This study elucidates the application of the Multidimensional Partner Trauma Model (MPTM) (APSATS, 2022; Steffens & Caudil, 2021) for treating UWs ~~w~~ho seek professional support after discovering they have been targets of intimate betrayal. Using a transcendental phenomenological framework for discovery, this PI suspended preconceptions and judgment in order to learn from the UW's experience. While the study may motivate scholars to further

explore how the MPTM framework might be employed for treating other populations (e.g., male partners in heterosexual or homosexual relationships, female partners in homosexual relationships, or additional underrepresented and marginalized groups who seek recovery from IBT) they may also learn from the narratives of UWs about what the counseling experience is like for clients feeling vulnerable and relationally unsafe.

Practical Significance

This study has practical significance for scholars, practitioners, and counselor educators committed to providing appropriate mental health treatment for UWs who may or may not choose to remain in a relationship with SASs with OCB (APSATS, 2022; Carnes, 2011; Collins, 2017; Laaser et al., 2017; Laaser & Laaser, 2020; Laltrello, 2020; Sheets Juergensen, 2022; Steffens & Caudill, 2021). Although IBT is a relatively new way of conceptualizing the effects of relational betrayal and the MPTM framework is only recently recognized as a model for treating UWs in relationships with sexually addicted mates (APSATS, 2022; Steffens & Caudill, 2021), further studies can inform counselors on messages that can potentially validate UWs' experiences (APSATS, 2022; Laaser et. al., 2017; Laaser, 2018; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2021), recognize their desire to salvage their relationship after discovering their SASs' OCSB (Weiss, 2018), and facilitate their desire for reconnection (Steffens & Caudill, 2021) and personal growth (Laaser et al., 2017). Due to the divergent conceptualizations about sex addiction (Carnes et al., 2014), UWs seeking counseling are subject to messages tied to theoretical strongholds associated with addiction models of codependency (Minwalla, 2012; Vogeler et al., 2018) and systemic barriers to their wellness (Gomez et al., 2016). While, the MPTM framework validates the UW's experience so she can envision recovery and reconnection (APSATS, 2022; Steffens & Caudill, 2021), further

investigation into the implementation of the three stages of the model may reveal strengths and weaknesses that need to be addressed. Individual, marriage and family, and group counselors intentional about understanding a UW's experience, validating her pain (Steffens & Caudill, 2021; Weiss, 2018), and appropriately assessing her stage of recovery may be conduits for emotional safety as UWs grieve losses, build resilience, and reconnect in healthy ways (APSATS, 2022; Laaser, 2018; Laaser et al, 2017; Steffens & Caudill, 2021).

Situation to Self

My passion for this study is based on my dedication to a professional understanding of how people respond to traumatic events and my recognition that in my personal experience with relationally traumatic experiences, positive relationships have enhanced my sense of relational safety contributing to my resilience, growth, and meaningful reconnections. In my roles as sibling, spouse, friend, educator, and student, I have developed an appreciation for the complexities of human nature and richly contextualized relationships. Therefore, until the LORD calls me home, I resolve to be forever amazed and curious about how individuals live out their experiences of blessings and traumas. As a practitioner and a scholar, I believe we owe it to our clients to hold a safe space for their trauma and to be a conduit of healing.

My recent work in mental health counseling confirmed what I learned as a special educator. While theories influence professional practice, if our theories or practice harm our clients, we work against our ethics (ACA, 2014). Therefore, as a researcher and practitioner, I am privileged to learn from the UWs' narratives about their experiences with discovery, receiving messages from professional mental health counselors, and the cumulative effects that have shaped their healing process.

Finally, as an UW who believed what many perceived to be a partner in the ideal marriage, the discovery of my SAS's OCB reset my values and beliefs significantly. While seeking support from trained sexual addiction counselors, I received verbal and non-verbal messages that were shaming and condemning while I was still in the initial phases of seeking professional support to address my traumatic discovery. My need to heal gave me an insatiable curiosity to understand sexual addiction and how this behavioral addiction manifests itself as out-of-control sexual behavior. Additionally, my treatment by mental health professionals propelled me to find sources of support and treatment messages that were accurate and healing.

Research Questions

This study used a theoretical framework from the MPTM (APSATS, 2022; Steffens & Caudill, 2021) to guide development of questions for the participants. The study focused on the central question: How do UWs describe their experience of seeking help from mental health professionals after discovering their SAS' OCB? The three sub-questions which pertain to the counselor messages as UWs seek support moving through the three phases (i.e., seeking safety, remembering, and mourning, and reconnecting) from the APSATS (2022) Multidimentional Partner Trauma Model framework:

Subquestion 1: How do UWs describe mental health professionals' messages immediately after discovery?

Subquestion 2: How do UWs describe the experience of receiving counselor messages as they began their recovery process after initial discovery?

Subquestion 3: How do UWs describe their experience of receiving counselor messages as part of their process to reconnect and reengage?

Conceptual Framework

This study's conceptual framework for exploring the lived experience of UWs seeking support from a professional counselor after discovering their SAS' OCB was comprised of the following interrelated concepts from the literature on partners of males who are sexually addicted: features of sexual addiction, cognitive distortions of individuals with sexual addiction, secrecy and shame's negative impact on UWs, experiences of UWs in relationships with sexually addicted men, attachment trauma, gaslighting, discovery, disclosure, and frameworks embedded in counselor messages conveyed to UWs seeking treatment post-discovery. A formal review of the literature in Chapter Two develops these concepts more thoroughly. Additionally, APSATS' (2022) MPTM (Steffens & Caudill, 2021) provided a framework for organizing and analyzing data during the study, and the transcendental phenomenological framework challenged the PI to prioritize the UWs' experiences through bracketing and metacognitive awareness.

Theoretical Framework

Transcendental phenomenological studies seek to explore the essence of participants' experiences void of preconceived assumptions or biases. Undertaking a phenomenological study requires the researcher to explore the unknown as if encountering the phenomenon for the first time (Moustakas, 1994; Peoples, 2021). Rather than interpreting the experiences of UWs, the PI remained aware of biased thought processes that may have tainted the results by bracketing reactions to the participants' experiences and remaining focused on the content of the UWs' interviews to understand how they receive counseling messages. While application of the theoretical frameworks is mentioned below, the PI explored the UW's reaction to therapeutic interventions as though she had little to no experience with their implementation in therapy (Peoples, 2021).

In his earliest work, Carnes (1983) posited parallels between excessive, distressing sexual behavior and other chemical addictions, adapting frameworks from the family systems models inclusive of the notion of *coaddicts* who played a role in perpetuating their SAS's OCB. Carnes asserted that because family members are part of an interdependent system, addictions impact relational dynamics among family members. Hentsch-Cowles and Brock (2013) concurred with Carnes' earlier theories about the partner (1983) and claimed that addictive tendencies or overinvolvement by a family member predisposed the UWs to emotional dysregulation, despair, and dissociation from reality. Accordingly, coaddicts' obsessions with their addicted mates contributed to unhealthy relational dynamics, making partners such as UWs responsible for contributing to SASs' OCB (Carnes, 1983, 1991, 2001). Carnes asserted that UWs typically leave "disengaged" or "rigid" relational dynamics in their families of origin (Carnes, 2011, p. 70) and suggested that UWs intuitively seek out mates with similar pathological traits (Carnes, 2011). Black (2019) reinforced this notion by suggesting that women examine their family of origin dynamics and acknowledge how these dysfunctional relationships contributed to their current role as victims of their SAS's OCB. According to Carnes (2001), in attempts to maintain the family system status quo, those close to individuals with addictions lack self-awareness about their emotional distress and mirror their mates' presenting symptoms. In his earlier work, Carnes (1983) asserted that the UWs' functioning parallels the beliefs, behavior, and chaotic nature of their SAS's OCB (Carnes 1983, 1991, 2001, 2011), especially as UWs confront the consequences of AIDS (acquired immune deficiency syndrome), unwanted pregnancies, and venereal disease.

Despite the benefits of research on the complexities of SAS, seminal work framed the conceptualization of the UW as a coaddict or codependent (Baird, 2011; Black, 2009, 2019;

Carnes, 1983, 2011; Cermak 1991; Hentsch-Cowels & Brock, 2013; Milrad, 1999). The former conceptualization of UWs has been reexamined more recently. With evidence that not only is discovery traumatic for the UWs (Steffens, 2006), but in many cases unexpected (Hall, 2016), scholars seek to understand the nature of their IBT and effective ways to help UWs recover (APSATS, 2022; Juergensen Sheets & Katz, 2019; Laaser, 2018; Laaser et al., 2017; Seyed Aghamiri, 2022; Skinner, 2017; Steffens & Caudill, 2021; Stokes et al., 2020; Vogeler et al., 2018). For example, Steffens & Rennie (2006) observed parallel reactions between UWs and experiences noted in other interpersonal trauma survivors such as combat veterans and rape survivors (Herman, 1991; 2015). The UW's symptoms were exacerbated by the SAS's chronic OCB and continued deception post-discovery (Corley et al., 2012; Corley et al., 2013; Steffens, 2005). Steffens's (2005) findings and subsequent adaptation of the Herman's trauma recovery model to the UW's experience provided a framework, the MPTM (APSATS, 2022, Steffens & Caudill, 2021), useful for treating UWs through phases of recovery.

Multidimensional Partner Trauma Model

Rather than labeling the UWs, the MPTM framework prioritizes safety, healing, and adaptive recovery for the UW. Steffens (2005) recognized that what may have been previously thought to be expressions of control, deception, and manipulation could be better explained as the UW's need to find emotional safety after discovering that she had been the target of IBT (Gobin & Freyd, 2014). Steffens (2005) normalized UWs' emotional, physiological, and behavioral reactions that were otherwise observed as coping mechanisms for recovery from interpersonal trauma (Herman, 1992, 1997, 2015). When mental health professionals utilize the MPTM model for treating UWs (APSATS, 2022; Steffens & Caudill, 2021), they validate the normative response to the traumatic nature of discovering SAS' OCB, take steps to provide for

the UWs' safety and stabilization, and convey optimism for mental wellness rather conceptualizing their condition in pathological terms (Gomez et al., 2016). Rather than pathologizing the UW for the traumatic reality of events that were out of her control (Gomez et al., 2016), the MPTM helps the UW contextualize her IBT to grow through her healing process (Laaser et al., 2017; Laaser, 2018).

Scholars understand that in the early stages of trauma, the victim needs support to gain safety and stability from relational abuse (Herman, 2015; Keffer, 2018; Minwalla, 2021). In the second stage of the MPTM, the partner works through therapeutic interventions to process traumatic memories while integrating those memories into new ways of coping. In the first two stages of the MPTM model, the clinician establishes a safe rapport with the client, taking appropriate steps so she can come to terms with her newly discovered reality. Recovery from traumatic events occurs when individuals can process the trauma in a way that releases the disturbance and allows the individual to tolerate painful associations (Herman, 1991; Shapiro, 2018). Coming to terms with trauma allows the individual to reprocess the thoughts and beliefs associated with the event in a way that is empowering (APSATS, 2022). Counselors' interventions for the MPTM include timely goals for UWs to grow from their experience as they build resilience by enhancing their values and beliefs about themselves (Laaser et al. 2017). Exploration of the MTPM framework reveals steps taken to guide the UW through a three-stage process through which she can heal and grow from the IBT.

Phase One: Safety

The UW who discovers her SAS's OCB is catapulted into a reality of crisis and trauma. As the UW rebounds from the traumatic nature of discovering that she has been betrayed by one whom she entrusted with her intimacy, connection, and emotional safety, her crisis response is

normative for a person who realizes she is unsafe. Steffens and Means (2021) observe that UWs must contend with the aftermath of their SAS's out-of-control risky behavior, which may necessitate a physical evaluation for STDs, the discovery of children with other women, and financial and legal difficulties. Consequently, as a means of establishing safety and stabilization, counselors will need to support the UW as she navigates the effects of the initial crisis assessing her need for her SAS's truth telling, monitoring for further relational abuse such as domestic violence, and addressing re-traumatization from support personnel that blame, shame, or mislabel her trauma (APSATS, 2022). Optimally, the SAS works with a trained mental health professional to address his responses to the crisis after his UW's discovery. As it becomes evident that the SAS is taking ownership for his role in the relational betrayal, therapists for both the UW and the SAS prepare the couple for a formal disclosure as a means of restorative accountability for the SAS, expulsion of traumatic deception, and the possibility of rebuilding intimacy in the relationship (Gottman, 2011; Juergensen Sheets, 2019; 2022). Just as UWs experience healing due to their SAS's vulnerability and honesty, SASs can choose to mend the relational rupture and experience the freedom of disclosing secrets (Bird, 2006; Corely & Scheider, 2012; Drake & Caudill, 2019; Laaser, 2018; Laaser, 2018; Laaser & Laaser, 2020). Because of the high relapse rate among SASs, counselors, UWs, and SASs may need to repeat interventions with each new discovery or disclosure (Corely et al., 2013).

Steffens and colleagues (2022) advise counselors to recognize the UW's presentation in her initial counseling visits as a response to a crisis. In addition to validating the UW's narrative empathetically, counselors' assessment of physical, emotional, relational, financial, and existential safety is paramount in treatment. In many cases psychoeducation about trauma and sexual addiction is necessary to rectify inaccurate information that UWs receive about their role

and responsibility associated with their mate's behavior. As the UW gains a greater understanding of what has happened to her, Steffens and her colleagues (APSATS, 2022) import exploring with her strengths that she formerly availed during other crisis situations while intervening with empirically supported techniques for trauma treatment. As the UW shows evidence that she can manage her trauma symptoms and triggers while setting appropriate safety boundaries, her counselor continues to work collaboratively to treat her trauma while acknowledging her personal and existential grief (APSATS, 2022).

Phase Two: Remembering and Mourning

As the UW recovers from the traumatic nature of the initial discovery and the subsequent professionally lead disclosure, the betrayed partner confronts her new reality. In many cases, the UW seeks a trauma-trained mental health professional so that she can find relief from trauma symptoms and process grief of a relationship that is different than what she thought she had. Concurrently, the SAS works with his professionals and support systems to establish and maintain sobriety. The SAS may engage in trauma and addiction treatment, and the UW may be receptive to psychoeducation on trauma, addiction, and relational repair. During this time, it may be necessary to revisit with her any experiences of re-traumatization by messages that she received from her anticipated personal, spiritual, and professional support systems. While Steffens and her colleagues at APSATS (2022) do not prescribe treatment modalities, they import using techniques with the UW that allow her to process and evaluate the complexities of her traumatic memories and develop adaptive strategies to confront them. The discovery of SAS's OCB not only undermines the UW's sense of safety, but it destroys her assumptions that her trusted intimate partner shares her values of integrity and loyalty. Consequently, mental health professionals establish safety for her when they recognize the nature of her fear and

mistrust, anxiety, depression, and PTSD symptoms. Professional practices that employ messages that recognize her trauma and employ evidence-based practices support her need to integrate her new reality with her beliefs about herself that foster growth (APSATS, 2022; Laaser, 2018; Laaser et al., 2017). As the UW integrates information from her traumatic discovery and grieves the loss of her beliefs about herself, her SAS, and her relationship, professionals reinforce safety precautions for herself and her SAS.

Phase Three: Reconnecting

According to Steffens and her colleagues (2022), when the UW finds relief from trauma symptoms and feels safer in her relationship with her SAS, she works with the professional mental helper to renew her sense of trust. Commensurate to this stage in the UW's healing is recognition of the SAS's work in recovery or the UW's decision to disavow her commitment to her relationship through separation or divorce. Whether or not the UW chooses to stay in her relationship, the mental health professional may work with her to explore the complexities of sex addiction, including the traumatic outcomes of the sex addiction and discovery. During this stage the UW may readily work to dispel inaccurate self- or other- accusations that she somehow caused her SAS's OCB. As a result of some safety and stability experienced from the work done in the previous two stages, she can process previous experiences of relational trauma and learn how to increase her capacity for healthy relational dynamics. In instances where the UW chooses to recover with her SAS, they strive to become a source of relational safety to one another. When supported professionally and appropriately, couples can work together to make meaning of the traumatic rupture in their relationship, develop empathy for one another, and learn how to form attachments that are safe and secure (APSATS, 2022; Juergensen Sheets, 2022). As partners

grow through and heal from their traumatic experiences, they tend to be open to reconnecting and supporting others.

Definitions of Terms

Insertion of operational definitions for the purpose of this current study include the following: sexual addiction, out-of-control sexual behavior, sexual addiction, discovery, coaddict, codependence, intimate betrayal trauma, gaslighting, disclosure.

Sexual addiction – Sexual addiction is unhealthy and out-of-control sexual behavior (Carnes, 1991, 2001, 2005; Limoncin et al., 2022) demonstrated through compulsive and repetitive patterns of behavior directed toward self or others to cope with unpleasant thoughts or emotions (Carnes, 1991, 2001, 2005; Weiss, 2013). Carnes (2001) observed that individuals with sexual addiction maintain distorted belief systems about self and others to replace a life-giving relationship with sexual desire. Comorbid addictions and habitual patterns of deception accompany sexual addictions (Carnes, 2001; Daniels & Farley, 2022; Phillips et al., 2020). Individuals with sexual addiction may struggle to fulfill responsibilities in vocational and personal roles and experience a decreased desire for connection (Kraus, 2015). In this study, sexual addiction is used to describe chronic sexual behaviors outside of committed relationships that last six or more months (World Health Organization, 2017) and cause distress for the SAS and his UW.

Sexually Addicted Spouse (SAS) – For the purpose of this study, SAS refers to the sexually addicted spouse who exhibits out-of-control behavior (OCB) that is chronic, excessive, and involves sexual behaviors outside the committed relationship. The SAS's OCB is discovered by the UW on one or more occasions with risk factors to the partners and possibilities for relapse.

Out of control behavior (OCB) – This term refers to compulsive behavior of a sexual nature and carries similar meanings to "hypersexuality," "sexual compulsivity," or "hypersexual disorder" (Crocker, 2015; Daniels & Farley, 2022; Limoncin et al., 2022). Sexually out-of-control behavior dominates the thoughts and emotions of impacted individuals at the expense of anything or anyone else (Susskind, 2019). Sexually OCB creates dynamics in the relationship that are chaotic and unpredictable. It is not uncommon for a SAS's OCB to be part of other commorbid psychological concerns and addictions.

Unsuspecting Wives – This term refers to women who were unaware that their spouses had a sexual addiction. Unsuspecting wives are married to SASs who conceal their chronic OCB from them and do so with secrets, deception, and gaslighting (Hall, 2016; Keffer, 2018; Minwalla, 2021; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2007).

Discovery – In this study, discovery refers to the moment that the SAS's OCB becomes a reality or problem to the UW, the SAS (Daniels & Farley, 2022), and their relationship (Steffens & Means, 2021). Discovery occurs when the partner uncovers evidence of the SAS's OCB or receives information from others (Corley et al., 2013). Skinner (2017) and others call the day of discovery 'D-Day' (Steffens & Means, 2021).

Coaddiction – A term adapted from a family systems framework used to describe the participation and perpetuation of an individual's addictive patterned behavior, Carnes (2001) labeled the behaviors of UWs as mirrored dysfunctions of their SASs.

Codependence – This refers to partners' behaviors that are theorized as pathological due to an overinvolvement with their sexually addicted partner with little regard for their own needs. Like coaddiction, codependence originated in family-systems theories applied in the chemical

dependence model of addiction counseling (Carnes, 2001; Cermak, 1991, Lantrello, 2020). Despite its rejection by the American Psychiatric Association as a mental health diagnosis (Weiss, 2018), individuals in relationships with addicted family members receive advice and counsel against becoming overinvolved with their loved one. When UWs seek counseling post-discovery, they may be advised to attend 12-step meetings for spouses of sexually addicted spouses or read material to help them change their codependent behavioral patterns. In this study, codependence referred to one of the messages that counselors conveyed to clients to change their relational dynamics between themselves and their addicted spouses.

Intimate Betrayal Trauma – Intimate Betrayal Trauma (IBT) is conceptualized in committed relationships (Steffens & Caudill, 2021; Steffens & Rennie, 2006) as a violation of an implicit trust that threatens emotional safety necessary in intimate relationships. The complex nature of discovering the SASs' OCB and potential patterns of chronic sexual acting out behavior leaves UWs with complex post-traumatic stress symptoms observed in individuals who suffer sustained trauma from combat or sexual abuse (APSATS, 2022; Herman, 1992, 2015; International Society for Traumatic Stress Studies [ISTSS], 2015). In this study, IBT refers to the experience of women who discover their SAS's OCB and cope with chronic symptoms observed in survivors of interpersonal trauma (Aghamiri et al., 2022; Minwalla, 2021; Skinner, 2017; Vogeler et al., 2018).

Gaslighting – This is a form of deception and emotional manipulation used by the perpetrator to make a partner question her sense of reality (Keffer, 2018; Minwalla, 2021; Skinner, 2017; Skinner & Caudill, 2021; Stark, 2019; Sweet, 2019). The SASs may gaslight their UWs by subverting the truth, falsifying information, or challenging their sense of reality. SASs compound the effects of emotionally abusive gaslighting (Minwalla, 2021) with additional

controlling tactics such as anger and intimidation (Keffer, 2018; Laltrello, 2020; Steffens & Means, 2021). Considering the perceived power differential that exists in the counseling realitonship, UWs who receive messages from therapists blaming them for their SAS's OCB may be targets of cultural gaslighting (Stark, 2019) because their reality is distorted for the second time (Tormoen, 2019). In this study, gaslighting referred to the deceit and blame directed at the UW (Minwalla, 2021; Skinner, 2017) by SASs and some professional mental health counselors.

Disclosure – According to experts working with couples in the aftermath of discovery, disclosure is necessary part of therapeutic healing and recovery for UWs and their SASs that must be facilitated by trained professionals (APSATS, 2022; Corely et al., 2013; Drake & Caudill, 2019; Juergensen Sheets, 2022; Steffens & Caudill, 2021). Sensitive to the recovery needs of the UW, the SAS, and the relationship, disclosure occurs in a safe space with mental health professionals who attend exclusively to the experience of the SAS and the UW (Drake & Caudill, 2019) or address the needs of both members of the couple. With consideration given to the traumatic nature of disclosing at least one and often multiple intimate sexual betrayals, the mental health professionals take procedural caution to help both parties manage the traumatic effects as the SAS devulges previously unknown information about his OCB. During disclosure the SAS shares factual information about significant deceptions, the timeline, and expenses incurred while he engaged in the behavior. In this study, disclosure refers to a professionally guided practice whereby the SAS reveals the unknown facts to his UW about his OCB.

Impact letter – In this study, an impact letter refers to written communication by the UW after she processes the formal disclosure. This allows her to convey to her partner how his behavior has impacted her.

Restitution Letter – In this study, restitution letter refers to a written statement by the SAS as a response to the messages conveyed in the impact letter. In the restitution letter, the SAS solely acknowledges that he heard the pain caused by his behavior without asking for forgiveness.

Mental Health Professional – The National Alliance of Mental Illness ([NAMI], 2020), a mental health advocacy and education organization, recognizes several certified workers as mental health professionals. Certified professionals typically pursue a formal education that spans on average five to ten years before meeting the local, national, and professional requirements for licensure. For the purpose of this study, mental health professionals include: psychiatrists, psychiatric nurse practitioners, psychologists, licensed mental health counselors, licensed professional counselors, licensed addiction counselors, and licensed clinical social workers.

Bracketing or epoche – In transcendental phenomenology, the researcher sets aside personal experiences with the phenomenon study to perceive it as though for the first time (Cresswell & Poth, 2018; Moustakas, 1994). In this study bracketing or epoche refers to maintaining an intentional awareness of being curious about the phenomenon studied by suspending preconceived ideas to focus on the analysis of the experience (Peoples, 2021).

Horizontalization – Analysis or review of the data contained in the interview transcriptions produces meaningful statements embedded in statements or quotes that reveal how (structural description) and what (textural description) participants experience. In this study horizontalization is the process that allows the PI to transfer the participants' narratives into data that explains the phenomena (Creswell & Poth, 2018).

Assumptions

The following assumptions helped clarify the study's scope and parameters. Despite divergent conceptualizations among mental health professionals regarding treatment and diagnosis of SA/OCSB (Carnes et al., 2012; Carnes et al., 2014; Crocker, 2015; Seyed Aghamiri et al., 2022), an in-depth discussion of this phenomenon is beyond the scope of this study. However, a brief introduction provides the reader with a background to understand common themes in the relational dynamics between SASs and their UWs, along with the confusion surrounding sex addiction inherent in messages that UWs receive from counselors when they seek support post-discovery. Furthermore, the study focused on how women received messages and how these messages positively or negatively impacted their ability to recover from the traumatic nature of discovering the SASs' OCB. The study's participants included female partners who were in committed heteronormative marriages when they discovered their SASs' behavior. The study assumed that the UWs may have detected problematic sexual behavior but were unaware of the nature of their SASs' behavior prior to their discovery.

Limitations

Limitations of the study included the self-selection of participants who sought counseling after discovering their SASs' OCB. Therefore, the study did not enlighten mental health practitioners and professionals about the perceived role, responsibility, and recovery among women who choose not to seek support after discovery. Additionally, the study did not attempt to explore the experience of counselors conveying messages to their clients or explore the intent of the counselors' messages. The study did not delineate whether messages about role, responsibility, or recovery had the greatest negative or positive impact.

Organization of the Study

The following chapter produces written scholarly discourse related to the experience of UWs who discover the SAS's OCB and receive messages about their role, responsibility, and recovery from their mental health professionals. Chapter three explains the study's research design, research questions, setting, participants, procedures, the researcher's role, data collection, data analysis, trustworthiness, and ethical considerations. Chapter four describes the study's findings and Chapter five contains the study's summary of findings, discussion, implications, limitations, recommendations, and topics for future study.

Summary

This chapter introduced the current study exploring the lived experience of UWs of SASs with OCB when they sought professional mental health counseling and received messages about their role, responsibility, and recovery. The study's overview, background of the problem, problem statement, purpose statement, and significance were discussed. Next, the study's research questions are delineated, followed by the study's conceptual and theoretical framework. Lastly, the study's assumptions and limitations were examined.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this transcendental phenomenology was to explore how UWs married to SASs with OCB describe their lived experiences of receiving messages from their mental health professionals when they seek professional support after discovering their SAS' OCB. This study contributes to the literature and has theoretical significance due to its implications for applying the MPTM (APSATS, 2022; Steffens & Caudill, 2021) as a framework for counseling UWs, because it systematically addresses the UW's trauma and offers hope and empowerment (APSATS, 2022; Juergensen Sheets, 2022). This study also enlightens professional counselors, counselor educators, counselor supervisors, mental health doctoral programs, and training programs regarding the experience of UWs who have been the target of intimate betrayal. UWs' voices inform us about what they found most effective when they sought treatment. The study's findings are significant as they provide evidence for the need for appropriate support for UWs seeking to recover from IBT, comparing messages and labels derived from traditional frameworks for treating spouses married to men with sexual addiction with those conveyed using a contemporary trauma-informed model for individuals who are targets of IBT. Lastly, this study promotes awareness that preparation for mental health professionals, conceptual frameworks, beliefs, and values influence messages and discourse directed at clients seeking mental health support.

This chapter reviews the literature related to the current study. The literature review is organized around major themes beginning with the general research on the divergent conceptualization of sexual addiction and out-of-control sexual behavior. Subsequently, findings on intimacy, shame, secrecy, discovery, gaslighting, and the intersectionality of models for codependence, coaddiction, and IBT are presented. Finally, the MPTM framework is explored as

an appropriate course of treatment for UWs who seek safety, stability, opportunities to resolve grief and trauma, and meaningful reconnections.

Strategies used for searching the literature included accessing Liberty University's university online library academic search engine and Google Scholar's search for peer-reviewed journals and publications published within the last ten years. The search was later expanded to include a search of seminal work within 20 and subsequently 30 years. Key terms searched involved combinations of the following words and phrases: sexual addiction, hypersexuality, out-of-control sexual behavior, partners, coaddicts, codependents, recovery, responsibility, family-systems, addictions, partners, betrayal trauma, interpersonal trauma, Intimate Betrayal Trauma, counseling, therapy. Because the search returned voluminous results related to sexual addiction, professional mental health workers, therapists, and messages, a combination of these terms was incorporated in the Boolean search on key terms. The next section includes the study's literature review.

Related Literature

Seminal work on the traumatic nature of discovering a SAS's OCB reveals that women experience symptoms that meet the criteria for post-traumatic stress (Laaser et al., 2017; Skinner, 2017; Steffens, 2005; Steffens & Means, 2021; Steffens & Rennie, 2007), including a sense of disempowerment, isolation, and negative self-appraisals observed in survivors of interpersonal trauma (Herman, 1992). Therapeutic interventions for treating interpersonal trauma prioritize attunement with the client (Parnell, 2013) to provide her with emotional safety and stabilization and allow her to integrate the thoughts and beliefs associated with the traumatic experience with her new reality (APSATS, 2022; Shapiro, 2018). Yet, UWs seeking professional mental health support after their traumatic discovery of the SAS OCB may receive messages and labels from

counselors and therapists that suggest they are culpable and dysfunctional. Labels and messages that seem incongruent with their experience disregard the contextual nature of their trauma (Gomez et al. 2016) and may confuse and revictimize UWs (Vogeler et al., 2018). Mental health professionals may convey subtle or covert messages to UWs that they are coaddicted (Baird, 2011; Carnes, 2001; Hentsch-Cowles & Brock, 2013; Laaser, 2001), codependent (Weiss, 2018), and culpable for their partner's addiction (Hentsch-Cowles & Brock, 2013). When messages from professional counselors and therapists discount that UWs are targets of their SASs' deception and broken trust (Keffer, 2018; Minwalla, 2021; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2007; Stokes et al., 2020; Vogeler et al., 2018), these messages may do more harm than good (Gomez et al., 2016; Tormoen, 2019).

Divergent Conceptualizations of SA/OCSB

Sexual addiction experts endorsed principles and treatment protocols from chemical addiction models (Carnes, 1983, 2011; Carnes & Lee, 2014), which integrated the family systems model for working with those affected by the addiction. Despite compelling evidence that UWs seek counseling to decrease symptoms of PTSD before they can explore their role and responsibility in their relationship (Hall, 2016; Keffer, 2018; Laaser et al., 2017; Skinner, 2017; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021), inpatient and outpatient centers for SASs with OCB and their UWs continue conveying messages and labels from the family systems model for treating addiction (Rosenberg et al., 2014), suggesting that UWs are culpable for contributing to their SAS's behavior (Hentsch-Cowles & Brock, 2013). Contemporary scholars justify using labels from disputed paradigms by asserting that family systems models in treatment for relatives including spouses correctly recognize that all family

members share the addicted member's disease (Stokes, 2020) and, therefore, all members are responsible for recovery (Hetsch-Cowels & Brock, 2013). While treatment and recovery is necessary for victims of IBT, more recent findings challenge the misapplication of a label that falsely implies the UW's role and responsibility for behaviors hidden from her by the SAS's deception (Hall, 2016; Laltrello, 2020; Minwalla, 2021). Some addiction counselors challenge the unjust nature of pathologizing members who choose to remain connected to an addicted partner (Weiss, 2018) while others question the injustice of pathologizing behaviors that are socioculturally imposed on women (Anderson, 1994; Weiss, 2018). Still, other mental health counselors voice concern over treatment that is ineffective and revictimizing (Minwalla, 2021; Skinner, 2017; Steffens & Caudill, 2021; Steffens & Means, 2021; Vogeler et al., 2018).

Lack of consensus on the etiology and phenomenology of unrestrained sexual behavior outside of committed relationships hinders counselor training and consistent treatment plans. Although extant research on sexual addiction reveals disagreements on the conceptualization of sexual addiction, scholars agree that clients seek treatment for obsessive, compulsive sexual urges that negatively impact significant aspects of the individual's functioning. Notable features of sexual addiction include compulsivity, impulsivity, secrecy, comorbidities, and personality disorders. Familiar terms for sexual addiction include "hypersexual disorder" (Kafka, 2010; Reid & Kafka, 2014), "non-paraphilic sexual desire," "paraphiliac sexual behavior (Kafka, 2001; Klein et al., 2014), "compulsive sexual disorder" (ICD-11; World Health Organization, 2020; Kraus et al., 2018), "sexual addiction," and "compulsive sexual behavior." Between 1% and 6% of adults perceive their sexual behavior as problematic (Dickenson et al., 2018; Kafka, 2010; Kraus et al., 2018), 10.3% of men and 7.0% of women believed their uncontrollable sexual urges negatively impacted their psychosocial functioning (Dickenson, 2018), and 3 to 10% reported

severe levels of distress (Bothe et al., 2020b; Dickenson et al., 2018). Despite religious and moral beliefs against sexual behavior outside of committed relationships (Gola et al., 2022; Grubbs et al., 2018; Grubbs et al., 2020; Lewczuk et al., 2017; Volk et al. 2016), between 50 and 60 percent of men who belong to religious communities battle sexual acting-out behavior (Lee, 2016, as cited in Laaser, 2018).

Expressed concern about pathologizing, medicalizing, and moralizing human sexuality has prevented a universal acceptance among scholars (Hall, 2016; Klein, 2016; Markovic, 2017) of the label "sexual addiction" (Carnes, 1991). Nevertheless, for clinicians, the addiction model is a recognized framework for treating problematic sexual behavior and the associated unwanted consequences (Carnes et al., 2005; Daniels & Farley, 2022; Laaser, 2018; Rosenberg et al., 2014). Practitioners have access to empirical studies validating the neurological impact of excessive sexual behavior. Like gambling, sexual addiction is a process addiction with high relapse (Corely et al., 2013; Rosenberg et al., 2014). Mental health professionals advise SASs with OCB desiring to change their patterns of sexual behavior to join 12-step support groups such as Sex Addicts Anonymous, Sexual Compulsives Anonymous, Sex and Love Addicts Anonymous, Sexual Recovery Anonymous, or Sexaholics Anonymous (Efrati & Gola, 2018) with foundational principles of recovery found in chemical addictions treatment. Partners seeking relief from the trauma of discovering their SASs' OCB may also receive advice from their therapists or professional mental health counselors to join groups such as COSA, Co-SLAA, SRA-Anon, or S-Anon that adhere to the AA philosophy by incorporating the Twelve Steps for their own recovery (Baird, 2011). Additionally, mental health professionals may overtly or covertly convey messages to UWs that it was their dysfunction that contributed to her SAS's OCB (Hentsch-Cowels & Brock, 2013; Steffens & Means, 2021), that she was colluding

with the addiction, and suggesting that she work on recovering from a disease for which there is no cure (Steffens & Means, 2021).

SASs who struggle with OCB betray their partners through multiple forms of sexual behavior outside of the committed marriage. These activities include, but are not limited to, pornography consumption, masturbation, frequenting topless bars and strip clubs, participating in cybersex, child pornography, sexting, random hook-ups, date rape, and voyeurism (Keffer, 2018). Conceptualized as a behavioral addiction (Carnes, 1991; Hall, 2016; Rosenberg et al., 2014), OCB was associated with traumatic childhood abuse accompanied by comorbid addictions and mental health issues (Carnes, 1993; 2001; Schneider, 2011). Problematic sexual behavior, when compared to normative sexual behaviors, features tendencies observed in other behavioral and chemical addictions such as dependence, tolerance, and withdrawal (Carnes, 2001; Love, 2016; Weiss, 2013). Minwalla (2021) expounded upon discourse for conceptualizing secretive sexual activities performed outside committed relationships, positing the nature of these behaviors should be considered psychological abuse committed against the unsuspecting partner, in this case the UW. He suggested that abusive, deceptive, and manipulative behaviors may reveal entitlement traits among SASs who exert relational control by concealing behaviors from their partners. Out-of-control sexual behavior is disruptive to a marriage because it compromises intimacy through shame provoking practices of deception, manipulation, and gaslighting. Sociocultural factors that associate sexuality with shame exacerbate the realization that one is in a committed relationship with a spouse addicted to sex (Rosenberg et al., 2014) and, therefore, engaged in sexual acts outside of sexual norms.

Intimacy

As part of developing commitment in relationships, couples create assumptions about how the other will become a source of safety, security, and fulfillment of attachment needs (Steffens & Means, 2021). Healthy intimate sexuality, an expression of this longing, brings connection through vulnerability, trust, and a desire to respond to the other's physical needs. However, changing social values and norms on sexuality may be responsible for the acceptance of detached sexuality (Estellon & Mouras, 2012) with a growing tolerance of sexual infidelity (Twenge et al., 2015) and what researchers deem risky (Estellon & Mouras, 2012) or pathological behavior (Seyed Aghamiri et al., 2022). Trust, foundational to vulnerability and intimacy, is compromised when a UW discovers that her SAS has been chronically acting upon unrestrained sexual urges outside of the committed relationship (Carnes, 2020; Hall, 2019; Laaser, 2018; Laltrello, 2020; Schneider & Corley, 2020; Schneider et al., 2012).

Safety and emotional trustworthiness, foundational for creating vulnerability and intimacy, become established when spouses value the needs of the other in deference to their own (Butler & Spencer, 2018; Dansby Olufowote et al., 2020). Ongoing experiences of connectedness are evident when UWs and SASs validate the other's needs to encourage shared intimacy (Butler et al., 2022). Conversely, when individuals find it difficult to establish intimate connections, sexual fantasies and activities may provide the SAS with a means of escape from mental distress to avoid feeling vulnerable (Crocker, 2015). While building defenses against intimacy, SASs who struggle with OCB seek sexual release outside of their committed relationships, and while they avoid feeling exposed, they miss the benefits of authentic intimacy (Lew et al., 2020; Reid et al., 2008; Reid et al., 2011). When the addict perceives sexual behavior as the primary means of coping, and the sexual behavior becomes the central organizing event of

a person's life (Laaser, 2018), it compromises other aspects of human functioning, including connection and intimacy. The SAS may gradually find less sexual fulfillment with his partner, coerce her to engage in sexual behaviors that cause her distress, or withdraw from her physically and emotionally (Hall, 2019). An earlier study of cybersex and relational intimacy revealed that, at the onset of use, over two-thirds (68%) of the participants experienced diminished intimacy with their partner, and more than half (52%) lost interest in relational sex, as did one-third of their partners (Schneider, 2000). Findings in Schneider's study (2000) suggest that perceived betrayal, regardless of sexual activity, undermines safe and intimate connections (Manning, 2006), with detrimental effects on sexual satisfaction and sexual intimacy. Schneider (2000) found that sexually addicted individuals in committed relationships who used cybersex tended to avoid intimate sexual relations with their partners, made excuses for avoidance, and seemed emotionally detached during sexual relations. In these same relationships, UWs voiced their negative reactions and insecurities, becoming overinvolved with initiating sex to fulfill sexual needs or diminish their SAS's online sexual behavior (Schneider, 2000).

While earlier studies suggest that sexual behavior outside the committed relationship decreases the mate's interest in intimate sex (Carnes, 2001), Hall (2016) found that mates can engage in sexual experiences both outside and inside the committed relationship, compartmentalizing or differentiating erotic sex from connected sexual engagement. Hall's (2016) findings challenge the notion that UWs should detect their SAS' sexual infidelity. In a study on sexual addiction and distress, when 349 took an online screening test for sexual addiction, 93% met the criteria, but 59% admitted to significant distress regarding their behaviors (Spenhoff et al., 2013). Findings in another study indicated that sexual frequency in committed relationships is independent of the SAS's desire to engage behaviors, although he

may augment sexual urges through secretive sexual behaviors without his partner's knowledge (Bothe et al., 2021). The complexities of sexuality and associated behaviors that enhance or detract from intimacy challenge the notion that UWs should have sensed their SAS' detachment from their sexual union. Hall (2016) defends the UW's oblivion to her partner's detachment by refuting earlier assertions that SASs were sexually unavailable to their partners (Carnes, 1991). Minwalla (2021) uses the metaphor of an intentional hidden life of the SAS's sexual addiction that is outside the realm of a wife's awareness. These findings suggest that SASs may engage in the routines of sexual behavior with their wives while gratifying their sexual needs outside of the relationship, making it plausible for wives to be unaware of their SASs' OCB.

Many scholars, clinicians, and partners perceive unrestrained sexual behavior outside of committed relationships as a betrayal of the UW's trust and a violation of assumed fidelity (Corley et al., 2013; Gottman, 2011; Laaser, 2018; Laaser, 1992, 1996, 2004; Schneider et al., 2012; Seyed Aghamiri et al., 2022; Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2007; Vogeler et al., 2018). Studies on intimacy and cyber sexuality reveal discrepant findings on cyber sexuality and the impact on intimacy. In one study, partnered viewing of pornography showed evidence of improved openness about sexuality (Kohut et al., 2018), yet another investigation showed evidence that the consumption of pornography is associated with negative consequences in relationships. In one study, SASs' consumption of pornography was associated with the likelihood of an affair (50%), and though less statistically significant (25%), divorce (Doran & Price, 2014). Other studies reveal that a SAS's pornography consumption negatively impacts relationship satisfaction and decreases the female partner's self-esteem (Lambert et al., 2012; Newstrom & Harris, 2016; Resch & Anderson, 2014; Wright et al., 2014). In situations where extreme uncontrolled sexual behaviors are contrary to the values of

either member of the partnership, their relationship satisfaction suffers (Perry, 2017). Seen as a violation of trust, sexual addiction and out-of-control behavior compromises a basic need for connection, ruptures the partner's perceived attachment bond (Gomez et al., 2016), and creates distress for the unsuspecting partner (Scheider et al., 2012; Skinner, 2017). Chronic sexual addiction and sexual activities outside of a committed relationship differs from abandonment of trust through an affair because the former is a means of coping that existed before committing to fidelity in a partnership (Tripodi, 2006; Weeks et al., 2004), while the latter is indicative of triangulation due to a rupture in the relationship.

In response to sexually acting out behaviors, it is common for SASs to live with a distorted perception of reality (Carnes, 2001; Laaser, 2018) to protect their sense of self. Sexual addicts may withdraw and remain isolated from others while denying a problem exists (Carnes, 2001). Paunovic and Hallberg (2014) corroborated these findings when they observed that individuals preoccupied with sexual fantasies, urges, and behaviors tend to believe they are inferior because of their inability to control their acting-out behavior.

Shared Shame

Shame, a negative emotion directed toward the self, influences the development of one's identity, leaving the individual feeling vulnerable (Thomas, 2018). An expert who studied shame defined it as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (Brown, 2006, p. 45). Thomas (2018) observed that when destructive shame is internalized and repeatedly exacerbated with each new situation, individuals remain stuck in negative self-appraisals that increase the likelihood of psychological distress. While the emotion of guilt has adaptive and redemptive qualities toward maintaining

one's desired values, shame causes significant distress that undermine one's ability to adapt to traumatic events cognitively or emotionally (Lopez-Castro et al., 2019).

The evolving socio-cultural acceptance of non-traditional expressions of sexuality remains at odds with the social stigma of sexual addiction (Daniels & Farley, 2022; Rosenberg et al., 2014; Seyed Aghamiri et al., 2022), with negative consequences such as isolation and a feeling of being trapped (Brown, 2006) observed in wives and their SASs (Carnes, 2011; Keffer, 2018; Steffens & Means, 2021). While intimacy provides couples with a sense of connection through vulnerability, trust, and belonging, shame creates a feeling of unworthiness because of inherent flaws (Brown, 2012). Common core beliefs of SASs with OCB are associated with shame-based self-appraisals (Laaser, 2018), and these appraisals coupled with distorted thinking keep the SAS in a state of denial, perpetuating the lived double life of a spouse who continually engages in OCB yet minimizes or denies his actions to himself and to others. Studies revealed that feelings of hopelessness about change are associated with high degrees of shame related to an individual's problematic sexual behavior (Chisolm & Gall, 2015), and feelings of shame keep the individual from enjoying partnered satisfaction (Floyd et al., 2021).

In addition to the traumatic experience of discovering a SAS's OCB, UWs feel ashamed due to their intimate association with an individual who struggles with sex addiction (Carnes & Lee, 2014). Messages and labels conveyed to UWs about their role and responsibility to their SAS's behavior may perpetuate and exacerbate shameful self-appraisals. Individuals who perceive themselves as shameful tend to become isolated (Brown, 2006), which compounds the psychological distress that leaves the individual in a chronic pattern of shame (DeYoung, 2015) and feeling stuck (Brown, 2006). Mental health professionals who are considerate about gender roles in counseling (Gomez et al., 2016; Tseris, 2013) safeguard against conveying erroneous

messages to UWs, who have already been the target of deceptive messages (Keffer, 2018; Minwalla, 2021; Steffens & Caudill, 2021; Vogeler et al., 2018).

Some findings suggest that shame, a self-conscious negative appraisal, is a painful cognition that strongly predicts sexual addiction as a precursor to acting out and a consequence of the behavior. Studies reveal that shame-based cognitions exacerbate the SAS's inability to regulate emotions and observe sexual boundaries to prevent compulsive sexual behavior (Phillips et al., 2020). Further findings suggest that a sexually addicted individual's limited capacity to contend with the shame associated with sexual addiction increases the likelihood that he will either withdraw from others or externalize his distressing emotions through sexual behaviors (Reid et al., 2014) outside of committed relationships. Individuals who engage in out-of-control sexual behavior live with a distorted perception of reality (Carnes, 2001; Laaser, 2018) while perpetuating their experience by withdrawing, isolating, and denying that a problem exists (Carnes, 2001) to avoid the shame and distress associated with their excessive sexual behavior. A high degree of shame stems from a SAS's belief that he is inferior to others because of the perceived powerlessness to control his sexual fantasies and behaviors (Chisolm & Gall, 2015; Paunovic & Hallberg, 2014).

Shame, part of a SAS's distorted thinking, keeps the individual in a state of denial, perpetuating the secret double life. Despite their internal perceived inferiority (Paunovic & Hallberg, 2014), SASs mask negative self-appraisals about their sexual addiction with behaviors that beguile their partners (Carnes, 2001; Hall, 2019), adding to the wife's confusion about the benefits of remaining in a relationship with their spouse. When wives ask clarifying questions about perceived incongruencies in the spouse's behaviors, they receive messages from SASs, family members, and professionals that may reflect socio-cultural norms about sexuality

(Shabolt, 2009), but invalidate their concerns. A wife who may value fidelity to the vows of her marriage may find opposition from messages that permit pleasure-seeking sexual behavior void of relational connection or accepting of privileges afforded males as more powerful than females (Seyed Aghamiri et al., 2022).

Although the literature portrayed increased liberal acceptance of sexual behaviors outside of committed relationships (Estellon & Mouras, 2012), sexual addiction is stigmatized more than other addictions (Daniels & Farley, 2022; Hall, 2019; Rosenberg et al., 2014). Divergent beliefs regarding what is culturally (Shadbolt, 2009) and morally sanctioned sexuality (Grubbs & Perry, 2019; Leonhardt et al., 2018) contribute to the confusing discourse about what is normative compared to pathological sexuality. Sexual addiction, a subject of prejudice and misconception, presents challenges for mental health professionals working with SASs distressed about their OCB because they mask their shame through secrecy, deception, or minimalization of their excessive behaviors (Carnes, 2001; Carnes & Lee, 2014; Daniels & Farley, 2022; Hall, 2019; Phillips et al., 2022) Values and opinions about addiction, specifically sexual addiction, negatively impact the UWs seeking support pre- and post-discovery because of the shame associated with how others conceptualize their role and responsibility (Seyed-Aghamiri et al., 2022; Skinner, 2017). While experts admit that individuals with sexual addiction adroitly hide their OCB from sex addiction specialists, supervisors, and other family members (Daniels & Farley, 2022; Hall, 2019; Minwalla, 2021), unsuspecting partners are shamed by messages suggesting that not only did they accept their spouse's behavior (Black, 2019; Hentsch-Cowles & Brock, 2013), but colluded with their sexual excesses to the detriment of their needs (Carnes, 2001). Yet, Skinner (2017) discovered that sexually addicted individuals' shame-based self-evaluations, combined with fear about partners leaving them in the aftermath of the discovery,

perpetuate and justify SASs concealing their behavior. The UW's discovery sends shock waves of shame and humiliation when it becomes apparent that, counter to her assumption about the safety of her relationship and the trustworthiness of her spouse, she has been a target of deception about behaviors that were incomprehensible to her (Keffer, 2018; Lonergan et al., 2021; Skinner, 2017; Steffens, 2005; Steffens & Means, 2021; Steffens & Rennie, 2006). Internal and external messages are based in shame as she tells herself that she is not enough to meet his needs (Laltrello, 2020). Shame is overwhelming due to the stigma of being associated with her SAS's OCB (Steffens & Means, 2021), compounding her distress with messages that trivialize her expressed grief about the losses in the relationship (Lonergan et al., 2021).

Partners of mates with SA/OCSB may experience emotional discomfort and shame when receiving messages from their SASs that they are sexually unfulfilling, or they are asked to participate in sexual behaviors that feel repulsive (Tripodi, 2006). This distress is devastating when, upon discovery of the betrayal, partners experience intrusive thoughts, depression, and shame (Keffer, 2018; Seyed Aghamiri, 2022; Skinner, 2017; Steffens & Caudill, 2021; Steffens & Means, 2021) after they realize they have been devalued by partners whom they trusted. Their reality of betrayal, abandonment, humiliation, and shame (Milrad, 1999; Schneider, 2000, Steffens & Rennie, 2006) challenges their understanding of their role in their relationship while they cope with extreme reactions that make them feel crazy (Keffer, 2018). In a survey of 126 partners, Hall (2019) found that 92 percent of the partners of sexually addicted individuals felt shame, and 47 percent reported extreme shame. They experienced shame due to others' opinions about their desire to remain in their relationship with their mate (Daniels & Farley, 2022) and received messages from others that minimized their grief over the loss of their safe relationship (Lonergan, 2021). Many women fear "being the last to know" (Laltrello, 2020, p. 92) and being

the object of another's gossip and pity is experienced as trauma that adds to the reality of the SAS's OCB. Just as labels stigmatize SASs whose out-of-control sexual behavior deviates from norms and expectations, UWs who receive stereotypical messages about their role and responsibility for their SASs' OCB experience shame. While some suggest that SASs protect themselves from experiencing shame by hiding their behavior from their UWs (Adams et al., 2020; Bothe et al., 2020a; Carnes, 2011; Chisholm & Gall, 2015), others counter that SASs may deflect their shame through secrecy, which safeguards their power and control in the relationship (Minwalla, 2021).

Secrecy

Secrecy protects the SAS from experiencing shame associated with excessive sexual behavior, but undermines intimacy between the SAS and his UW. Due to modern technological platforms, SASs have multiple opportunities to secretly engage in sexual behaviors without their wives' knowledge, and they are able to deny their acts of infidelity (Schneider et al., 2012). Gottman (2011) observed that secrets diminish relationship quality and perpetuate addictive behavior.

While secrecy may initially shield the SAS from the shame of being found out, concealment adds to the distorted belief that no harm is done to self, wife, or relationship (Carnes, 2000,2001; Hall, 2019). The SAS becomes masterful at keeping his sexually excessive behavior from wives, friends, supervisors, family members, and spiritual leaders in order to guard against judgment about his character. As secrecy becomes an ingrained habit, SASs may conceal their out-of-control behavior through dishonesty and deception (Drake & Caudill, 2019; Juergensen Sheets & Katz, 2019; Keffer, 2018) while rationalizing that behavior kept secret is protecting their wife from becoming hurt (Nyaga et al., 2017). As SASs rationalize withholding

information, they minimize the serious consequences of their behavior (Keffer, 2018). Minwalla (2021) asserts that the deceptive nature of withholding sexual behavior from a wife or partner is a form of manipulation and abuse of power perpetrated against the unsuspecting partner, eroding the integrity of intimate relationships (Gottman, 2011; Minwalla, 2021).

When UWs discover their SASs' secrets, they are repulsed and disoriented as they come to grips with the knowledge that the people they most trusted kept excessive betrayals hidden from them (Minwalla, 2021; Skinner, 2017; Steffens & Means, 2021). As UWs seek to understand their spouses' sexually excessive behaviors, SASs manipulate the dynamics by concealing the reality of the out-of-control behavior (Minwalla, 2021), redirecting the UWs' questions by suggesting that the UWs are crazy (Keffer, 2018), out of touch with reality, the cause of abnormal behavior, or all of these (Daniels & Farley, 2022; Hall, 2016; Juergensen Sheets, 2022; Keffer, 2018; Minwalla, 2021; Steffens & Caudill, 2021). SASs safeguard their secrets about their OCB behavior by falsifying information, stonewalling (Gottman & Silver, 2015), or refusing to answer their UWs' questions (Keffer, 2018; Steffens & Caudill, 2021). Such erosion of relational integrity is a form of psychological abuse that deserves the attention of professionals treating the UWs and the SASs when they seek support post-discovery (Drake & Caudill, 2019; Juergensen Sheets, 2022; Minwalla, 2021; Steffens & Means, 2021).

Discovery

A UW's discovery occurs when she uncovers indisputable evidence, receives a tip from another, or confronts the addict, who acquiesces to her discovery (Corely et al., 2013). In one study, 84% of the discoveries were out-of-the-blue and produced for the UWs a crisis in which they reported physical, psychological, and emotional distress (Steffens & Rennie, 2006). Symptoms of trauma negatively impact UWs' relational, occupational, and other significant

areas of functioning (Seyed Aghamiri et al., 2022; Steffens & Rennie, 2006). Discovery by UWs unaware of their SAS' OCB or incognizant of the gravity of such behavior experience shock, distress, and trauma (Hall, 2016; Hentsch-Cowley & Brock, 2013; Keffer, 2018; Manning, 2006; Laaser, 2018; Laaser et al., 2017; Reid et al., 2010; Skinner, 2017; Steffens, 2006; Steffens & Caudill, 2021; Steffens & Rennie, 2007, Vogeler et al., 2018). Details about the SAS that may have previously seemed questionable but unsubstantiated (Hall, 2016; Skinner, 2017) are now revealed, confirming the UW's sense there was a problem in her relationship (Laltrello, 2020; Steffens & Means, 2011; 2021). Information about the suspicious expenditure of time or money and unusual behavior repeatedly withheld by the SAS begins to make sense. Hall (2016) argued that it is plausible for UWs to remain unaware of their mate's excessive sexual behavior outside of the relationship due to technological advances as well as work requirements for extended hours and travel assignments. Additionally, with the myriad of tasks UWs accomplish in their multiple roles as partners, mothers, caregivers, and employees, focusing on their responsibilities takes away from concentrating on whether or not their mates remain sexually faithful (Daniels & Farley, 2022). Therefore, it is not unthinkable for UWs to miss their mate's concealed behavior. When UWs uncover evidence of their SAS' behavior, their SASs may deny or minimize their UWs' reality (Laltrello, 2020). UWs often receive messages from professionals and non-professionals insinuating that they must have known and denied their mate's behavior, adding further shame, disorientation, and self-doubt to the UW's experience. Similarly, because work may demand countless hours on computers or business trips may take the SAS away from home, alternative explanations justify the man's consuming activities away from his family and relationships. Finally, it is a normative assumption that because he made a vow to commit to his marital relationship, a mate would safeguard his commitment to his relationship.

In some instances, children discover evidence of the parent's sexual excesses (Carnes, 2011) before the partner, and other times the parents erroneously assume the children are unaware of the sexual behavior. Many women recall their day of discovery (D-day) (Skinner, 2017, p. 64) as the most painful day of their lives, experiencing psychological, emotional, and physical distress. Minwalla (2021) observes that as a partner discovers her SAS's deceptive sexual behavior, her "previous perceptions of reality are injured and forever altered," (Minwalla, 2021, p. 10). When Barbara Steffens (2006) studied how discovering of a mate's out-of-control sexual behavior affected partners, she found that close to 70% of women experienced functional impairment because of uncovering their mate's SA/OCSB. Unsuspecting partners and wives thrust into the discovery of their mate's hidden sexual OCB are predisposed to symptoms of post-traumatic stress that undermine self-appraisals of identity, sexuality, gender, attachment, and relationships, (Minwalla, 2021) and challenge the wives' existential beliefs (APSATS, 2022; Laaser, 2018; Laaser et al., 2017; Seyed Aghamiri et al. 2022). These attachment wounds predispose the UW to chronic instability of safety for her physical, emotional, and relational experience (APSATS, 2022; Minwalla, 2021). It is common for partners to experience shame and disgust when they discover their SAS's behavior (Schaumberg, 2019; Schneider, 2000). Unfortunately, some partners endure multiple D-days because of the high rate of relapse in sexual addiction (Corely et al., 2013; Schneider & Corley, 2020; Steffens, 2005; Steffens & Means, 2021; Steffens & Rennie, 2007). As the UW seeks safety and stability after discovering her SAS's OCB, his pervasive deception, blaming, and gaslighting may keep her in an ongoing state of emotional crisis. Mental health professionals may contribute to her traumatic experiences with messages and labels that feel incongruent to her reality about herself and her circumstance.

Gaslighting

When UWs discover their SAS' OCB, the SASs may redirect the focus away from their sexual behavior by calling attention to their wives' shortcomings or finding loopholes in their hunches. Experts who study this relational dynamic posit that gaslighting, a form of psychological manipulation, is an abuse of relational power because it dominates another person's perception (Minwalla, 2021; Steffens & Caudill, 2021; Sweet, 2019). According to Keffer (2018), "When a betraying spouse becomes a master of deceit, he hides his shameful secret from his wife, family, friends, and workplace to protect his reputation" (Keffer, 2018, p. 235). Yet, others suggest that gaslighting is a covert form of abuse against the integrity and agency of another (Minwalla, 2021). Gaslighting, by individuals and institutions, is a form of control and domination inflicting psychological harm on victims, causing them to doubt their sanity and intuition (Keffer, 2018; Minwalla, 2021; Stark, 2019; Tormoen, 2019). To deflect the focus away from the behavior in question, a SAS may rebound with pejorative messages that convey to the partner she is controlling, crazy, unattractive, and paranoid. Keffer (2018) identified common SASs' tactics such as "blocking, blaming, and bullying" (Keffer, 2018, p. 243) that diminish a UW's morale when she asks for clarification or truth about questionable behaviors or occurrences. SASs who gaslight partners assert their power in the relationship but do so by suggesting that their partner imagined problematic relational patterns (blocking), diverting the attention away from the problematic behavior through externalization (blaming), and demeaning the partner's character (bullying) (Keffer, 2018). When Keffer (2018) studied women who had been gaslighted, she found that while 35% of the women expressed distress over discovering their partner's SA/OCSB, 65% were traumatized by their mate's chronic

deception. Among this same group of women, 92% of the women admitted that their partner's continual lies caused them to doubt their sense of reality (Keffer, 2018).

Gaslighting undermines intimacy in committed relationships and prevents a partner from believing she can trust what she believes about her relationship, her partner, and her intuition (Skinner, 2017). When Skinner (2017) studied women's experiences of gaslighting, he found that of 998 participants, when 81% sought clarification from a mate about suspected sexual improprieties, in at least half of the communications SASs retaliated by telling their partners that they were insecure. In this same study 414, or 34%, of the women were blamed by mates who suggested that because they were not sexual enough, the SASs resorted to out-of-control sexual behavior. Gaslighting tactics imposed by one person over another is psychologically abusive (Minwalla, 2021). When perpetrated by institutions entrusted by others to offer professional support, gaslighting at a social level can be equally if not more devastating (Stark, 2019; Sweet, 2019). Sadly, when traumatized UWs seek professional mental health after the discovery of their SASs' OCB and a realization that they have been the target of deception (Minwalla, 2021), counselors perpetuate their spouse's gaslighting when they convey messages based on the traditional beliefs about their "coaddiction" (Baird, 2011; Cermak, 1991; Carnes, 1983; 1992; Hentsch-Cowles & Brock, 2013; Stokes, 2020; Weiss, 2018) or contributing disease (Black, 2019).

Women may feel that their professional mental health workers gaslight them when they pathologize what would normally be considered a reaction to a traumatic event beyond someone's control (Gomez et al., 2016; Steffens & Caudill, 2021; Tormoen, 2019; Tseris, 2013). By nature of their relationship with SASs, UWs may receive messages that are counter to the support they need. Weiss (2018) observed that when loved ones of addicted mates seek

professional guidance, mental health professionals often convey their assumptions that partners are "enmeshed, enabling, controlling, and thus contributing to the problem" (p. 6). Rather than validating normative responses to feeling demoralized, shocked, shamed, and unsafe or realizing that a relationship has been upended, partners may receive messages with labels that feel confusing and retraumatizing (Vogeler et al., 2018). Despite their ability to function in all other aspects of their lives (Daniels & Farley, 2022; Hall, 2016) women may be told that they are as ill as their addicted mate (Carnes, 2001; Hentsch-Cowels & Brock, 2013), and although they receive messages to work on themselves (Baird, 2011; Weiss, 2018) they are also told they will never recover from their disease (Steffens & Means, 2021). Gendered stereotypes (Anderson, 1996) conflated with cultural perceptions of pathological behaviors in families confronting addiction (Weiss, 2018) invalidate the UW's traumatic experience (Gomez et al. 2016) when she receives pejorative messages about her role, responsibility, and reaction (Hentsch-Cowles & Brock, 2013). Earlier conceptualizations for treating SASs with SA/OCB and their partners wrongly accused women in their role and responsibility and focused on reducing the addict's shame (Carnes, 2001). Treatment plans based on frameworks from the "coaddict", or "codependent" framework may further gaslight UWs seeking treatment from professional counselors and exacerbate the traumatic experience of their SASs' betrayals. The betrayal trauma theory explains how vulnerable individuals who depend on caregivers, trusted partners, or trusted members in organizations may appraise the relationship positively while ignoring ongoing abusive behavior directed toward them (DePrince, 2012; Gobin & Freyd, 2009). UWs experience the effects of IBT when SASs violate their sexual boundaries and gaslight them to conceal their behavior. Counselors may prolong this experience when they convey messages that invalidate the traumatic nature of her experience. Like domestic gaslighting, institutional gaslighting

diverts the responsibility of the trauma perpetrator by calling attention to the pathological traits in the traumatized victim (Gomez et al., 2016; Tormoen, 2019). Counseling messages that perpetuate institutional gaslighting (Stark, 2019; Sweet 2019) misrepresent the UW's role and responsibility in her SAS's OCB and pathologize her normative responses to feeling demoralized and unsafe. While addiction specialists warn against shaming the addict, some clinicians argue for making the partner aware of her responsibility for contributing to the disease and prolonging the addictive behavior through her codependent behaviors (Hentsch-Cowles & Brock, 2013). Others argue that such messages are counter to the recovery of the UW or SAS (Weiss, 2018).

Betrayal Trauma

Practitioners who use frameworks endorsed by scholars form the basis for conceptualizing mental health treatment plans for UWs (Black & Tripodi, 2012; Hentsch-Cowles & Brock, 2013; Laaser et al., 2017; Laaser, 2018; Laaser & Laaser, 2020; Schneider et al., 2012; Skinner, 2017; Steffens & Rennie, 2006; Tripodi, 2006). Additionally, because studies show that women may be too ashamed to seek support early in their discovery (Laaser et al., 2017), the messages counselors convey while offering psychoeducation about sex addiction may, in fact, prevent UWs from returning for professional support. Differing views about the UW's relationship with the SAS, as well as their role, responsibility, and experience, result in inconsistent messages that UWs receive from their mental health professionals. Furthermore, messages conveyed to UWs that are out of line with their reality confuse and invalidate them (APSATS, 2022; Steffens & Caudill, 2021; Steffens & Means, 2021; Vogeler et al., 2018), potentially rupturing the therapeutic relationship (Tormoen, 2019).

Although scholars agree on the traumatic nature of discovering an intimate betrayal (Carnes, 2011; Corely et al., 2013; Daniels & Farley, 2022; Hetsch-Cowels & Brock, 2013;

Laaser et al., 2017; Laltrello, 2020; Manning & Watson, 2007; Pollard et al., 2013; Reid et al., 2010; Schneider, et al., 2012; Seyed Aghamiri et al., 2022; Skinner, 2017; Steffens & Caudill, 2021; Steffens & Means, 2021; Steffens & Rennie, 2006; Stokes et al., 2020; Tripodi, 2006; Vogeler et al., 2018), they differ on the partner's role, responsibility, and experience post-discovery. While the addiction model and 12-step programs are a useful framework for diagnosing and treating SASs with OCB (Carnes et al., 2005; Steffens & Means, 2021; Stokes, 2020; Weiss, 2018), contemporary practices involved in work with UWs recognized incongruencies with the wives' experience and the messages they received from mental health professionals and other individuals entrusted to support them. While labels to describe UWs' experiences originally garnered labels such as codependent or coaddicted, more recently studies dismiss claims that UWs colluded with their mates or brought their own disease into the relationship. Instead, scholars and partner advocates assert that these claims are not only inaccurate but retraumatizing to the UW seeking support from professional mental health workers post-discovery (APSATS, 2022; Minwalla, 2021; Steffens & Means, 2021). Instead, the growing body of work suggests that UWs have been the target of psychological abuse and that discovery of her SAS's OCB is traumatic (APSATS, 2022; Keffer, 2018; Laltrello, 2020; Minwalla, 2021; Schneider et al., 2012; Skinner, 2017; Steffens, 2005; Steffens & Means, 2021; Steffens & Rennie, 2007; Vogeler et al., 2018). In reviewing the literature on counselor messages based on existing frameworks for treating partners, a brief discussion on coaddiction, codependence, and IBT are presented.

Conceptualizations about the Partners

Although the treatment of a SAS's OCB receives ongoing attention in research, the dearth of research on treating UWs leaves mental health professionals uncertain about how to

conceptualize the role and responsibility of the UW, which creates ambiguities in treatment and recovery plans. Mental health professionals who employ the addiction framework (Black, 2009; Hentsch-Cowles & Brock, 2013) incorporate the family systems model with an emphasis on the role and responsibility of the UW as coaddicted or codependent. However, a growing body of research reveals that the discovery of a SAS's OCB is a form of relational trauma that causes the partner "extreme emotional pain and psychological damage" (Steffens & Means, 2009; p. 4). Counselors who conceptualize the partner's experience as an intimate betrayal trauma (Skinner, 2017; Steffens & Caudill, 2021) recognize the importance of providing their client with a professional relationship that initially provides safety and stabilization so that she can progress through her trauma.

Coaddiction

UWs who discover the SAS's OCB may seek professional support post-discovery but may receive messages from counselors suggesting that they are culpable for their role in their SAS's addiction. Carnes (2001) concluded that *coaddicts*' beliefs about their undesirability negatively influence their choice of partner and prohibit them from expressing their needs or confronting their spouses with concerns. It was previously thought that coaddicts numb their feelings to prevent them from experiencing fear, hopelessness, and worthlessness. Like their SASs who deny they have a problem, Carnes (2001) posited that UWs remain in a state of denial about problematic aspects of their relationship by dismissing their intuition and rationalizing mates' unusual behavior. Carnes (2001) further characterizes UWs as either grandiose or inadequate—grandiose because they take responsibility for others' actions and inadequate due to their exaggerated sense of personal shortcomings (Carnes, 1991). Carnes (1991) suggested that

coaddicts protect their sense of inferiority/inadequacy by blaming their mates' sexual addictions for the problems in their relationships.

Some maintained that coaddicts' distorted cognitions were evident in behaviors that included preoccupation, controlling, enabling (Carnes, 2001; Hentsch-Cowles & Brock, 2013), and duplicity (Carnes, 2001). Carnes (2001) observed that UWs ignored their discomfort with abandonment by becoming overinvolved in the outcomes of their sexually addicted mates' OCB, as evident by their need to control the habits of the sexually addicted mate. He concluded that because UWs distrust their mates' integrity, they impose accountability measures but wait for them to fail their expectations (Carnes, 2001). Nevertheless, Carnes (2001) concluded that the same partners who policed their mates enabled their behavior while concealing it from others (Carnes, 2001). Borrowing from family systems theories applied in chemical addiction therapeutic interventions, Carnes (2001) asserted that dysfunctional family dynamics enabled the addict's unmanageability and secrecy (Carnes, 2001). While less obvious in more recent literature on conceptualization of UWs, remnants of the codependent model are evident in contemporary literature (Baird, 2011; Black, 2019; Hentsch-Cowels & Brock, 2013) and, therefore, codependent labels are more nuanced in treatments for UWs. Mental health professionals accepting UWs for treatment still conceptualize UWs as coaddicted rather than survivors of IBT (Steffens & Caudill, 2021).

Codependence

More recently, addiction professionals replaced the "coaddict" label and characterized UWs' relational dynamic with SASs' by labeling them "codependent" (Hall, 2016; Laltrello, 2020). Karen Horney's theories conceptualized in the 1940s explained the development of self and the need to please others to avoid anxious feelings (Steffens, 2018). Proponents of

conceptualizing codependence as a disease (Whitfield, 1991) or an inherent personality trait (Cermak, 1986) laid the foundation for the conceptualization of women who, due to traumatic pasts, failed to defend themselves against trusted partners who were cruel, emotionally avoidant, and unreliable (Laaser, 2004). Codependence, like coaddiction, was employed as part of the family systems theory in chemical addiction work to label family members of alcoholics (Bacon et al., 2018; Keffer, 2018; Steffens, 2005; Weiss, 2018). It subsequently garnered interest in popular self-help literature (Steffens, 2005) and proliferated in scholarship and research (Bacon et al., 2018). Anderson (1994) took issues with pathologizing women for traits that were socioculturally expected from women and later, Weiss (2018) challenged the injustice of blaming and shaming family members who were doing their best to manage the crisis of being in a close relationship with someone with an addiction. When mental health practitioners default to treatment plans based on outdated frameworks and convey messages to a woman that discounts her experience and invalidates her trauma, they perpetuate her experience of being the target of confusing and inaccurate messages (Gomez et al., 2016; Tormoen, 2019).

In their recommendations for treating partners of mates with out-of-control sexual behavior, Hentsch-Cowels and Brock (2013) argued for the benefits of applying the family systems model and holding the female responsible for the role she played in the dysfunctional relational dynamic. They restated earlier observations that when one family member struggles with pathology, all other family members are responsible for the dysfunction. More specifically, scholars opined that partners of mates with addictions contributed maladaptive relational dynamics from their family-of-origin (Black & Tripodi, 2012; Carnes, 1997; 2001; Schneider et al., 1998), struggle to regulate their emotions, and mirror their mates' duplicity, anxiety, avoidance, and addictions (Adams, 2009). Recommended recovery for UWs of SASs who

exhibit OCB included augmenting therapy with attendance to 12-step meetings, where a UW is expected to introduce with a stigmatizing label that identifies her as “diseased” (Steffens & Means, 2021) and somehow responsible for her SAS’s behavior (Baird, 2011). At some meetings, she may be asked to introduce herself as a "coaddict," while other groups provide her with a script that reminds her to introduce herself to other partners as a "co-sex addict," "codependent to a sex addict," or "sexual codependent" (Baird, 2011). Like her SAS, she is expected to get a sponsor, do the work on herself, and distance herself from her SAS with love if necessary (Steffens & Means, 2021; Weiss, 2018).

Similar to ambiguities and disagreements about sexual addiction, scholars disagreed on empirical evidence for “codependent”" traits, but the label has maintained a stronghold in literature (Minwalla, 2012; Vogeler et al., 2018) and continues to be synonymous with individuals who contribute to their dysfunctional relationships with their sexually addicted mates (Hentsch-Cowles & Brock, 2013). Conflating themes from chemical addictions frameworks and excessive self-sacrifice exhibited by family members coping with the chaotic nature of addiction, women receive messages that they are codependent for failing to develop more rigid boundaries with their difficult SASs (Laltrello, 2020; Weiss, 2018). Such messages negate the UW’s experience of being in a relationship with a SAS who has mastered the art of concealing sexually excessive behavior and whose cognitive distortions defy truth-seeking even among trained experts (Efrati & Gola, 2018; Rosenberg et al., 2012).

Hall (2016) observed that mental health professionals often conceptualize partners as “codependents” to explain why they chose a mate with an addiction (Hentsch-Cowles & Brock, 2013) and, for many, advising UWs to explore their fractured past is an initial step in many counseling practices. Many women who grew up in families where they were expected to

provide excessive or inappropriate caregiving and deny their personal needs became susceptible to developing codependent habits (Hall, 2016; Steffens & Caudill, 2021). However, it has been argued that expectations placed on women to be self-sacrificing caregivers is not only normative in most cultures (Anderson, 1994), but the common experience of women (Weiss, 2018) regardless of their commitment to mates with an addiction. Yet, for UWs in relationships with SASs with OCB, recovery from coaddiction or codependence occurs when partners admit that they are powerless over their addicted mate's recovery, set boundaries to protect themselves from their mates, and work on their own recovery (Baird, 2011; Steffens & Means, 2011, 2021).

Hentsch-Cowels and Brock (2013) argued for the benefits of maintaining the coaddiction or codependent label when treating the partner because it appropriately conceptualizes the partner's role and responsibility. However, findings that reveal that UWs were unaware of their SASs' OCB because it was hidden from them challenges this approach to treatment (Hall, 2016; Minwalla, 2021) because it blames or revictimizes the target of the SASs' OCB and its consequences (Gomez et al. 2016). When mental health professionals conceptualize the treatment of partners with the coaddicted or codependent framework, they miss the UWs' narrative (Gomez et al., 2016), confuse them (Vogeler 2018), and disregard the courage it took to seek support to cope with the tumultuous aftermath of IBT (Steffens & Caudill, 2021). Furthermore, studies indicated that when factoring out the distress caused by an SAS's betrayal, partners showed evidence that they were psychologically healthy (Reid et al., 2011). Rather than pathologizing and labeling women for being in a committed relationship with a SAS, an alternative may be to explore with her the aftermath of her intimate betrayal trauma.

Intimate Betrayal Trauma

While some mental health professionals viewed unsuspecting partners as "codependent" (Carnes P. J., 2001; Hetsch-Cowels & Brock, 2013; Tripodi, 2007), others recognized the traumatic nature of the intimate betrayal (APSATS, 2022; Keffer, 2018; Minwalla, 2021; Skiner, 2017; Steffens & Caudill, 2021) and sought to provide safety and restorative care (APSATS, 2022). Findings revealed that once safety and trust were established in the clinical relationship and unsuspecting partners grieved the losses of their idealized relationship, they had opportunities to reconnect (APSATS, 2022; Steffens & Caudill, 2021) and transform their experiences into positive growth (Laaser et al., 2017: Laaser, 2018).

Counselors skilled in treating IBT recognized the devastation and emotional unsafety that a UW experiences when she discovers that her SAS's excessive sexual behavior outside of the committed relationship has violated her sense of trust and safety. Additionally, when the UW realizes that she may have been put in harms way and that she has no guarantee against ongoing unpleasant discoveries or disclosures (Corley et al., 2013; Drake & Caudill, 2019; Juergensen Sheets, 2022) she finds herself in a continual state of psychological distresss (Skinner, 2017; Steffens & Rennie, 2006). In one study, 60% of partners who experienced IBT met the criteria for PTSD (Laaser et al., 2017). Scholars who supported the trauma model for treating UWs challenged the "codependent" label as inaccurate and unjust (Keffer, 2018; Laltrello, 2020; Stafford, 2001; Steffans & Rennie, 2006) because these labels pathologized unsuspecting partners and failed to differentiate the reality of living with mates with secretive, sexual acting-out behaviors from those with more easily identifiable chemical addictions (Hall, 2016; Laltrello, 2020; Stafford, 2001; Steffens & Means, 2021). Trauma-based treatment professionals normalized the UW's need for safety (Schneider, 2012; Schneider et al., 2012; Schneider et al.,

2012; Seyed Aghamiri, 2022; Skinner, 2017; Steffens, 2005; Steffens & Means, 2021; Steffens & Rennie, 2006) and integrated this need as a priority for clinical care. Confronting the harsh realities of discovering a relationship with a SAS with OCB is challenging enough; still, evidence shows counseling messages that label a UW "coaddict" or "codependent" revictimize and confuse her (Vogeler et al., 2018), hindering her recovery from the emotional chaos and instability typical in survivors of IBT (Forbes et al., 2014).

Unsuspecting wives' discovery of sexually deviant behavior is emotionally overwhelming after learning about multiple or prolonged affairs, undisclosed children, criminal behavior, financial devastation, and sexually transmitted diseases (Carnes & Lee, 2014), along with other behaviors beyond the realm of an UW's awareness (Hall, 2016; Steffens & Caudill, 2021). Women who are the target of a SAS's betrayal suffer financial hardships for themselves and their children (Leopold, 2018; Steffens & Caudill, 2021). Additionally, women shamed by their mates' sexual addiction (Carnes & Lee, 2014) along with accompanying psychological abuse (Minwalla, 2021) suffer social isolation as they grapple with decisions about choosing supportive individuals with whom they can share their experiences. Steffens and Caudill (2019) found that women struggle with internal negative self-appraisals that are compounded by shame-based external messages conveyed by those they entrust for support. Women face existential and spiritual consequences as they confront the disconnection between their assumptions and their reality (Seyed Aghimiri et al., 2022; Steffens & Caudill, 2021).

Finding out about the intimate betrayal shatters the assumed sense of emotional security and intimate trust of the partner (Keffer, 2018; Steffens & Rennie, 2006) while compromising beliefs about herself and the rest of her world (Steffens & Means, 2021). The trauma associated with the discovery of the SAS's behavior is often painful and chronic, causing unsuspecting

partners to question their perception of reality (Abramson, 2014; Minwalla, 2021), especially after their SASs dismissed their suspicions with lies, manipulation, and gaslighting tactics (Stern, 2007, as cited in Fuchsman, 2019). Daniels and Farley (2022) observed the shame and guilt associated with sexuality, compounded by the personal nature of intimacy, intensifies a sense of betrayal, inadequacy, and moral disgust (Daniels & Farley, 2022) associated with the discovery. In these moments of relational crisis after the discovery, UWs may choose to either isolate or seek support from others. Similar to instances where responsibility for abuse is misplaced from the perpetrator to the victim (Tseris, 2013), when mental health professionals target UWs with inaccurate and pejorative labels and messages as part of the UW's treatment plan, they prolong the UW's traumatic experience of gaslighting and manipulation (Minwalla, 2021; Stark, 2019; Sweet, 2019). According to Laaser et al. (2017), "It is important for clinicians to remember that even with the best intentions, 'off-the-cuff' comments are often perceived by relationally betrayed women as unhelpful and damaging" (p. 442).

Recovery

A trauma-informed model for IBT (Association of Partners of Sex Addicts Trauma Specialists [APSATS], 2012), the MPTM, imports safety and trustworthiness in the counseling relationship after providing stability for the UW (Carnes & Lee, 2014). When the counselor or therapist follows the MPTM framework, priority is given to validating the UW's experienced trauma when she discovers her SAS's OCB (Keffer, 2018; Skinner, 2017; Steffens & Caudill, 2021). After the initial shock of the discovery and the pain of disclosure, the mental health professsional employs therapeutic techniques that guide her through the process of mourning the loss of what she believed about her relationshp and infuse hope that she can rebuild a new "normal" through reconnection and re-engagement with others (APSATS, 2022; Steffens &

Caudill, 2021). Laaser et al. (2017) posited that traumatic experiences could be opportunities for personal growth when an individual has access to appropriate resources. Effective therapeutic interventions must consider the UW's readiness to move through stages of growth (Hall, 2016; Laaser et al., 2017; Steffens & Caudill, 2021). Professional mental health training programs that prepare students and professionals to meet the needs of survivors of IBT must help them identify their symptoms of IBT and empower them to envision growing through the traumatic experience. Experts recommend providing UWs with a safe therapeutic space and validating the traumatic nature of their discovery. Attuned mental health professionals offer partners hope that they will be empowered to determine whether they want to reconnect with their SAS, become support personnel for other hurting betrayal trauma victims, and engage in their new reality in a meaningful way (Steffens & Caudill, 2021). Laaser and colleagues (2017) recognized that similar to women who experienced other types of abuse, partners in relationships with SASs benefit from therapeutic interventions that support growth.

Multidimensional Partner Trauma Model (MPTM)

Steffens and colleagues observed that interpersonal trauma inherent in IBT is the result of the UW discovering that she is married to an individual who struggles with sexual addiction and has concealed his behaviors from her through deceptive behaviors including gaslighting. Furthermore, IBT is compounded by the SAS's chronic, sexual acting out behavior post-discovery (Steffens, 2005; Steffens & Caudill, 2021; Steffens & Means, 2021). The UW's presenting symptoms to mental health professionals mirror those of individuals suffering from complex relational trauma observed in individuals who experienced combat as well as other types of relational abuse (Herman, 2015). Steffens (2005) recognized that the need for safety and stabilization after the traumatic experience of witnessing carnage as a war veteran, or surviving

child abuse or rape, was also a need for women who unexpectedly discovered their SAS's involvement with pornography consumptions, multiple affairs, or child pornography, along with other illegal and risky sexual behavior. Appropriately, the MPTM approach to treating the UWs adapts Herman's model (2015), an empirically based framework for treating complex relational trauma. The MPTM has potential benefits for UWs who desire therapeutic interventions that support their need to process their IBT physically, cognitively, and emotionally to heal from their relational trauma. The MPTM's adaptation of Herman's (2015) model for recovery focuses on three stages of recovery which include: "safety and stabilization, remembrance and mourning, and reconnecting tasks & re-engaging" (Steffens & Caudill, 2021, p 734). In the first phase of treatment, because the counselor recognizes the UW's discovery of IBT as a crisis, the professional establishes a rapport with the client that ensures emotional safety. During the second phase, the counselor integrates the UW's narrative in evidence-based practices for trauma treatment. As the UW experiences well-being because she has emotionally and psychologically accessed the trauma in a therapeutically productive way and has developed a sense of agency, the counselor supports the UW's ability to reconnect and find new meanings from her experience. The discourse below briefly describes the tasks from each phase/stage.

Phase One – Safety and Stabilization

During stage one, the counselor supports the UW's need to feel safe and establish self-agency. The professional's demeanor is supportive while assessing for indicators of self- or other inflicted harm, as well as educating the woman about the need to access medical assistance to rule out STDs (Steffens & Means, 2021). In addition to confronting the crisis of discovery, the UW may, for the first time, gain knowledge about the SAS's financial or legal consequences which may compound the traumatic nature of her discovery. The counselor, employing an

empathetic presence, listens as the UW recalls how, where, and when she discovered her SAS and the effects that the IBT has had on her functioning. The mental health professional explores with her how she discovered her SAS's OCB and to what degree her shocking reality has impacted her physically, emotionally, and cognitively (APSATS, 2022). For example, according to Steffens (2005), common physical responses included vomiting, fainting, and body tremors. Common thoughts included a felt lack of safety and disbelief (Steffens & Means, 2021; Steffens & Rennie, 2007) that accompanied emotional responses of fear, horror, repulsion (Steffens, 2005; Steffens & Rennie, 2007), shame, humiliation, and anger (Schneider, 2013). It seems that rather than compounding the UW's trauma by making her identify her role and responsibility or pathologizing her response to the discovery of her SAS's OCB, a trauma-informed counselor would normalize her response to her discovery while assuring her that she was not responsible for her SAS's secretive sexual behavior outside of their relationship.

Psychoeducation is necessary to debunk erroneous messages the UW may have received that devalue her experience in favor of making her take on a role or carry the burden of responsibility for her SAS's OCB. Subsequently, empowering the UW by providing her with tools to cope and self-soothe when she is triggered will help to reduce her repetitive depression, anxiety, and trauma. To prevent shame-based isolation that partners frequently experience, support groups facilitated by trauma-trained mental health workers can offer safety, structure, information, and hope for women seeking answers (Steffens & Means, 2021).

Although full disclosure can be emotionally stressful for both the UW and her SAS, when the SAS is forthcoming with information about his sexual betrayal the UW can make decisions about to what extent she can rebuild a sense of trust and safety (APSATS, 2022; Drake & Caudill, 2019; Juergen Sheets, 2022; Laaser et al., 2017; Steffens & Means, 2021). The

disclosure process facilitates her need to know the truth about her SAS's behavior. As the SAS shows evidence of making progress in recovery, trained professionals facilitate a formal disclosure process with the UW and her mate (APSATS, 2022; Drake & Caudill, 2019). Programs devoted to working with UWs of SASs recommend facilitating a full disclosure as soon as possible (Drake & Caudill, 2019; Steffens & Means, 2021). Without the truth about the SAS's betrayal, the UW will not feel safe (APSATS, 2022) and will continue with intrusive imaginings of his OCB (Juergensen-Sheets, 2022). Commonly, professionals trained as C-SATS (IITAP, n.d.) or trauma specialists who support partners of sex addicts (APSATS, 2022) develop protocols that ensure a degree of safety and "stop the bleeding" in the relationship (Drake & Caudill, 2019; Juergenson-Sheets, 2022). The most effective disclosures include information about the behaviors, timelines, expenses, and other pertinent information affecting the partner. In instances where the partner's physical safety was compromised (e.g., strangers were in the house; unprotected sexual behavior) or the SAS engaged in behaviors with relatives or friends, the UW is entitled to that information. Due to possibilities that the content of the disclosure is potentially retraumatizing, the mental health professional advises the UW to pre-plan a way to take care of her emotional, physical, and psychological well-being post-disclosure. As the UW and therapist undergo the preparation, formal disclosure, and aftermath, consideration is given to supporting the woman's ongoing need to attend to triggers and emotions that may occur during the disclosure. The SAS's counselor or therapist prepares him to recognize his UW's emotions and behaviors as normative for stress and grief. As the UW stabilizes, she is more receptive to grieving the disruption of her relationship and to receiving tools that empower her to manage her responses to her IBT (APSATS, 2022; Laaser et al., 2017; Laaser, 2018). Similar to the

experience of grieving the death of someone close, the UW will need to go through stages to heal but will continue to have memories associated with the betrayal.

Women heal through resources that empower them through the removal of barriers that make them feel shamed, isolated, and powerless (Brown, 2006). When building support systems, counselors can help clients determine who are the safe people that will help them heal as they share their experiences. Support groups facilitated by trained coaches or counselors give partners opportunities to share their experience with other women who have experienced similar trauma (APSATS, 2022; Laaser et al., 2017; Steffens & Means, 2021). While women receive messages that they should neglect their needs for the sake of others, counselors may reframe this message (Weiss, 2018) by helping them explore ways to practice mental, emotional, physical, and spiritual self-care (Steffens & Means, 2021). Steffens and Means (2021) observe that navigating the crisis during stage/phase one takes time and effort but has the potential to empower women to develop tools that Laaser et al. (2017) observes helps them grow with a new perspective. This growth is the result of an altered and enhanced set of beliefs about the way the world works (Laaser et al., 2017; Laaser, 2018) with a re-establishment of existential truths (APSATs, 2022; Juergensen Sheets & Katz, 2019; Seyed Aghamiri et al., 2022). Mental health professionals who acknowledge the complexity of the UW's IBT while refraining from conveying messages that pathologize her empower the woman to move through the healing process with options for growth (Gomez et al., 2016; Laaser et al., 2017; Laaser, 2018).

Phase Two: Remembering and Mourning

Carnes et al. (2015) noted that betrayal shatters the perception of the ideal mate and the desire for romance. In other related investigations, Laaser (2018) and her colleagues (Laaser et al., 2017) observed that relational betrayal such as IBT undermines the betrayal target's

paradigms, beliefs, goals, and narrative. In the APSATS MPTM (APSATS, 2022), UWs who benefit from interventions that help to establish a personal sense of safety, empowerment, and stabilization become ready to reconcile their grief about their troubled relationship. When the integrity of a committed relationship erupts (Minwalla, 2021), UWs ruminate about their SASs' unwillingness or inability to cherish and protect the sacredness of their relationship (Carnes et al., 2015; Means, 2020). The disruption of safety extends beyond the bedroom when UWs face the reality that sexual temptations for the SAS are omnipresent and some SASs deny that they have a problem (Carnes 1991). As the UW faces her new reality, the optimism she once felt about herself, her mate, and their relationship may deteriorate to negative feelings of regret about her commitment to her spouse. Feelings of hopelessness about her inability to compete with her SAS's fantasies (Bergner & Bridges, 2002) are overwhelmed by shame and anxiety about the future of the relationship (Carnes et al., 2015; Steffens & Means, 2021). After the initial stage of shock and instability, trauma-informed counselors provide room for the betrayed spouse to take inventory of her losses with the accompanying heartbreak over broken promises, stigmatization, and isolation. Women left to confront their SAS's OCB continue to contend with the possible financial, legal, and physical consequences of their excessive behavior (Minwalla, 2021; Steffens & Means, 2021).

However, evidence shows that a SAS's honesty about his OCB (Corely et al., 2013) and the value the wife places on her relationship (Goetz & Maria, 2019) may positively influence a UW's willingness to work to restore the relationship. Conversely, repeated deception on the part of the SAS (Corley et al., 2013) negatively impacts the UW's motivation to remain in the marriage. Counselors trained to work with sex addiction and IBT help SASs empathize with their

partner's trauma and guide UWs to discern whether their SASs are working toward recovery (Juergensen Sheets, 2022).

Fear, grief, and anxiety negatively impact the woman's sense of ability to regain control of her life after the unexpected discovery of her SAS's OCB. When survival instincts take over, women traumatized by the discovery of their SAS's OCB report that rather than remaining cognizant and emotionally present, they dissociate (Steffens & Means, 2021). Dissociation is an ego mechanism that prevents women from becoming overwhelmed by the pain of their new reality. Mental health professionals trained in working with traumatized individuals guide UWs through therapeutic interventions that help them stabilize and integrate the traumatic material with less distressing thoughts and beliefs about the event. For example, the UW may seek therapeutic interventions to address trauma symptoms such as general relational distress, cognitive distortions, sleep disturbance, and somatic dysfunctions (Caudill, 2013). In a study of betrayed partners, Laaser (2017) found that 72% sought individual therapy as a helpful resource post-discovery. Trauma-informed counseling frameworks include eye movement desensitization, or EMDR (Shapiro, 2018), cognitive behavioral therapy (Resick et al., 2017), and strategies such as self-compassion (Neff, 2011). Therapeutic frameworks may help women explore their unique narrative and experience (Gomez et al., 2016; Pollard et al., 2013), normalize their desire for connection (Brown, 2006; Laaser, 2018) and explore ruptures in current and former close relationships (Dallos & Vetere, 2014) to heal (Laaser et al., 2017; Laaser, 2018). As part of the grieving process, UWs explore their sense of lost selves, including their passions and goals in life (Laaser, 2018). While acknowledging the pain of betrayal that has robbed them of their passion, disempowered and shamed them (Brown, 2006), counselors guide partners through exercises that encourage them to reclaim meaningful and fulfilling tasks as part of their healing

process (Laaser, 2018). Additionally, mental health workers encourage UWs to find opportunities to separate their thoughts and reactions associated with their non-stop fear and grief by finding activities that distract them from their pain and help them reconnect with positive aspects of themselves (Steffens & Means, 2021). When UWs receive appropriate support to mourn the losses of their perceived idealized relationship and develop ways to cope with their trauma, they benefit from interventions that help them to find new meaning and integrate their growth into their future paradigms.

Phase Three: Reconnecting & Reengaging.

Dealing with the devastating and traumatic effects of IBT (Gingrich, 2018; Herman, 2015; Steffens & Means, 2011, 2021) as women progress through the former two phases, they become empowered to make meaningful relational connections and approach their new reality in healthy ways (APSATS, 2022; Keffer, 2018; Laaser et al., 2017; Laaser, 2018; Steffens & Caudill, 2021). As UWs experience a sense of safety (APSATS, 2022; Gingrich, 2018; Herman, 2015) and a noticeable reduction in trauma symptoms (APSATS, 2022; Gingrich, 2018) they are more equipped to perceive themselves in a healthier way (APSATS, 2022; Laaser, 2018), which enables them to reengage in healthier relationships (APSATS, 2022; Gingrich, 2018; Laaser, 2018). Ongoing supportive relationships that "provide empathy, help and encouragement" (p.148) throughout the healing process are recommended. As partners are given opportunities to grieve the loss of their idealized relationship and develop coping strategies to address their trauma, they may seek counselors who can work with them to make meaning from their traumatic experience and, through the growth process, feel empowered to reconnect with their new reality.

In phase three of the MPTM (APSATS, 2022), UWs may invest in rebuilding their relationships with SASs or seek help with the dissolution of their relationship. UWs can support other women moving through the phases of unsafety and instability toward grief work and reconnection. Support groups facilitated by trained coaches and counselors (APSATS, 2022; Juergensen Sheets, 2019; Laaser et al., 2017) provide opportunities for women to reconnect with women who are currently experiencing or have previously experienced the traumatic discovery of their SAS's OCB (Steffens & Means, 2011, 2021) and realize that she is not alone (Herman, 2015). As women participate in the treatment for IBT, they learn to establish boundaries with their SASs that help to maintain their emotional, psychological, and physical safety. SASs invested in recovering with their betrayed partners learn to recognize and acknowledge trauma triggers (Juergensen Sheets, 2022; Juergensen Sheets & Katz, 2019). Steffens and Means (2021) import that while UWs come to terms with their powerlessness to change their SASs' behaviors, they develop communication skills to convey their need for physical and emotional safety in firm and respectful ways. Clinicians familiar with the posttraumatic growth framework (Herman, 2015; Laaser et al., 2017; Laaser, 2018) can provide resources for not only helping UWs survive IBT (APSATS, 2022; Steffens & Caudill, 2021) and anticipate hopeful outcomes (Laaser et al., 2017), but anticipate positive growth. While post-traumatic growth is possible during all phases, the clinician judiciously considers the timing for conveying messages that there is opportunity to grow through the pain (Laaser et al., 2017; Laaser, 2018). If introduced too soon, the UW may interpret the messages from mental health workers as a ploy to minimize her pain (Lonergan et al., 2021) or rush her through her process of grief and trauma recovery (APSATS, 2021; Laaser, 2018). However, sensitive incorporation of post-traumatic growth with the MPTM framework provides guideposts for the clinician to convey to the UW that she can develop new ways of

viewing the world and herself (Herman, 2015; Laaser et al., 2017; Laaser 2018), enrich her relationships (APSATS, 2022; Gingrich, 2018), build on personal strengths, and reconstruct existential paradigms (APSATS, 2022; Herman, 2015; Laaser et al., 2017; Seyed Aghamiri et al., 2022).

The MPTM provides UWs who choose to stay in their marriages post-discovery with tools to reduce the shame associated with the stigma of being in an intimate relationship with a SAS. Because IBT destroys the UW's trust in the viability of her relationship (Keffer, 2018; Skinner, 2017; Steffens, 2005), couples need tools to rebuild trust and safety while recognizing emotions that are commonly experienced by the betrayed partner and the SAS (Butler et al., 2021). Trained clinicians use evidence-based techniques to help rebuild trust, vulnerability, and intimacy (Drake & Caudill, 2019; Laaser & Laaser, 2020). Couples therapy is considered effective when the SAS can recognize the UW's pain (Juergensen-Sheets, 2022) and both the wife and husband are better able to regulate their emotions rather than avoiding them. Butler et al. (2021) observed that "as relationship conflict increases following betrayal, offenders realize that the fallout from their actions will not just 'go away' or the trauma be resolved, or trust restored simply by ending the affair" (p. 241). However, a strong predictor of relational growth for the partnership and personal growth for the betrayed spouse takes place when the UW can demonstrate compassion for her SAS and makes a choice to forgive him (Butler et al., 2021). Trained mental health professionals guide this process as the SAS demonstrates his investment in his recovery by restraining from OCB and empathizing with his UW's pain caused by his addiction (Juergensen Sheets, 2022; Laaser et al., 2017). Couples who work intentionally to restore ruptured attachments have a greater likelihood of healing (APSATS, 2022; Butler et al., 2021).

When Laaser and colleagues (2017) studied partners who experienced IBT, they found that significant trauma destroys the individual's sense of self-agency and safety. Yet, despite the dramatic changes that occur after a traumatic event, their findings also suggest that traumatic experiences create more opportunities for individual growth (Laaser et al., 2017). A woman faced with discovering that she is in a committed relationship with a SAS may find it beneficial to educate herself about SAS and, if she chooses to stay in the marriage, create healthy boundaries and relational dynamics while learning to advocate for her needs in the relationship. Because trauma shatters a partner's assumption about herself and her interactions with the world, she may benefit from rethinking what has and has not worked for her in past situations. Wang et al. (2019) found that individuals who invested in becoming more self-aware and self-accepting were likely to grow through traumatic and difficult circumstances.

Experienced counselors working with betrayed partners promote support groups facilitated by trained counselors who understand sex addiction, interpersonal trauma, and the woman's need to establish healthy beliefs and behaviors for themselves and with others (APSATS, 2022; Steffens & Means, 2021; Laaser, 2018; Laaser et al., 2017). When Brown (2006) studied shame, she found that connections versus isolation reduced a woman's experienced shame. Women who join groups decrease feelings of isolation and powerlessness brought about by shame (Brown, 2006) when they are able to share their story with other women who have had similar experiences. Effective group therapy promotes posttraumatic growth because women who have recently discovered their SAS's OCB can learn from other women who have progressed through the stages of the MPTM and glean hope from their process (Laaser et al., 2017).

Recovery from IBT is a complex process affected by circumstances related to the UW, the SAS, and their relationship (Laaser, 2018). Due to the complexities of sexual addiction which include shame, secrecy, and ruptured intimacy, the recovery process is fraught with ambiguity and uncertainty. The mental health professional working with the UW must be willing to provide space for the woman to share her narrative, realizing that what was formerly conveyed to partners about their role and responsibility is counter to providing her with safety and stability. Professionals in the mental health field must hold space for the UW to grieve the loss of what she perceived as her ideal relationship while she processes aspects of the trauma that negatively impact her. As the UW is empowered to see areas from which she can grow through her traumatic event, the counselor or therapist can look for ways for her to reconnect with hopes that she has a new sense of purpose.

Summary

This review of the literature related to the current study on the lived experience of UWs seeking support from mental health professionals and the messages they received after discovering their SASs' OCB. The literature addressed the divergent conceptualization of sexual addiction and out-of-control sexual behavior. Subsequently, findings on intimacy, shame, secrecy, discovery, and gaslighting and the intersectionality of models for coadependence, coaddiction, and IBT were presented. Finally, the MPTM framework was discussed as a course of treatment for UWs seeking safety, stability, opportunities to resolve grief and trauma, and to establish meaningful reconnections. Chapter 3 discusses the study's methods.

CHAPTER THREE: METHODS

This transcendental phenomenological qualitative study was purposed to explore the lived experience of UWs seeking professional counseling after discovering their SASs' OCB and how messages they received supported or deterred recovery from IBT. A review of the literature reveals that divergent theories about the nature of the SAS's OCB also impact assumptions about the role and culpability of their unsuspecting partners. Consequently, when UWs seek support after learning about their SASs' OCB, they are subject to counseling practices with embedded messages that reveal the professional's conceptualization and treatment goals. This chapter describes the current study's methods including research design, research questions, setting, participants, procedures, the researcher's role, data collection, data analysis, trustworthiness, and ethical considerations.

Research Design

Despite extant research on men who struggle with sexual addiction, the scarcity of research on the UWs' experience leaves unanswered questions about the impact their treatment. While Manning and Watson (2007) informed mental health professionals about the types of support UWs sought post-discovery, this phenomenological study furthers counselor understandings because it presents UWs' experiences of receiving messages when they seek support (Creswell & Poth, 2018) from mental health professionals. This transcendental phenomenological study allows me to elucidate the participants' personal meanings associated with their experiences related to the topic (Peoples, 2021) by honoring their voices that present the contextual feature of their experiences (Creswell & Poth, 2018). Just as effective counselors focus on the essence of the "why" and "how" of their presenting issues, researchers who conduct transcendental phenomenological studies follow procedural steps to remove personal biases

which taint the essence of the participants' experiences that emerge from their narratives (Cresswell & Poth, 2018).

The choice of qualitative rather than quantitative was appropriate for capturing the complexities of the experience under review. While a quantitative approach would have produced causal relationships and reported findings from preconstructed categories, a qualitative approach makes space for subjective meaning to emerge from the lived experience of the participants. It was necessary to expose the complexities of the UWs' experiences seeking support from mental health professionals to better understand how the messages they receive shape their healing process. I bracketed my experiences, including preconceived constructs, to allow data to emerge from women's responses to open-ended interview questions. The meanings and themes came from the interviews transcribed by a software program onto a Microsoft Word document.

A transcendental phenomenological approach is appropriate for exploring UWs' experience with messages from mental health professionals post-discovery because it represents the collective experience from several participants (Creswell & Poth, 2018) and has had minimal exposure in research (Teherani et al., 2015). Because the findings are based on descriptions as the participants presented them, the findings produced empirical evidence co-constructed by the participants themselves, void of preconceived assumptions about the UW's counseling experiences that extend our understandings of the experiences of marginalized individuals with counselors, best practices for recognizing and treating IBT (Steffens & Caudill, 2021), as well as counselor recognition and treatment of relationships ruptured by a SAS's OCB.

Purposive sampling was used to identify participants based on their expressed willingness to share their narrative in a way that gave a descriptive account of their experience (Hayes &

Singh, 2012; Van Mannen, 2014). The transcendental method of qualitative study (Moustakas, 1994) provides the mental health community with the narratives of UWs seeking professional support as part of their recovery from symptoms associated with their traumatic discovery (Patton, 2014).

Rationale for Research Questions

This study used the MPTM (APSATS, 2022) framework to guide the study. Through the application of a transcendental phenomenological methodology the participants' answers to the research questions posed during a semi-structured interview availed the mental health community with a deeper understanding of the experience of UWs seeking professional mental health for IBT after discovering their SASs' OCB. This study was focused on the central question: How do UWs describe their experience of support from mental health professionals when they seek therapeutic interventions after discovering their SAS's OCB? Three subquestions pertain to findings about the UW's need to progress through three stages after their discovery (APSATS, 2022). As with recovery work with individuals who are targets of interpersonal trauma, trauma work in mental health counseling addresses safety and stabilization, integration of distressful memories into a new reality, and the opportunity to grow through reconnection (APSATS, 2022; Herman, 1992; Parnell, 2013; Resick et al., 2017; Shapiro, 2017). The questions from the MPTM framework include:

- Subquestion 1: How do UWs describe counselor messages immediately after discovery?
- Subquestion 2: How do UWs describe counselor messages during the therapeutic process?
- Subquestion 3: How do UWs describe counselor messages as they seek to reconnect?

Setting

The study explored the lived experiences of UWs in committed relationships with SASs with OCB when they received messages from professional mental counselors after their discovery. The study's setting consisted of interviews with participants across the United States who self-identified as targets of intimate betrayal trauma and sought support from mental health professionals. I sent an e-mail to mental health counselors and posted a flyer on Instagram, Linkedin, and Facebook (See Appendix B: Recruitment Letter and Appendix C: Social Media Flyer). The flyer's content invited UWs who had discovered their SASs' OCB and sought support from mental health professionals to participate in the study. UWs had to meet inclusion criteria (See Appendix D: Screening Questionnaire). After women expressed interest in participating in the study, they received an IRB approved consent form (See Appendix A). Upon completion and submission of the consent form, participants were given access to a link to a scheduled Zoom audio/visual conference. The videoconferences took place in the researcher's office (See Appendix E: Interview Manual), where measures were taken to ensure confidentiality and eliminate exposure of personal data during transport (See Appendix A). The setting was appropriate for the study because of the private nature of the setting. Because I was sensitive to the content and her experience in trauma counseling, partners were supported as they shared their narratives regarding their experiences seeking support and recovery. Prior to consenting to participate in the study UWs confirmed that they had access to mental health counseling if the interview triggered distress.

Participants

This study aimed to recruit between seven and fifteen participants recommended for a phenomenological study (Creswell & Poth, 2018). Priority was given to establishing deep

meanings from interviews with participants and to understanding their lived experiences with counselor messages. Throughout the process of recruitment, engagement, and reporting, I established procedures to convey valued respect and collaboration with the participants (McLeod, 2011; Moustakas, 1994) and a commitment to adhere to the ethical codes for research (ACA, 2014; G.2.a, c, d). Participants that I recruited met the stated criteria for inclusion in the study (age, gender) and were currently married to a SAS for three or more years. Participants agreed that they were unaware of their SASs' OCB prior to their discovery and that they sought professional mental health counseling six months to two years after discovering their spouses' behavior. Prior to seeking counseling from mental health professionals, four participants were working in couples counseling. Of the four, one participant was in couple's counseling for more than ten years for issues related to her husband's alcoholism, while the other three were seeking to work on relational concerns. Of the eight participants, five sought individual counseling, but none of the concerns related to addictions, psychosis, or personality disorders and none of the participants had been hospitalized for major psychopathology. Finally, participants agreed they had technology suitable for participating in an audio/visual semi-structured interview that I recorded.

Sampling

This study potentially filled in gaps left by a scarcity of research on UWs' experience with seeking professional mental health counseling and non-existent research on the interaction between spouses struggling with IBT and their professional mental health counselors. Therefore, purposive sampling seemed appropriate because of the potential each UW had for providing a rich narrative that could explain the phenomenon of interest (Hayes & Singh, 2012). Participants were selected based on the following criteria:

1. Participant self-identified as a female cisgender UW married to her SAS for three or more years.
2. Participant was 21 years or older.
3. Participant was a citizen of the United States.
4. Participant was unaware of the SAS's OCB prior to discovery.
5. Participant sought professional mental health counseling 6 months to 2 years after the major discovery (D-Day) (Skinner, 2017).
6. Participant confirmed that she had no major psychopathology (suicide ideation, major depression, psychosis, or addiction).
7. Participant confirmed that she had access to professional mental health counseling in case the interview triggered distress.
8. Participant was willing to participate in the study and agreed to sign the informed consent.

The rationale for selection of participants was to gather data from UWs who have demonstrated a commitment to their marriage as evidenced by marital longevity of three or more years. Furthermore, the three or more years' time span in the relationship was useful for exploring whether their SASs were working on their own recovery. Choice of participants who had no awareness of their SAS's OCB helped to explore the experiences of women who are challenged with integrating their new reality while mourning the loss of the relationship they thought they had. Exclusion of an UW suspicious of her SAS's OCB also helped explore the experience of women who are not aware of their SAS's behavior but receive messages that they played a role in their SAS's OCB. The timeframe for seeking counseling contributed to collecting data from women who committed to working with one or more mental health

professionals to seek relief from the symptoms of IBT. The UWs' willingness to participate in the survey was an indication that as UWs move through the stages of the recovery, they may be ready to share their narrative as a way of connecting with their experience in new ways while offering their story to other women who are trying to heal from their IBT.

Present Study Procedures

Procedures were put in place according to the recommendations of the department:

1. Attained approval from Institutional Review Board (IRB) (See Appendix A).
2. Recruited participants through electronic distribution of recruitment letter (See Appendix B) to supporting organizations and professional mental health counselors.
3. Screened participants via electronic distribution of screening questionnaire (See Appendix D).
4. Sent informed consent document via link or email.
5. Made available appointments for participants to choose for 60-90 minute audio-visual Zoom interviews.
6. Met with participants for 60-90 minutes Zoom interviews (See Appendix E).
7. Continued interviewing participants until saturation was reached.
8. Transcribed audio-video recordings and conducted brief follow-up meetings for data clarity.
9. Collaborated with data auditor to ensure credibility and research validity.

Throughout data collection and analysis, I bracketed my subjective experience by journaling (See Appendix F).

The participants were informed about the nature of the study, their rights as research participants, and measures to ensure confidentiality. They were asked to complete a digital

survey informing the principal investigator of their gender, age, years married, and timeframe for seeking professional mental health counseling after discovery of the SASs' OCB. Participants were asked whether they were aware of their SAS's OCB prior to discovery and asked to confirm that their reason for seeking counseling was related to the discovery of their SAS's OCB. Participants were asked about any professional mental health counseling experiences prior to discovering their SAS's OCB to rule out major psychopathology (i.e., psychosis, addiction). Participants were asked about their education and employment as well as the number of children under their care at the time of discovery. Finally, participants were asked to provide an email and telephone number for text communication. Participants were required to answer all but one of the fourteen questions. Participants were given the option of providing me with information regarding their race and ethnicity, and willingly informed.

Participants were informed that although interviews would be recorded, their information would be kept confidential on a password-protected computer. Participants were instructed to provide all but one of the answers to qualify to participate in the study. The participation selection was based on completion of agreed-upon documentation and their self-report on the 14-question survey. After completing the 14-question survey, an in-depth audio-visual interview was scheduled with the recommended 7-15 participants (Creswell, 2007; Moustakas, 1994). Upon review of the survey answers, the researcher contacted 8 participants through a follow-up email requesting an agreed-upon time of between 60 and 90 minutes to meet for an interview.

During the initial meeting, the researcher revisited the participants' rights (ACA, 2014) and answered participants' questions about the purpose and expectations for their participation. The researcher prompted the UWs to discuss their experiences while she digitally and manually recorded them. Using the recording and transcription of the interview, with a follow-up call or e-

mail she clarified misconceptions, validated the emerging themes, and triangulated the data (Carter et al., 2014). The intended purpose of member checking was to improve the validity of data and establish trustworthiness for quality assurance (Cresswell & Miller, 2000). Participants were given transcripts of the interviews. However, adhering to warnings about the potentially traumatic effects of member checking (Hallet, 2013), I utilized caution to prevent avoidable retraumatization inflicted on women sharing their experiences. At the same time, I conveyed to the participants the benefits of using a follow-up phone call to avoid misinterpreted or confused verbiage. Establishing a rapport with the participants proved beneficial when it was necessary to review difficult aspects of their narrative to protect the study's validity and trustworthiness. Prior to the interview process, participants confirmed that they had access to services from a mental health professional if recalling their experience provoked a trauma experience for them. They were advised of their right to withdraw from the interview and signed their acknowledgment of their right and consent to proceed with the study.

The Researcher's Role

In transcendental phenomenological research, the investigator's role is to ensure integrity and trustworthiness while collecting and analyzing data by intentionally immersing oneself in the experience with as little subjective interference as possible (Moustakas, 1994). The researcher must exercise diligence in collecting and coding the data while experiencing the meaning that emerges from the data. Qutoshi (2018), citing former descriptions of the disciplines of phenomenological study, suggested that it is not only a way of knowing but a method of proving "how we know what we know" (Qutoshi, 2018; p. 220). Researchers accomplish this by suspending embedded assumptions (*epoche*) with an awareness (*bracketing*) of personal biases

and assumptions (McLeod, 2011). A disposition of humility, curiosity, and respect for participants and their stories must be evident in the study's procedures.

Bracketing and suspending subjective notions were necessary given this researcher's experience with IBT in counseling and personal experiences. Encounters with IBT among clients seen in practices and as a consumer of therapeutic services proved advantageous for understanding the importance of establishing safety with women while empowering them to share their experiences. Triangulation of written and verbal data and interaction with the research committee provided accountability measures to ensure that the findings objectively presented the women's experiences interacting with their SAS's OCB, as well as how IBT messages received from professional mental health counselors impacted them. Transcendental phenomenological inquiries involve methodical and intentional ways, such as journaling and self-reflection, to remain accountable and to prevent personal aspects from tainting the results (Creswell et al., 2007; Moustakas, 1994). Using multiple means of data collection and attending to coding and recoding disciplines, I became immersed in the shared experiences of women.

Data Collection

Data collection began April 7th and was completed April 15th. Data collection methods used were semi-structured interviews obtained from participants who met with me via Zoom. With permission from the participants, interviews were recorded to ensure accurate transcription of content and that there was adherence to transcendental phenomenological research methods (Moustakas, 1994). Additionally, I recorded the date, time, and duration of the interviews.

Data Analysis

Of primary importance to this study were the narratives that the participants shared during the in-depth semi-structured interviews (Creswell et al., 2007). The participants' written

answers on the original documents provided demographic data, information about the details of the relationship, discovery, and professional help-seeking post-discovery. The written transcript and the recorded interviews provided multiple sources for data collection. The semi-structured interviews were recorded, participants reviewed their transcripts to safeguard against the resercher's misunderstanding(s), and a follow-up phone call clarified any confusion that occurred during the interview. In order to obtain saturation of data, as Cresswell (2007) recommended, a larger pool of participants was necessary to reach the recommended number of 7-15participants in case participants chose to drop out of the study. Codes were assigned themes in the data (Creswell et al., 2007), and repetitive themes gave evidence of data saturation.

Application of Moustakas's (1994) process for data analysis included epoche, imaginative variation, phenomenological reduction, and synthesis of themes and meanings. Collaboration with a data auditor ensured rigorous data analysis (Hays & Singh, 2012). After transcribing the audio-video recordings into a narrative text, I organized the data according to themes and categories.

Epoche or Bracketing

To gain a comprehensive understanding of the lived human experience under investigation, the researcher suspended assumptions and 'bracketed' personal values and biases (Cresswell & Poth, 2018; Hays & Singh, 2012; Moustakas, 1994). Bracketing and epoche, synonymous terms, describe the first step undertaken in the process of analyzing data in a transcendental phenomenological study. The researcher continually 'brackets' or suspends personal interpretation of the data collected to provide a true representation of the studied experience of a phenomenon; researchers suspend their personal consideration unless deciding to purposefully apply it to the research (Creswell & Poth, 2018; Hays & Singh, 2012). Epoche is

the first step in data analysis for a transcendental phenomenological study that allows the researcher to observe the phenomenon as it is presented, void of subjective interpretation (Moustakas, 1994).

Phenomenological Reduction

In the second step of data analysis, I examined the essence of the phenomenon. I immersed myself in all aspects of the phenomenon under investigation, attempting to uncover each participant's experience with the phenomenon. A five-step process was necessary for phenomenological reduction (Moustakas, 1994). Initially, I bracketed the focus of the research so that the entire process was rooted in the phenomenon under investigation and guided by the research questions. Analysis of each participant's statements, or horizontalization (Creswell & Poth, 2018; Moustakas, 1994), phrases, and explanations yielded derived meanings about their experiences with professional mental health counselors, void of subjective insertions. In the third step, I checked in with participants, seeking more clarity on the meaning of their contributions. In the fourth step, I clustered salient themes of the phenomenon until a reduction of the information created a "coherent textural description of the phenomenon" (Moustakas, 1994, p. 97).

Imaginative Variation

Once textural descriptions were derived from the phenomenological reduction process, I sought to uncover meanings essential to the phenomenon (Moustakas, 1994). Giving consideration on equal terms or horizontalizing the data (Moustakas, 1994; Patton, 2014), the contributions were organized by clustered themes, allowing me to remove irrelevant or redundant expressions. Universal experiences provided the structure from which to generate meanings that represented core themes associated with the phenomenon (Hays & Singh, 2012).

As I identified invariant themes that represented the phenomenon, the imaginative variation process allowed examination from multiple perceptual vantage points to enhance its meaning (Hays & Singh, 2012; Patton, 2014). I considered the universal structures that were temporal, special, and personal while noticing how they precipitated beliefs and thoughts associated with the phenomenon (Moustakas, 1994).

Synthesis of Meanings

The final step required intuition on my part because it was necessary to contextualize the data to describe the phenomenon (Moustakas, 1994). I integrated the contextualized descriptions to describe how the participants experienced being UWs who discovered their SASs' OCB, how they sought professional mental health support post-discovery, and the meanings they gave to their experiences. Through analysis of this data, I identified universal meanings shared in each participant's descriptions. As I combined textural and structural descriptions as part of the synthesizing process, the lived experience of the group emerged from the study (Patton, 2014) with the understanding that the description of the experience represents the description as told by the researcher at a particular time and place (Moustakas, 1994).

Trustworthiness

While counselors advocate for effective and ethical practices when working with UWs experiencing IBT (APSATS, 2022; Steffens & Caudill, 2021)), divergent theories about their SASs' OCB, along with their role and culpability, preclude treatment plans that competently address their needs. Qualitative research inserts humanity into the investigative approach by using the narratives from participants' experiences as data on which to develop new understandings. In this way, they uphold the values of the counseling profession to adhere to their client's right to autonomy, equity, and integrity (ACA, 2014). The reduction of a power

differential was evident because I was immersed in and committed to the human narrative and perception to understand the studied phenomenon (McLeod, 2011). For example, qualitative studies have examined effective attributes found in therapists (Skovholt & Jennings, 2004), counseling practice informed by the culture (Cushman, 1990, 1992, 1995), and clients' views about their experiences with their therapists (Bedi et al., 2005). While quantitative studies add value to our knowledge-for-practice, qualitative inquiries add depth to our understanding of spiritual, relational, and intellectual aspects of our human experiences.

Qualitative data are collected in natural environments to understand individual, societal, or cultural phenomena (Lockwood et al., 2015) void of research bias (Moustakas, 1994). Like with quantitative research, data collection was tantamount to supporting evidence from research claims; however, qualitative researchers develop the basis for assertions from narratives rather than numeric formulations. Qualitative researchers engage in an intellectual process to present themes that emerge from broader theoretical assumptions (Creswell et al., 2007; Lockwood et al., 2015) by capturing the participant's experience rather than the scholar's analyses or explanations (Creswell, 2007). The final written study "included ‘the participants' voices, the researcher's reflexivity, and a complex description and interpretation of the problem that extends the literature or signals a call for action” (Creswell et al., 2007, p. 37). Giving voice to UWs who share their experiences of seeking professional counseling after learning about their SAS's OCB provides a deeper understanding of how women are impacted by counselor messages and how these messages impact recovery from IBT (Steffens & Caudill, 2021). To ensure validity, I utilized auditing assistance for oversight of my interpretation of the data and credibility of the study. Similarly, despite precautionary measures against overgeneralizing the results for other groups, I took measures to describe the design, participants, settings, methods, and procedures to

avail the consumers with aspects of the research that are transferable (Hays & Singh, 2012). In the description of the methodology, I demonstrated dependability of the research with the possibility that findings could potentially apply to other studies. Because I remained intentional about truthfully presenting the participants' narratives, the study meets the criteria for authenticity (Hays & Singh, 2012). The research design appropriately adhered to the contextual aspects of the underlying investigation of the study. Recruitment practices ensured the appropriate amount of participants took part in the study.

Triangulation of data was achieved through analysis of the interviews, the surveys, and the follow-up call that ensured a degree of accuracy and validity of themes. Careful attention to coding or segmenting the narratives into chunks of meaning, revisiting the work, bracketing, and journaling were techniques employed to arrive at themes based on the UW's account. Member checking or interpretive validity (Hays & Singh, 2012) helped to ensure the participants' narratives were accurately portrayed. During data collection I sought clarification during the interview and revisited ambiguities with the participants. Intentionality and systematic adherence to the procedures of qualitative inquiry increase the likelihood that the findings are transferable to other studies.

I organized pertinent information such as research timeline, participant contacts, informed consent documents, demographic information, recorded data collection, reflexive journal entries, transcripts, and the recordings. In keeping with ethical requirements for best practices in research, an objective qualitative auditor reviewed all research material and supported my adherence to proper auditing.

Ethical Considerations

Throughout the process of recruitment, engagement, and reporting, I established procedures to convey valued respect and collaboration with the participants (McLeod, 2011; Moustakas, 1994) and to convey a commitment to adhere to the ethical codes for research (ACA, 2014; G.2.a, c, d). Pseudonyms were used to protect the identity of the participants. I utilized an evidence-based protocol for working with women survivors of IBT (APSATS, 2022; Forbes et al., 2020; Herman, 1992, 2015; Steffens & Caudill, 2021) to prevent retraumatization and confirmed that they had access to professional mental health counseling if participating in the interview caused distress. Upon approval from the Institutional Review Board (IRB) of Liberty University (See Appendix A), participants were recruited from a pool of respondents to a brief survey sent to women who expressed an interest. All information collected from the participants remained confidential and I was the only one with access to each participant's information. The selection of cisgender female participants in married heterosexual relationships intentionally narrowed the study's focus, availing me to study a phenomenon in a predominant group. The intent of this study was to provoke other scholars to investigate the experience of unsuspecting husbands as well as committed partners in other relationships.

Summary

In this chapter, a description of the study's methods included the overview, research design, research questions, setting, participants, procedures, researcher's role, data collection, data analysis, trustworthiness, and ethical considerations. This study focused on the experience of UWs who discovered their SASs' OCB SA/OSCB and the messages they received when they sought support from mental health professionals. A transcendental phenomenological approach

(Moustakas, 1994) was selected as the research design for this study. Chapter 4 discusses this study's findings.

CHAPTER FOUR: DATA COLLECTION AND ANALYSIS

This study explored the lived experience of UWs receiving counseling messages from mental health professionals when they sought support after discovering their SAS's OCB. This chapter develops the answer to the central research question pertaining to UWs' experiences of support (or lack thereof) from mental health professionals when they seek therapeutic interventions after discovering their SASs' OCB. Employing the framework that delineates the subsequent progression through three phases of trauma treatment (i.e., establishing safety, processing traumatic reactions, and reconnecting through post-traumatic growth) from the Multidimensional Partner Trauma Model (APSATS, 2022; Steffens & Caudill, 2021), this study gleaned new information from synthesizing salient features of narratives taken from individual interviews after they were coded and clustered into meanings. In this chapter, the research question, the sample description, and individual descriptions of the participants accompany further discussion of the research procedures' extracted themes from the interviews presented as the lived experiences of UWs. The chapter summary concludes the data collection process and the analysis which prepares the reader to review the study's findings found in Chapter 5.

Participants: Sample Description

Based on information provided informally, to the best of my understanding, participants for the study either responded to an IRB approved document, a recruitment letter sent to an APSATS listserve (Appendix B) or flyer (Appendix C) distributed through social media platforms. One of the participants (Michelle) responded to the recruitment letter on APSATs listserv, and the remaining seven participants (Liz, Tabitha, Sylvia, Judith, Rachel, Becky, and Asher) responded to the flyer posted on social media. All 8 participants completed the online screening questionnaire that was available through a private link in Outlook forms (Appendix D)

and were found to be eligible based on the criteria of the study. Subsequent to determining eligibility, participants were sent an IRB approved consent form and asked to return the form with their signature via email. The participants who returned their signed informed consent documents were then emailed with three or more choices of interview dates and times. After agreeing upon a date and time posted in eastern standard time, participants were sent a private zoom link. From the March 22nd IRB approval eight interviews were conducted, audio/visually recorded, transcribed, and checked for accuracy.

All participants were cisgender females and were 21 years or older. Participants' ages ranged from 45 to 65 years of age. After their discovery eight participants sought couples' counseling, and all but two continue to work with their SAS and mental health professionals on their marriage. Prior to discovery, four women were in couples' counseling; three were seeking to improve the relational dynamics in their marriage. One participant had been working in couples' counseling for over 10 years on issues related to her husband's alcohol problem. One of the participants, who discovered what she believed was a gambling addiction accompanying an online affair, worked with her husband and marriage counselor for over nine months until she and her spouse realized they were confronting his sexual addiction. Of the eight participants, none of the women claimed to have a history of major psychopathology.

Individual interviews were conducted and recorded during the end of March and beginning of April of 2023 via Zoom. A second recording device ensured continuity of the interview process. Upon completion of the recording, I uploaded the transcript onto Microsoft Word 350, sent the transcript to the participant, and scheduled a 15-minute phone session to ensure accuracy of the data. While the study aimed to recruit 7-15 participants, common and overlapping experiences resulted from analysis of eight interviews.

Participants: Individual Descriptions

The table below displays common features among participants as well as differences in their experiences of discovery and help seeking. Pseudonyms and a 5-year age range were implemented to protect the participants' identities. The pseudonyms were Liz, Michelle, Tabitha, Sylvia, Rachel, Judith, Becky, and Asher. A detailed description of each of the participants follows in Table 1.

Table 1

Characteristics of Participants

Pseudonym	Age	Ethnicity	Years married at the time of discovery.	Help seeking attempts	Current Clinicians with specialties	Professionally led disclosure
Liz	50-59	Caucasian Non-Hispanic	19	4	sex addiction/ EMDR/IFS	yes
Michelle	40-49	Caucasian Non-Hispanic	19	2	APSATS, CSAT	yes
Tabitha	40-49	US born/African American	24	3	MFT APSATS CSAT	yes
Sylvia	40-49	Asian/ non-Hispanic	3	4	CSAT	yes
Rachel	50-59	Caucasian/ non-Hispanic	21	3	APSATS	yes
Judith	60-69	Caucasian/ non-Hispanic	40	6	CSAT	yes
Becky	60-69	Caucasian/non-Hispanic	32	6	CSAT	yes
Asher	60-69	Caucasian/non-Hispanic	28	7	CSAT/APSAT/ EMDR	yes

Liz identifies as a White/Caucasian cisgender female between the ages of 50-59 years old. At the time of her discovery, Liz was married 19 years. After discovering her husband's OCB, she made attempts to find a counselor trained in trauma and sex addiction. She currently receives individual therapy from a counselor who is trauma-trained. Her couples counseling is a conjoint weekly meeting with her counselor and her husband's counselor trained in sexual addiction. Her current counselor is trained in EMDR (Eye Movement Desensitization and Reprocessing) and IFS (Internal Family Systems), both forms of trauma interventions.

Michelle identifies as a White/Caucasian cisgender female between the ages of 40-49 years old. At the time of discovery, Michelle was married 19 years. Michelle was in marriage counseling to address relational issues that stemmed from her husband's alcoholism. After discovering her husband's sex addiction, she made two attempts to find the counselor with whom she is currently working. She and her husband work with a trained trauma counselor who is also certified as CSAT and APSAT. Her counselor meets with both her and husband individually and works with them in couple's counseling.

Tabitha identifies as an American-born African-American cisgender female between the ages of 40-49. At the time of discovery, Tabitha was married 24 years. Tabitha was in marriage counseling working on relational dynamics. After discovering her husband's sex addiction, she made two attempts to find a counselor trained in trauma and sex addiction. Her current counselor is CCPS-S and CSATS trained.

Sylvia identifies as an Asian/Non-Hispanic cisgender female between the ages of 40-49. At the time of discovery, she had been married for three years. Sylvia had seen a marriage and family counselor prior to her discovery of relational issues. After discovering her husband's sex

addiction, she made four attempts to find the counselor with whom she is currently working. Her current counselor is C-SATS and trauma-trained.

Rachel identifies as a White/Caucasian cisgender female between the ages of 50-59. At the time of discovery, she was married for 21 years. Rachel currently sees an individual counselor for complex trauma.

Judith identifies as a White/Caucasian cisgender female between the ages of 60-69. At the time of discovery, Judith was married 40 years. After discovering her husband's sex addiction, she made six attempts to find the counselor with whom she is currently working. She is in individual and couple's counseling. Both counselors are CSAT certified and trauma-trained.

Becky identifies as a White/Caucasian cisgender female between the ages of 60-69. At the time of discovery Becky had been married 32 years. After discovering her husband's sex addiction, she made six attempts to find the counselor with whom she is currently working. She is in individual counseling with a certified CSAT counselor.

Asher identifies as a White/Caucasian cisgender female between the ages of 60-69. Asher had been married 28 years at the time of discovery. After discovering her husband's sex addiction, she made seven attempts to find the counselor with whom she is currently working. She is seeing an individual counselor who is a CSAT/APSAT trauma-trained counselor.

Results: Emergent Themes

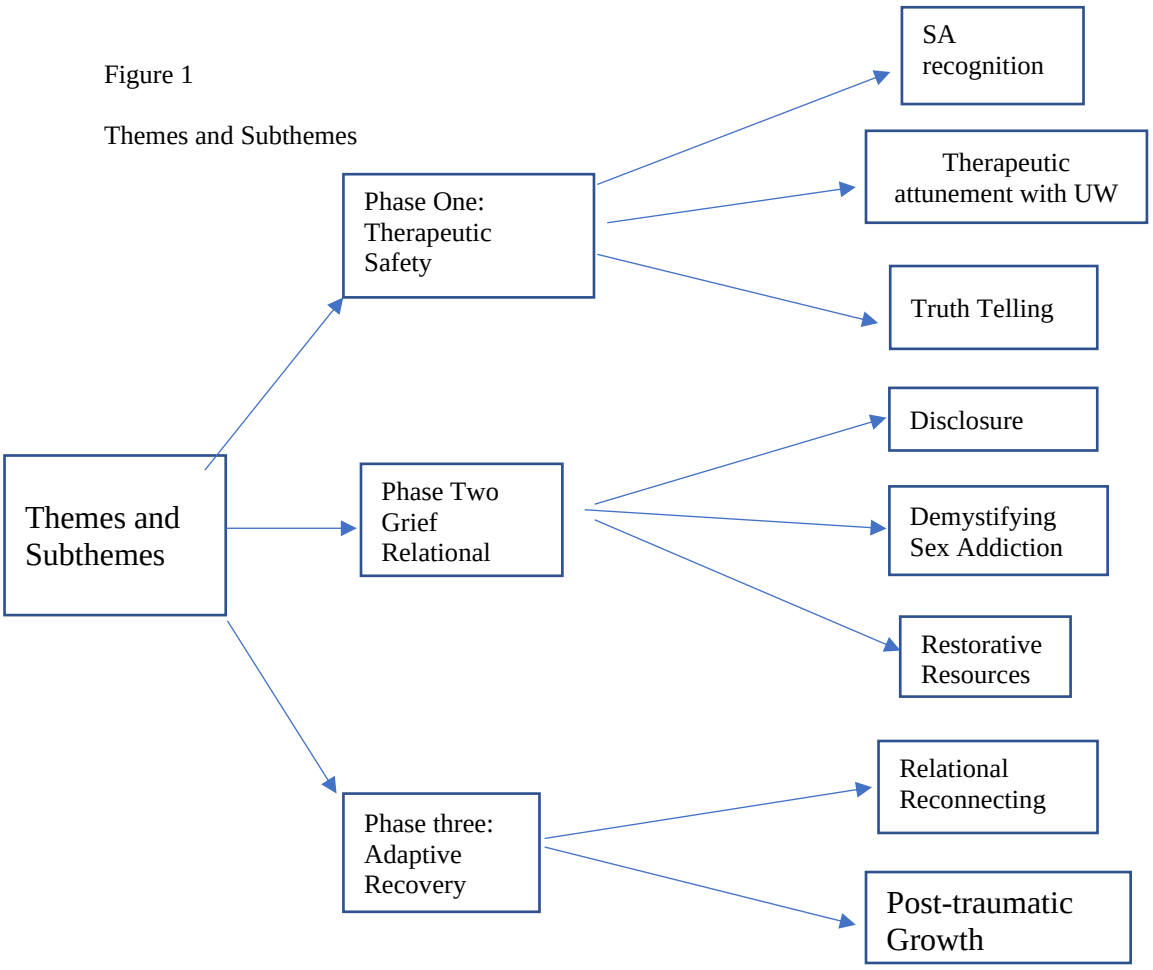
The central research question was: "How do unsuspecting wives describe their experience of support (or lack thereof) from mental health professionals when they seek therapeutic interventions after discovering their SAS's OCB?" Participants were asked a series of questions related to their experience post-discovery and, more specifically, with their help-seeking attempts with mental health professionals. In keeping with the methodology of the

transcendental phenomenological approach to scientific inquiry (Cresswell & Poth, 2018; Moustakas, 1994; Peoples, 2021), three subquestions were embedded in a semi-structured interview consisting of open-ended questions. The three subquestions included:

- How do UWs describe counselor messages immediately after discovery?
- How do UWs describe counselor messages during the therapeutic process?
- How do UWs describe counselor messages as they seek to reconnect?

Figure 1

Themes and Subthemes



Data analysis revealed three major themes: therapeutic safety, couple healing, and adaptive recovery. All three themes connected the experiences of women seeking support from mental health professionals post-discovery of their SASs' OCB and were related to the subquestions.

Theme Development

Prior to each of the eight individual interviews, I attempted to bracket myself by writing a reflective research journal (Appendix F) about my thoughts, feelings, and attitudes regarding the explored phenomenon and the research process. Throughout the research process, I noted significant themes that emerged from the interviews, discrepancies that differed from the common themes, commonalities noted in the UWs' experiences, and the essence of the experience that uncovered the phenomenon under investigation. I noted thoughts, feelings, attitudes, biases, and reactions that were evident in each participant's transcript and during the transcription and data analysis. Examination of the emerging themes and subthemes by a qualitative data analyst, who objectively challenged the codes and themes, ensured trustworthiness, reliability, and rigor (Hays & Singh, 2012).

Revisiting Moustakas's (1994) four steps of data analysis—epoche, phenomenological reduction, imaginative variation, and synthesis of meaning—the essence of the study emerged. After detecting the essential qualities of the phenomenon studied, epoche, and self-bracketing (Cresswell & Poth, 2018, Moustakas, 1994), I safeguarded against preconceived assumptions through phenomenological reduction to bracket the data (Moustakas, 1994). By examining commonalities embedded in statements or phrases that gave context to the perceived phenomenon, interpretation of their meanings, and organization of these embedded meanings into emerging themes and subthemes, essential aspects of the phenomenon emerged (Moustakas,

1994). Considering all aspects derived from the data as equally significant, I examined and removed data that were presented as redundant or irrelevant. Additionally, I employed member checking to ensure the study's trustworthiness by emailing the participant's transcript and confirming transcribed details of the interview as it related to the study. Participants confirmed that the transcribed documents accurately reflected their experiences and answered clarifying questions. I used an intuitive approach to develop a color-coded structure with the support of the qualitative data analyst and engaged with her in examining my Excel spreadsheet.

There were repeated themes conveyed during the interviews by most, if not all, participants. In the subsequent sections, I define the themes and report on the experience of UWs as conveyed in their interviews. Samples of verbatim data and synthesized reactions support the inclusion of the themes. The themes that emerged are therapeutic safety (SA recognition, therapeutic attunement with UW, truth-telling), grieving and relational repair (disclosure, demystification of sex addiction, restorative resources), and adaptive recovery (relational restoration and post-traumatic growth).

Theme 1: Therapeutic Safety

The lived experience of UWs seeking support from mental health professionals after discovering their SASs' OCB is characterized by therapeutic safety. Phase one of the MPTM (APSATS, 2022) focuses on interventions that establish a sense of safety and stability for the UW. The need for UWs' safety post-discovery of an IBT is well documented in the literature (APSATS, 2022; Laaser et al. 2017; Skinner, 2017; Steffens & Caudill 2021; Steffens & Means, 2021). This study's participants described aspects of therapy after their initial discovery that compounded their felt sense of traumatization and lack of safety, which undermined their recovery. Conversely, their persistence while searching for a professional who recognized sexual

addiction and the partner's trauma response resulted in collaborative relationships with professionals that led to positive treatment outcomes. Due to SA's comorbidity with addictions, mental illness, and the addicts' habitual patterns of deception (Carnes, 2001; Daniels & Farley, 2022; Phillips et al., 2020), mental health professionals who lack training in assessing and treating SA may miss the individual's presentation in counseling. Seven participants recalled that failure by the mental health professional to properly assess and treat their spouse's behaviors symptomatic of a SA in their couple's counseling led to the escalation of addictive behaviors and the near destruction of their relationship. Participants described the lack of training as a missed opportunity for their addicted spouse to get effective treatment and failed their desire to set the work on a trajectory to heal their marriage. Establishing safety for the betrayed UW entails proper assessment of both her needs and the needs of her partner, therapeutic attunement (Parnell, 2013), and truth-telling (APSATS, 2022).

When UWs receive therapeutic interventions that recognize the patterns of SA in a way that is sensitive to their trauma and provides guideposts for their SASs' recovery (APSATS, 2022), they become empowered with the proper tools to work on their marriage (Juergensen-Sheets, 2022). While four of the participants were already in counseling, the focus of their counseling pre-discovery was on repairing relational ruptures or working on the effects of other addictions in their marriage. Liz, Michelle, Tabitha, and Sylvia reported being in couples counseling for three or more years. Liz, Tabitha, and Sylvia initially sought counseling to improve their relationship quality in their marriage, while Michelle was in couples counseling for her husband's alcohol addiction. Although Liz's current counseling relationship is effective and supportive, when her husband disclosed past sexual activities, she discovered that their previous couple's counselor concealed an affair from her that her husband shared during an initial

individual intake session. For over a year, she worked with her husband and this counselor while he and her husband concealed the secret betrayal from her.

Michelle and Tabitha were "shut down" during a regular counseling session by the mental health professional. Michelle was admonished by the counseling for "holding on" to semantics rather than dropping a matter that her gut told her seemed incongruent with her reality with her husband. After discovery, Tabitha sought clarity on an issue related to the dynamics in her relationship but was told that, because it was outside the prevue of sexual addiction, it was inconsequential. All participants were catapulted into a reality that stretched their comprehension about what they believed about themselves, their husbands, and their relationships. Yet, Judith and Sylvia were told by their counselors to "figure out" their reality. Sylvia's counselor told her, "I'm going to push you (to decide to stay in the relationship or leave)." Judith summarized her experience of messages that she received from one of her counselors in her words, "I got the feeling that my counselor was telling me, 'The sooner you figure out your sh--, the better you'll be. The problem was, I didn't know what the sh__ was that I had to figure out."

Rachel and Asher were shamed for their responsibility for their husband's sexual addiction. Rachel was advised by one of her first counselors to be "less independent" so that her husband would "feel more fulfilled" and told to forgive her husband because "that is what God wants her to do." Asher's and Michelle's sexuality was called into question during couples' therapy. Asher's mental health professionals asked her if she thought that her husband's OCB may be the result of her being menopausal. Asher later found out that her husband had begun his escalating OCB after she gave birth to her first son. Michelle's couple's counselor suggested that she be more sexually creative to connect sexually with her husband. Mental health professionals'

messages created a lack of felt safety by ignoring the root causes of their intimacy ruptures and placing the blame on them.

Sexual addiction Recognition

The eight participants confirmed findings in contemporary research revealing that while UWs sensed incongruencies in their spouse's behavior throughout their relationship, their lack of awareness of the nature of sexual addiction that expresses itself in OCB made their discovery that much more painful and chaotic. Literature now reveals that a UW's discovery, confrontation of the SAS, and his denial and gaslighting tactics (Corely et al. 2013) create a crisis that impacts the UWs physically, psychologically, and emotionally (APSATS, 2022; Steffens & Rennie, 2006). Upon discovery, Michelle, Tabitha, Sylvia, Judith, and Asher sought support from a counselor they had seen previously for what they perceived as serious but out of their realm of the awareness of sexual addiction.

Michelle credits her alcohol addiction counselor, whom she and her husband saw for over ten years, for recommending that they attend 12-step and support meetings for partners, but recalls situations where her female mental health professional reinforced her husband's manipulative behavior by undermining her felt sense that he was gaslighting. When she recognized that she tended to overinvest in pleasing others she became more independent and learned to set healthier boundaries. However, she recalls that before her discovery she raised concerns about her husband's psychological manipulation during the session. Yet, she felt "shut down" by this counselor when she tried to voice concerns that she sensed something wrong about discrepancies in her husband's words and his behaviors—"The counselor colluded with his gaslighting. 'You've got to let it go and stop hanging on to semantics.' I wanted to let go, but I wasn't safe (in my relationship)." Stark (2019) calls the mental health professional's attention to

dynamics in therapeutic settings that perpetuate a woman's experience of gaslighting on multiple levels.

Sylvia had a similar counseling experience because her counselor's lack of knowledge on treating sexual addiction compounded her lack of awareness about this type of addiction. Sylvia felt "stuck" and "hopeless" in marriage counseling. When she discovered the gravity of her husband's OCB, she felt confused by her counselor's response. "I kept asking questions because what he was telling me didn't add up. My counselor told me to either leave the relationship or stay but 'let go' of my questions," she said. Similarly, Liz reflects on her experience with her original marriage counselor's short-sighted approach to her husband's concealed affair. She regrets his failure to confront her husband about an affair he shared with the counselor during an intake session before their joint sessions. She stated, "I reached out to him after D-day, and he never got back to me." While scholars continue the dialogue on what constitutes problematic sexual behavior and its accompanying issues, conclusive evidence points to the devastating effects that impact UWs (Seyed Aghamiri et al., 2022).

Becky had multiple experiences with counselors who failed to confront her husband on his OCB and missed behavioral patterns that indicated he had a sexual addiction. After working with a renowned intimacy counselor for six months, the counselor insisted that their relational problems were due to infidelity and dismissed her developing awareness that her husband had a sexual addiction. After his disclosure, she called the therapist to share what she had learned, and he apologized. Post-discovery, her husband saw six therapists whom she felt placated him and allowed him to blame her for their struggling relationship. Similar to Liz's and Michelle's experience, inaccurate conceptualizations about what constitutes recognized sexual addiction (Hall, 2016; Kingston, 2015) leaves the SAS's OCB undiagnosed. In these cases evidence shows

a failure of the mental health professional to honor the perception of the UW (Tyre et al., 2021), and rather collude with her spouse's deception (Stark, 2019; Tormoen, 2019).

The participants shared their experiences of seeking support from multiple therapists for themselves, their spouses, and their relationship. After discovery, they found resources from websites based on what they were experiencing and found support groups through social media that directed them to counselors trained in sex addiction and betrayal trauma. When partners could identify the nature of their SASs' OCB through counseling or finding resources, they felt more empowered to recover individually and in their coupled relationship.

Sylvia recalls that after discovering her husband's deception about his pornography consumption, she researched personality characteristics and behaviors connected to his undiagnosed problem while he was still seeing their couples' counselor. He agreed that he had a problem, and she found a support group on social media which led her to an organization that recommended a CSAT (Certified Sexual Addiction Therapist) for her and her husband. She said, "After that, I started to understand what this was all about, and it started to make sense."

Similarly Becky, who has sought help from six or more therapists for her and her husband, learned about what it means to live with a SAS, including how to set boundaries, work through trauma triggers, and trust her intuitions. As a result of her counseling work, she reflects, "We're finally starting to get the right help. I have started to educate myself about sex addiction, and I can never go back."

Asher, Liz, and Rachel use the metaphor "putting the pieces together" and, like Michelle, Becky, and Sylvia, realize they were not crazy about questioning the underlying ruptures in the relational dynamics of their marriages. After her husband's long-awaited full disclosure, Asher stated, "There's a great relief in putting some of the puzzle pieces in order. I mean I am still

trying to understand if it's a personality disorder or what it is. But at least I have some assurance that I have a pretty good idea what this is about. His willingness to take a polygraph test and commit to recovery means a lot."

Therapeutic Attunement

Participants describe blatant and nuanced dynamics that contributed to their felt sense of betrayal by their counselors. The literature supports the importance of therapeutic interventions for treating traumatized UWs in ways that ensure emotional safety and stability (APSATS, 2022; Parnell, 2013; Shapiro, 2018, Skinner, 2018). Each of the eight participants provided one or more instances where they felt gaslit, dismissed, or reprimanded by their couple's counselor.

When Liz reached out to her original couple's counselor to process why he concealed her husband's affair during over a year of couple's work, the counselor never returned her call. In another example, Liz sought counseling from a mental health professional post-discovery who recommended she read a book on codependency. After "shutting her down" and dismissing her concerns voiced during 10 years of marriage counseling where her husband deceived and gaslit her, the same counselor told her that she must have known all along but was in denial. This message felt disingenuous coming from the same professional whom she felt colluded with her husband's psychological manipulation during their counseling sessions. Judith felt dismissed and reprimanded by her husband's counselor when he refused to answer questions during disclosure that she later found were appropriate.

Tabitha and Rachel were reprimanded by their couple's counselors for not containing their emotions. Tabitha recalls, "I was finding things out, but my husband played the goody 2-shoes, and I was the emotive one." After discovering more deception, Tabitha "exploded." Her counselor looked up at her and said, "I think you need to go to individual counseling." This same

counselor seemed less concerned when, after the big discovery, her husband reportedly stopped attending individual counseling on a consistent basis.

Rachel recalled that weeks after her discovery, she enrolled herself in an intensive for betrayed partners. Alone in a room with a counselor, Rachel read the impact letter she wrote and was then handed a bat to relieve her anger by hitting a cube. After ten minutes, she recalls being handed a bible scripture on forgiveness and advised to forgive her husband. During another weekend for betrayed partners, Rachel was asked to role-play the Karpman Trauma triangle, inferring that she was making herself a victim. The exercise seemed incongruent to her experience of being thrown into her chaotic world and trying to figure out what she was confronting. She stated, "Examining my role as a victim seemed so foreign to my current experience."

When Becky set in motion the process to divorce her husband, he scheduled an appointment with a marriage counselor in hopes of stalling the divorce. Still devastated by her discovery, she found it bizarre when her counselor asked her what she liked most about her husband. She said, "I thought to myself, does she know why we're here?"

Michelle and Asher had their sexuality called into question by counselors insinuating that their husbands' OCB was the result of something missing in their sexual relationship. Asher's husband's counselor suggested that she explore hormone replacement therapy after asking about her age, stage of menopause, and libido functioning. Michelle's therapist recommended that she and her husband view pornography together and subsequently suggested that she explore creative ways to stimulate her own sexuality. Asher recalls her experience with her husband's counselor as one of the most traumatic experiences, while Michelle felt that her marriage counselor disregarded the values embedded in her faith.

Most of the women voiced their desire to feel safe in the counseling room as evidenced by seeking mental health professionals who empathized with the traumatic nature of discovering their SAS's OCB. All the participants gave examples of counselor messages that dismissed, disregarded, blamed, or shamed them for seeking answers to their SAS OCB. Some, like Becky, Judith, Asher, Michelle, and Rachel were relieved when they were finally connected with a mental health professional who conveyed that their SASs' OCB was not their fault.

Truth-telling

Participants recalled instances where they felt the mental health professional colluded with their SASs' OCB. It is well documented that SASs become masters at deluding themselves and others to avoid the shameful recognition of their behavior (Carnes, 2001; Drake & Caudill, 2019; Hall, 2019; Jurgensen Sheets & Katz, 2019; Keffer, 2018). All participants spoke about the isolation and shame they experienced prior to their discovery that was reinforced on D-day. They were careful about who to tell and who not to tell. However, all participants sought the truth about what had transpired in the years when their husbands concealed their behavior in their marriage. Initially, all eight participants were unaware that sexual addiction "was a thing." In her research, Hall (2016) recognized that of the partners she surveyed, 30% had heard of sex addiction, 25% did not believe it existed, and only 9% perceived it as problematic. The participants' reality was that after they discovered sexual behavior that went unnoticed for years, they sought the truth about the problematic nature of their partners' sexual behavior.

Liz wondered how things might have been different if her initial couple's counselor confronted her husband to reveal the affair her husband disclosed during his initial private intake. "We were seeing this therapist for over a year. I would have thought he would have confronted

him in counseling or sent him a text saying, 'you need to tell Liz.' I'm not blaming anyone, but I wonder if things would have been different if we addressed the affair in counseling," she said.

Asher's counselor saw her and her husband both for individual and couple sessions. While the counselor voiced that anything disclosed in individual counseling would be brought to the couple's sessions, Asher had little hope that the counselor would be able to challenge her husband's deception while he was still lying. She stated, "The further along we got, the more I sensed that he was lying. If he was still lying to me, I thought it was impossible for her to know if he was telling the truth."

In some instances, participants had to advocate for truth-telling as it related to the role in their ruptured relationship. During her couple's counseling, Becky broached the issue of telling her adult children about her husband's chronic betrayals. She became adamant when the counselor agreed with her husband's wish to conceal the OCB from her children. She said, "I told the counselor that I had a close relationship with my children. If my husband and I get divorced, I don't want my children to think it was because I couldn't give him another chance after a one-night stand."

Michelle felt that there were times when counselors colluded against her and favored her husband's needs. She recalls, "In every case, I sensed they detected something off with my husband, so they offered to work with him separately." These events created in Michelle a lack of emotional safety with professional mental health counselors, especially after being separated or dismissed from the counseling process. "When they dismiss you, you feel like they're going to have secrets about you and keep them from you," she stated. These relational dynamics compounded the psychological abuse she experienced from her husband.

Rachel and Sylvia were reprimanded while seeking the truth in marriage counseling. During what Rachel recalls as a session when she was trying to confront her husband about new betrayal information, she was yelling and crying while he was "shutting down." "The counselor admonished me for being too emotional and praised him for being calm," she said. Similarly, Sylvia discussed a time when she sought to find out a timeline and details about recently discovered behavior, and she said, "The counselor conveyed that I should either leave the relationship or 'let go' of the minor details I was asking about." Consequently, the uneasiness over the deception perpetuated nine months of tension and arguments during counseling, which she believes could have been avoided. Although a betrayed partner's behavior post-discovery may be misdiagnosed as aggression, hysteria, or a personality disorder, we now know that during the initial phase of discovery, UWs present with symptoms of complex post-traumatic stress. What was formerly conceptualized as the partner's need for control is better explained by the UW's need for emotional safety (CPTS) (APSATS, 2022; Steffens & Means, 2021).

Theme 2: Grief and Relational Repair

Couple's healing emerged as a theme from the study as partners shared their desire to find the truth about the behaviors that traumatized them, destroyed their beliefs about their safety in their relationship, and posed a threat to their families. During phase two of the MPTM model (APSATS, 2022; Steffens & Caudill, 2021) UWs become more aware of what they need to do to take care of their needs for safety. Within couples' healing are subthemes of disclosure, demystification of sex addiction, and finding restorative resources.

Despite the deleterious effects emotionally, physically, and psychologically, the UWs sought answers to the underlying issues that led their husbands to betray them. Based on her experience, Juergensen Sheets (2022) acknowledges that while she has borne witness to the

UW's desire to find help for her spouse, she wonders who this person is who betrayed her and how she found herself in her current situation. Perhaps the evolution of research and the availability of resources has availed the UWs with resources and support that provide tools for the answers they seek. All eight participants embarked on multiple help-seeking attempts to find counselors suitable for individual and couples' work. Similarly, all eight participants expressed regret for the time that it took to find a counselor who was skilled and attuned to their needs.

Although all eight participants discovered the SAS's OCB three or more years ago, all the partners were in individual and couples' counseling at the time. Eight of the participants are working with mental health professionals trained or certified in trauma interventions. Their partners are working with counselors trained in working with sex addiction. Seven of the partners are working with counselors credentialed by APSATS (Association for Partners of Sex Addiction Trauma Specialists) (2022), C-SAT (Certified Sex Addiction Therapist) (International Institute for Trauma and Addiction Professionals, 2022), EMDR (Eye Movement Desensitization and Reprocessing) (2018), and IFS (Internal Family Systems) (2023), and the other participant sees evidence that both her and her husband's counselors are appropriately trained to work with trauma and sex addiction. Experts who have worked with UWs and the SAS (APSATS, 2022; Drake & Caudill, 2019; Jurgensen Sheets, 2022; Skinner, 2017; Steffens & Means, 2021) have developed a framework for couples' healing. Within couples' healing are subthemes of disclosure, relational restoration, and finding restorative resources.

Disclosure

The benefits of truth telling through a professionally-led disclosure are well documented (APSATS, 2022; Skinner, 2017; Steffens & Means, 2021). All eight participants shared their experience of receiving guidance from trained mental health professionals about the disclosure

process. Upon finding trained mental health professionals, participants had their disclosure within months of discovery, while one participant endured ten years of staggered information, or "drips and drabs" (Schneider & Corely, 2012). All but one couple chose one or multiple polygraph tests to augment what their SAS revealed during disclosure.

Four participants, Liz, Michelle, Sylvia, and Tabitha were satisfied with their preparation prior to the formal disclosure. Michelle noted, "As soon as I knew I was getting that disclosure, my mind was able to relax, and I stopped asking questions." The participants were told what to expect from the process and the content that would be revealed during disclosure. Mental health professionals experienced in the formal disclosure process provided the UWs with templates to list their unanswered questions. All the participants wanted to learn the extent that their SAS's OCB negatively impacted their finances, their health, and their children. As part of the painful preparation for disclosure, partners prepared to ask questions about sexual contact outside of the marriage, the expenses incurred from sexually acting out behaviors, and emotional ties with those with whom they had sexual contact.

All but Judith received the information during the disclosure that put "the puzzle pieces together" and confirmed hunches UWs had about their husband's "off" behavior throughout their relationship. While UWs like Becky, Tabitha, and Asher found the process helpful for answering unanswered questions, Michelle and Sylvia were traumatized by learning the depth of the deceptions that had been targeted against them. Michelle reported collapsing hours after the disclosure and crying for hours that night and into the morning. While Sylvia received information about factual details of her husband's betrayals, the realization that he had repeatedly lied when she asked him about the timeframe with his "acting out" partner caused her to request another formal disclosure that gave her the opportunity to reconcile her felt sense of

deception throughout his acting out timeline. All but one participant discussed their impact letter as traumatic but helpful for processing the pain of betrayal.

Participants shared the reasoning behind the information they found important in addition to the critical information that their husbands needed to share. Liz stated that she did not want to know details about the places where her husband acted out. “I didn’t want to be in the city and be triggered if I passed by a spot where his acting out took place,” she said. Judith had a traumatic experience when her husband’s mental health professional eliminated half of the details that her husband wrote or that she requested. I wanted to know about expenses and gifts, but the mental health professional said, “She doesn’t need to know that.” Tabitha found it helpful when her mental health professional guided her through the process of discerning questions that pertained to her SAS’s OCB as opposed to questions that could be addressed in couples’ counseling. Subsequent to the disclosure, her new couples’ counselor offered her an opportunity to ask the questions that had been set aside during the disclosure. Drake and Caudill (2019) discuss the benefits of a professionally led disclosure for bringing truth into the marriage. Liz, Michelle, Sylvia, and Ashton observed more empathy from their SAS after they witnessed the pain caused by their OCB. Liz recalled that while her husband was in his intensive, the empathy letter he wrote was centered on how the discovery impacted him. However, after disclosure and the work he was doing in recovery, his restitution letter revealed an understanding of the damage that he caused her and their children.

Demystifying sexual addiction

Upon discovering their SASs’ OCB, the participants sought to understand how their SASs’ OCB could have gone unnoticed for so long. In addition to seeking answers from publications, books, websites, and online support groups, UWs found assurance in working with

mental health professionals who explained the nature of sex addiction and their role in the relationship. Contemporary work with UWs includes helping them understand the nature of sex addiction and its traumatic effect (APSATS, 2022; Steffens & Caudill, 2021) while honoring their decision to remain in a committed relationship with the SAS (Weiss, 2018).

As a result of working with her mental health professional, Tabitha gained clarity about ways that her husband "dabbled" in a variety of sexual behaviors. After seeking answers from both her individual and couples' counselor, Sylvia had a better awareness of her husband's sex addiction as a coping mechanism her husband used to "numb out" or act out of a place of shame. Rachel continues to process the struggle she has with reconciling whether her SAS's OCB is "maladaptive" or just "an addiction." Rachel, Liz, Becky, Judith, and Asher work with their counselors to understand the addictive nature of sex addiction that presents with other mental illnesses and addictions. Early in her counseling relationship with her current counselor, Michelle's mental health professional explained in detail the nature of sexual addiction and empowered her to look for evidence that her husband was working on his recovery. Similarly, as the result of goals they have established with their mental health professionals, all eight participants continue to work with their counselors on identifying triggers and setting boundaries that keep them emotionally safe.

Restorative resources

All eight participants described their experience of taking action upon discovery of their SASs' OCB. Liz, Michelle, Sylvia, and Becky asked for a physical separation. Liz, Sylvia, and Becky requested their husbands to leave the house, while Michelle insisted that her husband move out of the bedroom. In their book addressed to UWs, Steffens and Means (2021) recommend establishing boundaries for safety post-discovery.

While Liz and Michelle took the initiative to seek professional mental health counseling, Sylvia and her husband collaborated on finding trained professionals to work on his SA recovery and her healing. When given an ultimatum to find an inpatient intensive treatment center, Liz's husband moved out and subsequently found a therapeutic facility where he began recovery work. After her discovery, Michelle's husband started researching, found information about sex addiction, and obtained referrals for counselors who specialized in treating SA. He began interviewing professionals and setting up appointments. Michelle's husband discovered a credentialed and qualified counselor who specialized in sex addiction and betrayal trauma. Although the mental health counseling that Becky and her husband received proved to be an inappropriate fit, Becky's husband researched counseling to salvage his marriage.

Rachel's experiences finding restorative resources for herself and her husband traumatized her early in her recovery process. She regrets being accepted into an intensive program weeks after discovering her husband's intimate betrayal. "In hindsight, I should have never entered the intensive for partners without knowing what I was there for," she said. With regards to the intensive she attended with her husband, Rachel realizes that she enrolled her and her husband into an expensive program that saturated her husband with interventions and information while she was still in a state of shock. She experienced being overwhelmed by the experience and later learned the experience retriggered her trauma. She stated, "They handed me a checklist with all of the characteristics of a betrayed spouse, and I didn't see myself in any of them."

In their diligence to become educated about betrayal trauma and sexual addiction, partners like Judith and Liz asked their counselors for resources to help them with their healing process. Shortly after Liz's "traditional" therapist recommended that she read a book about

codependency. “As I was learning more and more about sexual addiction, I realized that therapist wasn’t a good fit,” Liz said. Similarly, when one of Judith’s original counselors recommended a support group for women married to SASs, she attended two meetings. However, the spiritual overtones of the meeting and the personalities of the group members were misaligned with her needs. Instead, Liz, Sylvia, Becky, and Judith connected with organizations that educate UWs about sexual addiction and demystify their experiences of shame, isolation, and trauma. Likewise, Liz’s, Michelle’s, and Sylvia’s husbands are committed to becoming more educated about their addiction and augment their research with work in support groups for individuals with sexual addictions.

Theme 3: Adaptive Recovery

Theme 3, adaptive recovery, is connected to the third interview question with answers that reveal the experience of UWs navigating through the first phase of traumatic recovery to seeking therapeutic interventions from trauma-trained specialists who work with families confronted with sex addiction. The theme of reset and recovery includes the work in the final phase of the MPTM model (APSATS, 2022; Steffens & Caudill, 2021) as women seek to rebuild relationships and grow through the events of their traumatic experiences. The theme of reset and recovery incorporates two subthemes of relational repairs and post-traumatic growth. All eight participants described the work they continue to do to reset their beliefs (Laaser et al., 2017) and recover from the traumatic nature of their discovery.

Relational reconnecting

Curative factors for IBT include relationships that are supportive (Steffens & Means, 2021). All eight participants shared their experiences about relationships with their current counselors that were instrumental in repairing their relationship and rebuilding trust. The

literature points to the detrimental effects of compromised trust experienced by UWs in relationships with SASs (Minwalla, 2022; Seyed Aghamiri et al., 2022). Liz, Sylvia and Asher appreciate the support they received that demystified the patterns and behavioral dysfunction associated with their husband's sex addiction. Liz, Asher, Tabitha, and Rachel shared ways that their counselors helped them regulate traumatic triggers that resulted in distress for themselves and their relationships. Liz and Tabitha recognize the benefits of regulating their emotions despite the trauma triggers because it has been helpful in the relational dynamics with their husbands. Michelle offered that her counselor has explicitly modeled a trusting therapeutic relationship by giving her permission to "call her out" if Michelle feels that she is not being heard in counseling. Liz and Tabitha accept the power of "doing their work" and becoming more aware of the root cause of their responses stemming from unresolved developmental issues. Four husbands are committed to attending support groups for sex addicts and augment the work in their 12-step groups with online classes on sexual addiction. Liz, Sylvia, and Judith use tools to repeatedly "check in" with their spouses to practice, if not maintain, a personal connection.

All eight partners would not wish their reality on anyone, but see evidence that they have become more self-aware, kinder, and compassionate. All eight participants shared that unless someone experiences the world of sex addiction, they have no idea how complex it is or why an UW would choose to stay with her SAS. Asher and Becky shared that their decision to stay in their marriage with their partner is also complex, but it is a choice they have decidedly made. Similarly, Liz and Rachel state they do not feel that their husband's sex addiction reflects who they are. Women voiced their relief that some mental health professionals who work with SASs and their UWs have evolved in their messages of codependence and give them permission to care for someone who has a problem (Weiss, 2018).

Post-Traumatic growth

While none of the partners explicitly articulated their process of growing despite their traumatic experience (Laaser et al., 2017), they noticed changes in themselves, their relationships with their spouses, and others. With sensitive integration of techniques to help the UWs grow past their traumatic discovery, UWs develop new beliefs about themselves, identify triggers and regulate emotions, and develop some acceptance about the loss of an idealized marriage that some thought they had. Four of the participants received confirmation about hunches they had regarding their husband's deception, manipulation, and betrayal. In their accounts of discovering their SASs' OCB behavior, Becky, Liz, and Tabitha shared their grief about what they believed about their relationship and the disbelief that their husbands were capable of the kinds of acts that ruptured their trust and put them in harm's way. Rachel, Becky, and Tabitha share their experience of shame for being associated with an addiction that is still culturally stigmatized by lay people and misdiagnosed in counseling. Yet they have committed to their own healing and supporting others along different phases of their journey. Five participants have developed supportive connections and friendships with UWs they have met on the group sites. Becky, Judith, Liz, and Sylvia attend meetings weekly. All four women benefit from closed groups that provide safe spaces for women to educate themselves about topics related to shame, trauma, isolation, and self-care.

The findings in the phenomenological study are consistent with the MPTM framework (APSATS, 2022) that suggests the UWs navigate through phases of the healing process after discovering their SASs' OCB. As discussed, the literature's emphasis on rethinking counseling practices for UWs necessitates challenging traditional models for counseling and addressing the misuse of professional power among counselors and their clients. As more and more research

emerges, training facilities and masters' level counseling programs will ensure that UWs are treated appropriately and ethically.

Summary

This chapter contained the findings of a transcendental phenomenological study that explored the lived experience of unsuspecting wives receiving counseling messages from mental health professionals after discovering their sexually addicted spouse's out-of-control behavior. The findings were presented as a synthesis of the narratives from semi-structured interviews. The following three themes and subthemes emerged from the analysis: therapeutic safety (sex addiction recognition, therapeutic attunement, truth telling), couple healing (disclosure, demystification of sex addiction, restorative resources), and reset and recovery (relational restoration, post-traumatic growth). Themes were developed by coding, recoding, and clustering meanings from the narratives collected in each participant's verbal descriptions and transcriptions of the individual interviews. This chapter also discussed how the research questions were addressed and how themes were developed. The next chapter concludes the study.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATINONS

In this study I explored the experiences of eight UWs who received messages from mental health professionals (pseudonyms: Liz, Michelle, Tabitha, Sylvia, Rachel, Judith, Becky, and Asher) to identify how these messages positively or negatively impact their healing. It was important to learn from their narrative how these messages supported their recovery, especially since the literature reveals divergent messages from mental health professionals regarding sex addiction and the UW's role and responsibility that impacts her recovery. This study employed qualitative phenomenology as its methodology with semi-structured interviews, audio-visually recorded, transcribed, and available to participants to check for accuracy. The findings that emerged from the thematic analysis of the data included (a) therapeutic safety, (b) couple healing, and (c) reset and recovery. The secondary themes of sex addiction recognition, therapeutic attunement, truth telling, disclosure, demystification of sexual addiction, restorative resources, relational restoration, and post-traumatic growth emerged from the main themes.

This chapter presents an interpretation and discussion of the findings as they relate to the literature and theoretical frameworks. This chapter addresses implications for change, limitations, and recommendations for further study. This chapter concludes with a summary of my experience with the process as the researcher.

Interpretation of Findings

The following themes emerged from this study: therapeutic safety with subthemes of sex addiction recognition, therapeutic attunement, and truth telling; grief and relational repair with subthemes of disclosure, demystification of sex addiction, and restorative resources; and adaptive recovery with subthemes of relational restoration and post-traumatic growth. As part of

the interpretation of these findings, the themes and subthemes are explored as they relate to the literature and framework.

Theme 1: Therapeutic Safety

All eight participants contributed to our understanding of the UW's need for therapeutic safety and validated the findings from literature describing the traumatic experience of discovering a SAS's OCB (Laaser et al., 2017; Steffens & Means, 2021, Steffens & Rennie, 2007) and messages they receive from counselors that perpetuate their sense of shame and experience of psychological abuse (Keffer, 2018; Minwalla, 2022; Stark, 2019). Specifically, the findings suggest that women seek safety in the counseling relationship to heal from the effects of IBT (APSATS, 2022; Steffens & Caudill, 2021), but may receive messages from counselors that they are part of their SAS's dysfunction and need to work on their own recovery (Hentsch-Cowels & Brock, 2013). The subthemes of recognition of the sex addiction (Hall, 2016); therapeutic attunement (Parnell, 2013), and truth telling (APSATS, 2022; Drake & Caudill, 2019; Steffens & Means, 2021) align with finding that women suddenly confronted with the discovery of the SAS's OCB must navigate a reality for which they feel ill-equipped and unprepared (Hall, 2016, Skinner, 2017, Vogeler et al., 2018). Upon discovering that they have been the target of an intimate betrayal women suffer with self-doubt and shame (Lonergan, 2019) that attack their core beliefs about their relational attachments, identity, and sexuality (Minwalla, 2021). Compounding that shame and self-doubt are counselors' messages that blame them for their husband's sex addiction. As Asher stated, "When my husband's counselor asked me about my libido, I can't remember, but I think that might have been the last time I went." Counselors must consider ways that beliefs, values, and conceptualizations of sexual disorders impact the messages they convey to UWs.

Mental health professionals who provide a safe therapeutic relationship recognize the importance of validating her experience (Steffens & Caudill, 2021; Steffens & Means, 2021) rather than pathologizing the client for something that was done to her (Gomez et al. 2016). However, in the cases of Tabitha, Rachel, and Asher, they were reprimanded by a mental health professional for a trauma response when they discovered they were the target of their SAS's chronic intimate betrayals. Their treatment by mental health professionals represents an example of the professionals' misunderstanding of the relational dynamics in partnerships where compulsive behaviors and chronic deceptions create a traumatic response in the target (Skinner, 2018; Laaser et al., 2017; Steffens, 2006; Steffens & Means, 2021; Steffens & Rennie, 2007). Rachel's experience reveals an example of messages that perpetuate the already traumatic experience of gaslighting (Tormoen, 2019). The participants' experiences reveal the importance of the mental health counselor's accurate conceptualization and treatment of sex addiction.

Sex addiction recognition

The review of the literature revealed the divergent conceptualizations about sexual addiction that prevent mental health professionals from recognizing its problematic consequences for the individual and his partner (Laaser, 2018; Rosenberg et al., 2014). Based on the literature, UWs who seek support from professional mental health counselors who lack training or endorse traditional frameworks confuse clients about their role and responsibility in the relationship (Minwalla, 2021; Vogeler et al. 2018). Participants identified the positive impact when they eventually worked with mental health professionals who properly diagnosed their spouse's sex addiction and demystified for them the problematic nature of the addiction and its effects on the individual and his relationship (Carnes, 2020; Daniels & Farley, 2022; Laaser, 2018; Rosenberg et al., 2014). Conversely, working with professional mental health counselors

who misdiagnosed the presenting concerns for the couples created a lack of therapeutic safety for the UW, especially when the counselors colluded with their SAS's behavior (Tormoen, 2019) and overlooked sexual behavior that created risks in the relationship (Twenge et al., 2015). Literature reveals that sex addiction presents with other comorbid addictions and mental illnesses (Carnes, 2001; Daniels & Farley, 2022; Phillips et al. 2020), yet in this study, mental health professionals who were treating couples troubled by alcohol and gambling addictions missed the signs of problematic sexual behavior and partner deception. All participants pursued marital counseling after discovery and five participants had been in long-term couples' counseling with husbands whose sexual addictions were undiagnosed. Two couples researched symptoms of compulsive sexual behavior, self-identified as having problematic sexual behaviors, and found mental health professionals with specialties in treating sex addiction and intimate betrayal trauma. Sylvia stated, "We were getting nowhere (in couples' counseling). The fights were escalating. I kept asking him questions because I knew he was lying to me." Michelle shared, "There was psychological abuse that she missed. My intuition told me that he was lying to me, but she kept shutting me down." After Becky discovered that her husband, who also had an undiagnosed problem with alcohol, had engaged in prolonged and chronic sexually acting out behavior, her husband found a marriage therapist. During an initial session, the mental health professional asked Becky and her husband to state what attracted them to the other person. Becky said, "My husband told her that he liked it when I danced and sang. I thought to myself, maybe this wouldn't have happened if I danced and sang more. Does she know why we're here?" As the professional mental health counseling community is better able to recognize sex addiction and the complexities of being in a relationship with a SAS, couples will have

opportunities to deal truthfully with sex addiction, which in turn will provide hope for healing the relationship.

Therapeutic Attunement

The traumatic experience for the wife of a SAS when she discovers that she has been the target of chronic deception and intimacy ruptures (Skinner, 2017) creates in her a felt sense of unsafety. When the person she most trusted to protect intimacy violates the boundaries of the relationship and ruptures her trust it creates emotional unsafety or betrayal trauma. As more research becomes available for best practices for creating therapeutic safety to those who present with symptoms of complex trauma (APSATS, 2022), UWs will experience relational repair with their counselors and trust themselves to rebuild their relationships. All eight participants willingly shared their experiences with mental health professionals who played a significant role in their recovery. Conversely, the participants continue to work with their present counselors to process their felt sense of revictimization from mental health professionals who perpetuated the gaslighting and imposed their values and beliefs about sexuality on the women. When Sylvia's counselor repeatedly told her that she "had to figure it out," Sylvia felt frustrated and confused. "We stayed with her for nine months when we could have gotten the help we needed," she said. Although Michelle's counselor silenced her during sessions when her gut told her that her husband was lying, she adamantly claimed that she was in denial about his sex addiction. "She was the first one I called," Michelle shared, "I couldn't believe that these were the first words she spoke to me." While the participants wished that they had received appropriate care during the first phase of healing, they express gratitude for finding mental health professionals who helped them process the traumatic effects of being betrayed by spouses and mental health professionals.

Truth Telling

Some of the participants felt that their mental health professionals concealed the truth or colluded with their SASs during the session. An intersection of diverse sociocultural values about sexuality (Seyed Aghamiri et al. 2022) and divergent beliefs about unrestrained sexual behavior outside of a committed relationship may contribute to what a mental health professional deems necessary to process in couple's counseling. Because sex addiction is still an enigma to many (Hall, 2016), UWs who work with mental health professionals in couples' counseling depend on the professionals to be forthcoming with information about their relationship. While Liz will not openly blame the mental health professional with whom they originally worked, she was hurt when during her husband's disclosure she learned that he had told their counselor about his affair. She stated, "I would have thought the counselor would have texted my husband and said, 'You need to tell Liz.'" When mental health professionals conceal information in couples' counseling, they collude with the sex addict and perpetuate deception. Beyond the relational dynamics in their marriages, UWs are targets of gaslighting (Tormoen, 2019) when mental health professionals conceal their SASs' OCB from them (Minwalla, 2021), making them targets of institutional betrayal trauma (Steffens & Caudill, 2012).

Theme 2: Grief and Relational Repair

Though challenging, UWs and their SASs can rebuild trust and restore their relationships. When UWs become better informed about the nature of their SAS's OCB, experience emotional safety, and receive truth about what was once concealed, they are better equipped to work on their relationship. Counselors need to hold space for UWs to grieve for the loss of what some participants thought was a typical, if not positive, relationship. Judith was initially angry with one of her counselors who told her that recovery could take three to five years. In hindsight, she

realizes there are no immediate solutions to treating problematic sexual behavior and the traumatic results of her ruptured trust or the idealized version of the marriage she thought she had. However, she and the other participants have seized multiple opportunities to learn about sexual addiction and get the support they need. In turn, they have offered support for women who find themselves in the same crises they have navigated over the years. Judith and the other seven participants have gone through the process of disclosure (Drake & Caudill, 2019; Juergensen Sheets, 2022; Steffens & Means, 2021) and have worked with their mental health professionals to identify triggers from the betrayal that cause them to become emotionally dysregulated (Skinner, 2017; Steffens & Means, 2021). One participant shared that as she continues to process her trauma, the images and shame about her husband's behavior have decreased. While each of the participants chose to remain in their marriage, they educated themselves about sexual addiction, sought truthfulness through disclosure, and have taken advantage of resources available to UWs. These findings confirm earlier work on partners who seek multiple sources of support post-discovery (Pollard et al., 2013). Subthemes that emerged for couples' healing were disclosure, demystifying sex addiction, and restorative resources.

Disclosure

Although the disclosure process differed for the eight participants, the process of hearing the truth about their SAS's OCB allowed them to "put the pieces together" about some of the dysfunction in their relationship. Experts who work with UWs and their SASs assert that disclosure is necessary for rebuilding trust in the relationship (APSATS, 2022; Corely et al., 2013; Drake & Caudill, 2019; Juergensen Sheets, 2022; Steffens & Caudill, 2021). If there are secrets in the relationship, barriers to intimacy prevail. One participant shared that, as painful as the disclosure process was, she finally witnessed empathy from her husband who observed the

pain it caused her. Another participant shared how relieved she was when some of her unanswered questions during disclosure were addressed later in her couples' counseling. A professionally-led disclosure provided safety for both the UW and the SAS and helped the participants gain a better understanding of the nature of their husbands' problems.

Demystifying sex addiction

After the UWs, and in some cases their husbands, could identify behavioral patterns and articulate the phenomena of compulsive sexual behavior outside of their relationship, they sought help from professional mental health counselors for themselves and their relationship. While some mental health professionals assert that UWs are in denial after learning about their SAS's OCB (Laltrello, 2020), during the process and immediately following discovery, the women in this study persisted in finding answers to the nature of his behavior as well as how and why his problematic behavior created chaos in their relational dynamics. Hall (2016) disputes the notion that women in committed relationships with SASs should be labeled codependent when they initially discover their OCB. Yet, she asserts that once women are made aware of the nature of their SAS's OCB, it is necessary to take steps to establish healthier patterns. As the participants understood the root of the SAS's OCB, all the participants pursued couples' counseling with mental health professionals trained to work with SASs and their partners. While three of the participants had previously worked with counselors who marketed themselves as addictions counselors, they failed to identify the symptoms and treat their husbands' OCB.

Restorative resources

Shameful experiences such as discovering a SAS's OCB leave UWs feeling isolated and powerless (Brown, 2006) and undermine what she believed to be true about herself and the safety of the world (Seyed Aghamiri et al., 2022). After recovering from the initial shock of

discovering the SAS's OCB, all the participants sought out mental health resources for themselves and their families. Through the process of finding restorative resources, many of the participants sought mental health counseling, connected with support groups on social media, and educated themselves about the nature of the problem they were confronting. Similar to the findings in a study on support seeking (Pollard et al., 2013) by those in relationships with SASs, all women were educated and persisted in seeking appropriate therapy. However, these women did not identify as coaddicts or codependents, and therefore did not find messages conveyed in 12-step meetings for spouses of SASs congruent with their reality (Baird, 2011; Pollard et al. 2013). Of the eight participants, four of their husbands researched sex addiction and mental health professionals who specialized in treating sexual addiction. As mental health professionals evolve in their practices for treating individuals with sex addiction and the UWs, they assert that SASs with OCB find some relief in therapeutic relationships that demystify the nature of their uncontrollable and unmanageable behavior (Juergensen Sheets, 2022). A participant allowed herself to be hopeful for the restoration of her marriage when her husband initiated the interview process and found a trained sex addiction specialist who recognized how important her faith was to her. Participants who had finally found a trustworthy relationship with their counselors spoke about the relief they found in relationships that were attuned to their needs. Some asked for recommendations for resources for their healing and were told to attend 12-step meetings for women married to men with sex addiction; in such cases, the participants continued working with their counselors, but also found support groups through research. However, one of the participants who sought help from a mental health professional lacking training in trauma or sex addiction discontinued her counseling relationship, for it seemed ineffective especially after the counselor suggested she read a book on codependence. Participants shared that when their

counselors recommended resources that seemed incongruent to their experience, they continued to do their own research. As a result of diligent work with counselors, retreats, intensives, support groups, podcasts, and literature the couples reached a phase where they adapted to their new reality and worked with their partners to recover.

Theme 3: Adaptive recovery.

An intimate betrayal creates a rupture in the relationship because it undermines trust that is assumed in an intimate partnership. As an individual navigates through to the third phase of the MPTM (APSATS, 2022), the work she has done with her mental health professional allows her to reconnect with her new reality and find relational patterns that provide her with emotional safety. As couples find new ways to be vulnerable, trustworthy, and emotionally safe to one another, they have opportunities to grow beyond the circumstances of their trauma (Laaser et al., 2017) and envision a more positive future (Steffens & Caudill, 2021). Consistent with the literature, participants became more self-aware of their dynamics and developed strategies to relate to one another in emotionally safe ways. Although the participants voiced their regret for the painful experiences post-discovery, they expressed optimism that their lives had become more stable, and they witnessed positive growth in themselves and their families.

Relational repair

As truthfulness and emotional safety became a reality for UWs and their SASs, individuals and couples moved beyond merely surviving. The participants openly shared the challenges they faced in navigating the original crisis of discovery, shared the experience with others, and entrusted their mental health and wellbeing to professionals who seemed unskilled or indifferent to their pain. However, all eight participants researched mental health professionals and made attempts to find appropriate therapeutic relationships until they found one attuned

(Parnell, 2013) to their needs. Part of the therapeutic work for an UW navigating the recovery process for IBT is grieving the loss of her perception of her relationship, while discovering new beliefs about herself (APSATS, 2022; Laaser, et al., 2017; Laaser, 2018). As a result of their counselors guiding them to be more in touch with their needs, participants were more confident about articulating their needs to their spouses and setting safety boundaries. Additionally, through the connections they have made with other women who shared their experience, they felt less isolated and experienced less shame.

Post-traumatic growth

When Laaser and colleagues (2017) studied survivors of intimate betrayal trauma, they found that growth through the painful process of recovery enabled them to view themselves and their world more positively. As UWs hold space for their painful emotions along with hope and optimism for their future, growth is possible. One of the participants agreed to the interview with the condition that she could participate before taking an extended vacation. While on vacation, she used an audio-visual platform to work with her counselor and remain connected to her support groups. Additionally, she was willing to extend the 15-minute follow-up phone call to share her experience in her journey to recovery. She makes herself available to support women who are beginning the painful journey post-discovery. A few participants referenced closed support groups started by an UW that posts literature and serves as a conduit of information and support for others. Four of the participants acknowledged the work they have done with their counselor growing through the stages of healing. One participant stated, “We wouldn’t still be married if it weren’t for our team of counselors.” As the participants shared their experiences, the phases of the MPTM framework (APSATS, 2022) were evident in their journey. UWs can benefit from a framework that validates and helps them process their IBT, and that provides

guidance through grief work and post-traumatic growth (APSATS, 2022; Carnes et al., 2015; Laaser et al., 2017; Laaser, 2018, Skinner, 2017; Steffens & Means, 2021). The underpinnings of the MPTM framework offer mental health professionals a structure for counseling those in a relationship ruptured by betrayal trauma to move through the phases of healing and growth.

Implications

This study honored the narratives of UWs who shared their journey of seeking help from mental health professionals after discovering their SAS's OCB. The stories of eight UWs revealed connections between their experiences and the literature. The findings revealed the following themes: therapeutic safety (recognition of a sex addiction, therapeutic attunement, truth telling); grief and relational repair (disclosure, demystifying sex addiction, restorative resources); and adaptive recovery (relational repair, post-traumatic growth). The stories of the participants provide insight that can lead to changes in preparation of clinical mental health students and in organizations that provide continuing education credits. Researchers, counselor educators, and supervisors can benefit from the findings of this study by learning from the experiences and insights offered in the participants' narratives. Significant to this study is the tenacity and perseverance that participants expended to restore their mental health and wellbeing while becoming educated about the nature of sex addiction to remain in relationship with the SASs.

While some mental health professionals have extended their scope of practice through training on sexual addiction and the traumatic nature of discovering a SAS's OCB, other mental health professionals may be unaware of its negative impact on the addicted individual and his spouse. Consequently, UWs lack a felt sense of therapeutic safety when mental health professionals perpetuate the UWs experience of being gaslit and deceived by messages that may

be confusing and retraumatizing (Hall, 2016; Minwalla, 2021; Stark, 2019, Sweet, 2019; Tormoen, 2019; Vogeler et al., 2018). Counselors who employ a more traditional conceptualization in treating UWs may convey messages that UWs are responsible for the dysfunction caused by the addiction (Hentsch-Cowles & Brock, 2013) and, therefore, recommend that they focus on recovering from a mental illness they felt was nonexistent prior to their traumatic discovery (Steffens & Caudill, 2021; Steffens & Means, 2021). UWs who, by their own account, enjoyed relationships with their children and friends, experienced a productive work life, and were optimistic about their relationship with their spouse prior to discovery suddenly became targets of pathologizing counselor messages post-discovery. While still reeling from discovering they had been the target of their SASs' intimate betrayals (APSATS, 2022, Collins, 2017; Skinner, 2017; Steffens & Caudill, 2021) they were chastised for denying they had a problem. Yet, experts on effective and appropriate counseling skills warn mental health professionals against assigning them "sick roles" or giving women pathological labels when they respond to traumatic experiences inflicted on them by others (Gomez, et al., 2016; Tyer et al., 2021). Practices that impose a mental health professional's values raise concerns about messages conveyed to marginalized groups by counselors who perpetuate micro- and macro-aggressions based on one's race, age, or gender and violate ethical codes of the profession (American Counseling Association, 2014).

While women receive messages that they are overinvolved in caring for their spouse with an addiction (Weiss, 2018), counselors imply that their sexual functioning or relational dynamics might be a root of their SAS's OCB. Women already feeling ashamed, isolated, and worthless post-discovery (Lonergan et al. 2021) receive messages to work on their codependent tendencies and to attend 12-step meetings for wives who identify with their husband's addiction (Baird,

2011). These messages seem disingenuous given the secretive nature of an addiction that their spouse kept hidden for prolonged periods of time (Minwalla, 2022). Yet, the women in the study found other venues for support from online groups, podcasts, and experts who were better able to explain sexual addiction and intimate betrayal trauma.

Although identification of sex addiction is still debated in literature, the mental health professionals must be aware of research pointing to the exponential growth in numbers of individuals who meet clinical levels for distress due to hypersexuality and its negative impact on intimate relationships (Bothe et al., 2020b; Dickensen et al., 2018; Kraus et al., 2016; Reid et al., 2012a; Wery et al., 2016; World Health Organization, 2019). This means examining how strongly held beliefs about a woman's role and responsibility generated by research that predated contemporary understandings about OCB and IBT (Steffens & Caudill, 2021) remain embedded in counseling messages that women receive. Although scholars once stated that women were aware of their SAS's problematic behavior, the women in this study confirmed Hall's (2016) findings that the changed lifestyles and demands make a plausible case that men can maintain a compulsive sexual lifestyle and keep it hidden from his UW. Couples' counselors can be more vigilant when couples present with relational dynamics where secrecy may be an issue. Additionally, counselors can be responsive to indicators that create impediments to intimacy such as excessive work demands including long working hours, travel, and overuse of technology. While these realities are accepted as part of the couple's lifestyle, spouses with a predisposition to sexual addiction will need work with a trained mental health professional to develop a plan for preventing an intimate betrayal against his partner.

Despite the prevalence of sexuality in modern culture, the shame associated with sexual addiction is a barrier that women must overcome when they discover their partner's out-of-

control behavior. The participants and some of the partners researched online sources which led them to sites that addressed topics related to sex addiction. From their searches they found books, organizations, and specialists. Having access to multiple sources seemed to empower women to find the help they needed. Access to organizations and treatment sites proved advantageous for one couple but had disadvantages for participants who enrolled in intensives without guidance from trained professionals.

This study has theoretical implications for further investigations into the MPTM framework to explore how, after moving through the three phases—safety, grief and relational repair, and adaptive recovery—couples receive the tools to grow through the traumatic experience with new beliefs about themselves and their relationship. In this way they will have the tools to rebuild intimacy. This information would enhance the practices of those who market themselves as specialists in sex addiction and intimate betrayal trauma. Moreover, this study demonstrates the need for further research on the conceptual underpinnings of messages from the mental health professionals' perspectives, especially as they address sexuality.

Limitations

There were a few limitations to this study. Despite my enrollment in a full-time course taught by an experienced qualitative researcher, my limited skills in conducting transcendental phenomenological studies impacted my data collection and analysis. The distribution material for recruitment was sent to an organizational and academic listserv. Therefore, the recruitment process may have attracted participants who were educated, and therefore more empowered to seek the help they needed. Additionally, based on the narratives of the participants, they had financial resources to pay out-of-pocket for specialists. This reality indicates that participants were invested in seeking the help and found means to do so. Additionally, the study does not

explore the counselors' experience conveying messages. It does not investigate the contextual messages regarding the UWs role, responsibility, or recovery and, therefore, limits our understanding regarding specific messages that positively or negatively impact the UWs healing. This study adds little to our understanding of help-seeking attempts when women lack resources. Even though I used bracketing for my study, my experience with betrayal trauma could potentially bias the data I extracted from the clients. To address this potential bias, I worked with a data auditor who objectively reviewed the process I used to code and draw meaning from the data. Additionally, some of the participants may have heard about the study from members of their support group, so they may have felt prepared to answer the questions.

Recommendations

Problematic compulsive sexual behavior is increasing, causing distress in relationships (Bothe et al., 2021; Krause et al., 2016), and scholars agree on the traumatic impact that discovery has on an intimate partner (APSATS, 2022; Skinner, 2017; Steffens 2005; Steffens & Caudill, 2021). A call for counselor educators and supervisors to increase awareness for counselors in training, by broaching sensitive sociocultural topics and skills, can be applied to improve counselor competencies through exploring beliefs and values about sex and sex addiction (Askren, 2022). Advocates within faith communities must avail their expertise to leaders to demystify the problem of sex addiction and the UW's role and responsibility in the coupled dyad. This is especially necessary to decrease shame and alienation experienced by couples struggling with sexual addiction.

Mental health counselors must be aware of the signs and symptoms of sexual addiction and intimate betrayal trauma. This includes assessing lifestyles that contribute to a decrease in sexual intimacy among couples, noticing indicators of psychological abuse in the relational

dynamics, and using tools to screen for addiction and trauma. A counselor's awareness of the SAST-R [Sex Addiction Screening Test-Revised] (Carnes et al., 2010)) could equip the counselor to assess for problematic behavior and help the professional broach the topic with a client. The Trauma Inventory for Partners of Sex Addicts [TIPSA] (Vogeler et al., 2018) may help the clinician and UW recognize symptoms of IBT and set a benchmark for treatment. Because the literature on sex addiction indicates that comorbid addictions and habitual patterns of deception are frequently observed in sexual addictions, counselor educators and supervisors must incorporate research and experiential learning into counselor preparation (Carnes, 2001; Daniels & Farley, 2022; Phillips et al., 2020).

Current research informs the mental health community of the relational dynamics that differ in the coupled relationships where sex addiction is present, yet more research is necessary to reveal the process couples go through when seeking healing and recovery from one or more addictions. This work invites scholars and researchers to present at professional conferences so that counselors in the future may refrain from conveying messages from the chemical dependence framework suggesting the UW colluded with her SAS's OCB (Minwalla, 2021; Skinner, 2017).

Not only must counselors develop competencies to detect sex addiction, but they must also be prepared to recommend resources that include experienced sex addiction counselors and trauma-trained, partner-sensitive mental health professionals to work with the betrayed individual. They must be aware of support groups, contemporary literature, and organizations that certify specialists to treat individuals with sex addiction and their betrayed partners. Programs that prepare marriage and family counselors must evaluate the readiness of graduate students to detect signs of sexual addiction and betrayal trauma. Training for marriage and

family counselors must equip them to evaluate significant findings in research on sex addiction and betrayal trauma. Preparation for clinical mental health professionals from all disciplines must take place in emotionally safe settings to encourage future counselors to be self-aware of values and beliefs about sexuality that they may superimpose in subjective messages to clients who already feel betrayed, shamed, and marginalized. Counselor education curriculum must broach issues relating to faith-based values that differ from the sociocultural norms so that counselors practice according to the professional ethics (ACA, 2014) while establishing an attuned relationship with their clients.

Further studies are needed to explore counselor approaches through each phase of the MPTM to determine how these approaches promote individual and couples' healing. For example, a professionally-led disclosure differs depending on the training and beliefs of the counselor conducting the disclosure. Therefore, further research about what's most effective in preparation, facilitation, and processing after the disclosure would inform practitioners on ways that individualistic styles improve or detract from the benefits of disclosure. Additionally, further research is necessary on partner-sensitive approaches and their impact on the overall healing of the ruptured relationship.

Further investigations into the MPTM framework should inform practitioners on how to effectively guide UWs and the SASs through the three phases while assessing the individual's readiness to progress to the next phase. While participants articulated the work that they were doing with their counselors, it was beyond the scope of this study to identify which elements from the MPTM they concentrated on that led them to the next phase of the model. More research is necessary to determine which features of the three phases play a significant role in the UWs' healing.

The significance of this study can be understood in terms of its application to the problem of UWs who receive messages from mental health counselors after discovering their SAS's OCB. The discovery of an intimate betrayal caused by out-of-control sexual behavior is painful and traumatic (Corely et al., 2013; Seyed Aghamiri et al., 2022; Skinner, 2017, Steffens, 2005; Steffens & Means, 2021, Steffens & Rennie, 2007). When UWs receive messages from mental health professionals that are incongruent with their experience, the experience compounds their intimate betrayal trauma (Vogeler et al., 2018) exposing them to revictimization at the hands of a professional entrusted to establish safety and stability. The messages UWs receive when they seek support from mental health professionals may be reflective of their views about sex addiction and relationships (Carnes, 2001; Baird, 2011, Hentsch-Cowles & Brock, 2013) or a reflection of sociocultural norms for characterizing women (Tyre et al., 2021). Scholars recognize that women are targets of pathological labels when they react negatively to psychological harm inflicted on them by others (Gomez et al., 2016). Women who seek safety from a trained mental health professional after discovering their SAS's OCB may receive covert or overt messages that blame and shame during a time when they are trying to make sense of their new reality. Finding a mental health professional knowledgeable about sex addiction and its traumatic impact on UWs takes persistence, time, and financial resources. Therefore, the findings of this study have implications for educational programs in clinical mental health. This study implicates the necessity for further research on counseling skills and values that relate to treating spouses and partners in committed relationships to individuals with sex addictions.

Further studies are needed that explore the efficacy of the elements of each phase of the MPTM to determine the efficacy of each of the features of the phases. For example, professionally-led disclosure differs depending on the training and beliefs of the counselor

conducting the disclosure, so further research might inform practitioners on ways that individualistic styles improve or detract from the benefits of disclosure. Additionally, further research is necessary on partner-sensitive approaches and their impact on the overall healing of the ruptured relationship. This study has theoretical implications for further investigations into the MPTM framework for providing clinical interventions for SASs and their UWs across the three phases. Moreover, this study demonstrates the need to further research on the conceptual underpinnings of messages from the mental health professional's perspective.

Researcher Positionality/Bias

This research and the proposal of this research study helped me reflect on my experience as a counselor working with betrayed partners and my own recovery from betrayal. Although I identify as a betrayed partner, my experiences were different in that my own counseling work and my training in trauma and partner work has allowed me to proceed with this work as a professional clinician. I believe I took measures to ensure validity and reliability through qualitative auditing, member checking, triangulation, and journaling.

Reflecting in my journal gave me the opportunity to process my reactions to my role as an interviewer and researcher as women shared their narratives. During the first few interviews I wondered if women found me to be distant as they told their stories. Consequently, after the second interview, I indicated in the transcript that I was conducting a phenomenological study and that my lack of interaction was a way to provide space to share their experience without reaction or direction. An overarching reaction to interviewing the participants was my admiration for the courage it took to tell their stories. All eight women shared the necessity to share their story to prevent the trauma they experienced in their counseling sessions.

Summary

Discovery of the SAS's OCB by UWs is traumatic. While the UW's hunches about secretive behavior that was habitually concealed are confirmed, when a UW realizes she has been the target of an intimate betrayal, she experiences symptoms recognized as complex post-traumatic stress. Depending on a mental health professional's theoretical framework for treating sexual addiction (SA) and partner betrayal, women may receive messages based on a family systems approach for addiction counseling or from a trauma model that prioritizes the client's need for safety. Messages that seem incongruent to the UW's reality perpetuate her experience of being blamed and gaslit by her partners.

Chapter 5 presented the interpretation of the findings as they relate to the literature and frameworks presented in Chapter 4. The results of this study had three themes as well as their subthemes: therapeutic safety (sex addiction recognition, therapeutic attunement, truth telling), grief and relational repair (disclosure, demystification of sex addiction, restorative resources), and adaptive recovery (relational repair, post-traumatic growth). These themes and subthemes emerged from the analysis of the transcripts. Implications were offered for improved counselor training and research that extends the MPTM framework. Limitations and recommendations for future research were also included.

Recognition of the experience of UWs receiving messages from mental health professionals is a necessary consideration for the field of counseling. Counselor educators that broach issues of beliefs and values as they relate to sexuality and addiction offer mental health trainees an opportunity to address the dynamics that could potentially traumatize UWs. Additionally, programs that prepare clinical mental health students with appropriate resources

will provide them an option to become specialized or to refer clients to mental health professionals with the expertise to work with SASs and UWs.

Conclusions

I explored the experience of UWs who receive counseling messages from mental health professionals after discovering their sexually addicted spouse's out-of-control behavior. The lack of research on the experience of UWs seeking counseling has resulted in practices by mental health professionals that women find confusing and retraumatizing. Despite an increase in the number of individuals seeking clinical mental health counseling for compulsive sexual behavior outside of their committed relationship, practitioners lack the skills and the resources to provide clinical interventions. Sociocultural values regarding what constitutes problematic sexual behavior create barriers to assessing and diagnosing.

While scholars agree on the traumatic nature of discovering an intimate betrayal, women continue to be the target of messages that they find confusing and retraumatizing. For example, Hall (2016) observed that changing lifestyles, work demands, and multiple technological devices make it possible for men to engage in compulsive sexual behavior for an extended period without the spouse detecting that there is a problem. To suggest she should have known adds to the psychological abuse and gaslighting that she has received by her sexually addicted partner. Despite an awareness that discovery of an intimate betrayal provokes a trauma response (APSATS, 2022), women are pathologized for their emotional reactions. While the MPTM framework provides a structure whereby clinicians can establish a sense of safety, addresses the trauma, and help the UWs reconnect and recover, there is evidence that women are subject to more traditional approaches that blame and shame them for their role and responsibility. However, the literature lacks evidence of how women receive counselor messages.

The goal of this study was to learn from the participants' narratives about their experiences receiving messages from mental health professionals. The UWs willingly told their stories about a felt sense of safety with a counselor who was skilled and empathetic to their needs. They also shared stories about mental health professionals who retraumatized them with messages that made them question their sanity. Unlike women characterized in older research, the women in this study established boundaries and gave their spouses ultimatums to get help or get out of the relationship. It was revealed that women did not stay with counselors whom they found to be condescending or abusing power. Instead, they became skilled in interviewing counselors and learned from other women whom they met in online support groups. While some women in remote areas had to travel a significant distance to find appropriate help for themselves and their spouses, they were willing to do so.

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APPENDIX A: Internal Review Board (IRB) Approved Consent Form

Title of the Project: Seeking Help for Intimate Betrayal Trauma: The Lived Experience of Unsuspecting Wives Receiving Counseling Messages from Mental Health Professionals After Discovering Their Sexually Addicted Spouse's Out-of-Control Behavior
Principal Investigator: Johanna Dillenbeck, MA, NCC, LMHC, Doctoral Candidate, Counselor Education and Family Studies Department, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must self-identify as a cisgender female (not transgender), age 21 years or older, reside in the United States, married for three or more years to your spouse with sexually addictive out-of-control behavior, discovered your sexually addicted spouse's out-of-control behavior but was unaware of it prior to discovery, and have access to audio/visual capabilities and internet service on your phone or computer. Additionally, to participate, you must have entered into counseling with a mental health professional between six months and two years after discovery. Finally, you must agree that you have access to professional mental health counseling if you experience any psychological distress during the study. Your participation in this research project is voluntary.

Please take time to read this entire form and ask questions before making your decision to participate in the research.

What is the study about and why is it being done?

The purpose of the study is to explore the lived experience of married women who discovered their sexually addicted spouse's out-of-control behavior and sought professional mental health counseling after their discovery. The study will provide an opportunity for mental health professionals to hear from wives struggling with intimate betrayal trauma (IBT) and learn how conveyed messages from mental health professionals support or impede their recovery. Professional mental health workers include licensed marriage and family counselors, licensed mental health counselors, licensed clinical social workers, psychologists, and psychiatrists.

What will happen if you take part in this study?

If you agree to be in this study, you will be asked to complete the following procedures:

1. Meet with the Principal Investigator (P.I.) for about 60 to 90 minutes for a semi-structured interview that will take place on an audio/video-recorded Zoom meeting.
2. Review your interview transcript that will be sent to you through email within one week after your interview. Your review will take approximately 10 minutes. This is an opportunity for you to check the P.I.'s transcription of your interview, ask questions, or make corrections to the information shared with the P.I.
    a. The P.I. may call you within a week of the interview to clarify a theme or idea that you expressed during the interview. This call should take no longer than fifteen minutes.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include informing stakeholders in the mental health professional field including mental health professionals, masters and doctoral training programs, and professional mental health certification programs about the impact their messages have on women struggling with intimate betrayal trauma (IBT) when they discover a sexually addicted spouse's out-of-control behavior. Practitioners and scholars will benefit from understanding the experiences of betrayed partners who seek support from professional mental workers and how these experiences support or prevent recovery. Further research on models used for counseling unsuspecting wives in relationships with sexually addicted spouses could increase options used by mental health professionals with the promise of providing effective treatment to partners who have experienced complex trauma through IBT.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the likelihood of being asked to recall and discuss prior trauma associated with discovering your spouse's sexually acting out-of-control behavior. Therefore, the P.I. is prepared to minimize risks by monitoring the participant's stress during the interview and discontinuing the interview at the request of the participant. Because the P.I. is trained in trauma counseling, she will use necessary techniques to ensure that participants are grounded, and traumatic material is contained. If at any time, participants wish to discontinue the interview, they may ask to do so. Participants are expected to have access to professional mental health counseling services to ensure necessary support for psychological distress.

Please be aware that the P.I. is a mandatory reporter, which means that if she receives information about child abuse, child neglect, elder abuse, or intent to harm yourself or others, she will be required to report it to the appropriate authorities. Additionally, if the P.I. detects that you are a target of domestic violence, she will advise you about a safety plan to remove yourself from your current danger.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.

- Interviews will be conducted in a private location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer, and hard copies of notes will be locked in a file cabinet. After three years, all electronic records will be deleted, and all hardcopy records will be shredded.
- Recordings will be stored on a password locked computer and external recording device for three years and then deleted and erased. Only the P.I. will have access to these recordings.

How will you be compensated for being part of the study?

Participants will not be monetarily compensated for participating in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study at any time, please contact the P.I. at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The P.I. conducting this study is Johanna Dillenbeck. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted]. You may also contact the P.I.'s faculty chairperson, Dr. John Thomas at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the P.I., **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you agree to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The P.I. will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

_____
Email

_____
Telephone Number (for text and phone calls)

APPENDIX B: Recruitment letter

Dear [Recipient]:

In fulfillment of my studies for completion of my PhD in the Counselor Education and Supervision program at Liberty University, I am conducting a study for my dissertation. The purpose of my research is to explore the lived experiences of unsuspecting wives (UWs) who seek counseling from mental health professionals after discovering their sexually addicted spouse's out-of-control behavior (SAS/OCB). My hope is that the findings will give mental health professionals information about how their approach positively or negatively impacts UWs' recovery. I am writing to invite eligible participants to join my study.

To be eligible, participants must self-identify as female cisgender spouse in a committed relationship with a sexually addicted spouse who was unaware of his behavior prior to discovery. Participants who volunteer agree that they sought counseling between six months to two years after their discovery of their SAS's behavior. If willing, participants will be asked to take part in a video-recorded semi-structured individual interview lasting approximately 60-90 minutes. Participants will have the opportunity to review their transcripts via e-mail and ask clarifying questions within two hours of their interview. All information will remain confidential, and participants will be given pseudonyms to protect their identity.

Participants interested in participating in this study are asked to complete the screening survey by clicking on the following link: https://forms.office.com/r/M8TpN3J86j . If eligible, you will receive an email to your preferred email address upon completion of the screening survey. Please note that all electronic devices that contain participants' information are password-protected and secured as required by ethical codes for research. The consent document supplies selected participants with additional information about this current research. If you

choose to participate, please sign the consent document, and return it to me via email at least twenty-four hours prior to our agreed upon interview.

Sincerely,

Johanna B. Dillenbeck

Counselor Education and Supervision, Ph.D. Student

APPENDIX C: Social Media Recruitment

Social Media: Facebook

ATTENTION Facebook Friends: I am conducting research as part of the requirements for a doctor of Counselor Education and Supervision degree at Liberty University. The purpose of my research is to explore the lived experience of unsuspecting wives who discovered their sexually addicted spouse's out-of-control behavior and sought professional mental health counseling after their discovery. To participate you must be a married cisgender female 21 years or older, live in the United States, be in a heterosexual married relationship for three or more years and unexpectedly discovered your sexually addicted spouse's out-of-control behavior. Additionally, you must have sought counseling or therapy from a mental health profession to address symptoms related to your discovery.

Participants must have access to a telephone or computer with internet service. Participants who meet eligibility criteria for the study will be asked to meet for no more than 60 to 90 minutes for a semi-structured interview on Zoom, review transcript within one week after your interview, and make yourself available to check to make sure your information was recorded accurately. Your total time commitment should be no more than two hours. Please review the details on the attached flyer. If you would like to participate and meet the study criteria, please click here **https://forms.office.com/r/M8TpN3J86j**

If you meet the criteria, you will receive a consent document in your e-mail for you to review and sign one week before your scheduled interview.

Social Media: Instagram

ATTENTION Instagram Friends: I am conducting research as part of the requirements for a doctor of Counselor Education and Supervision degree at Liberty University. The purpose of my research is to explore the lived experience of unsuspecting wives who discovered their sexually addicted spouse's out-of-control behavior and sought professional mental health counseling after their discovery. To participate you must be a married cisgender female 21 years or older, live in the United States, be in a heterosexual married relationship for three or more years and unexpectedly discovered your sexually addicted spouse's out-of-control behavior. Additionally, you must have sought counseling or therapy from a mental health profession to address symptoms related to your discovery.

Participants must have access to a telephone or computer with internet service. Participants who meet eligibility criteria for the study will be asked to meet for no more than 60 to 90 minutes for a semi-structured interview on Zoom, review transcript within one week after your interview, and make yourself available to check to make sure your information was recorded accurately. Your total time commitment should be no more than two hours. Please review the details on the attached flyer. If you would like to participate and meet the study criteria, please click here **https://forms.office.com/r/M8TpN3J86j**

If you meet the criteria, you will receive a consent document in your e-mail for you to review and sign one week before your scheduled interview.

Social Media: LinkedIn

ATTENTION LinkeIn Friends: I am conducting research as part of the requirements for a doctor of Counselor Education and Supervision degree at Liberty University. The purpose of my research is to explore the lived experience of unsuspecting wives who discovered their sexually addicted spouse's out-of-control behavior and sought professional mental health counseling after their discovery. To participate you must be a married cisgender female 21 years or older, live in the United States, be in a heterosexual married relationship for three or more years and unexpectedly discovered your sexually addicted spouse's out-of-control behavior. Additionally, you must have sought counseling or therapy from a mental health profession to address symptoms related to your discovery.

Participants must have access to a telephone or computer with internet service. Participants who meet eligibility criteria for the study will be asked to meet for no more than 60 to 90 minutes for a semi-structured interview on Zoom, review transcript within one week after your interview, and make yourself available to check to make sure your information was recorded accurately. Your total time commitment should be no more than two hours. Please review the details on the attached flyer. If you would like to participate and meet the study criteria, please click here **https://forms.office.com/r/M8TpN3J86j** If you meet the criteria, you will receive a consent document in your e-mail for you to review and sign one week before your scheduled interview.

APPENDIX D: Screening Questionnaire

Directions: Below are questions that will help the principal researcher gain a better understanding of your experience discovering your sexually addicted spouse's (SAS) out-of-control (OCB) and your experience with seeking professional mental health counseling after the discovery. Please answer each question as accurately and openly as possible. Interviews will be scheduled upon receipt of completed survey questions to participants who meet the eligibility criteria. Thank you for your generous participation.

1. Are you a cisgender female? *
    a. Yes
    b. No

2. Are you 21 years of age or older? *
    a. Yes
    b. No
3. Do you currently reside in the United States?
    a. Yes
    b. No
4. Have you been married for 3 or more years to your spouse with sexually addictive out-of-control behavior? *
    a. Yes
    b. No

5. Did you discover your mate'sout-of-control sexual behavior.
    a. Yes

b. No

6. After you discovered your spouse's sexually out-of-control behavior, did you seek counseling within six months to a year? *
    a. Yes
    b. No

7. Prior to discovering your spouse's sexually addictive out-of-control behavior, were you aware that he was engaged in sexual activity outside of your relationship? *
    a. Yes
    b. No

8. Prior to seeking counseling for your partner's sexually acting out behavior, had you been in counseling? *
    a. Yes
    b. No

9. If you answered yes to question #7, please provide the following: (1) the reason for counseling, and (2) your diagnosis if you aware of it. *

10. Do you have access to professional mental health counseling to ensure support for psychological distress if necessary? *
    a. Yes
    b. No

11. Do you have access to audio/video capabilities on your computer and internet capability?

    a. Yes

    b. No

12. What race/ethnicity describes you? (optional)

    a. African American/Black (non-Hispanic)

    b. First Nations/Inuit/American Indian/Alaskan Native Asian (non-Hispanic)

    c. Asian (non-Hispanic)

    d. Native Hawaiian and other Pacific Islander

    e. Hispanic/Latina

    f. Caucasian (non-Hispanic)

    g. Other: _____

13. Please provide me with a name you would like me to use during our correspondence.

14. Please provide an e-mail address that you would like me touse for

    our correspondence. *

15. Please provide a telephone number that you would like me to use for

    our correspondence. *

APPENDIX E: Interview questions

Directions: Thank you for taking the time with me to participate in this study and share your experience with me. The purpose of this study is to explore the lived experiences of unsuspecting wives (UWs) who seek counseling from mental health professionals after discovering their sexually addicted spouse's out-of-control behavior (SAS/OCB). My hope is that the findings will give mental health professionals information about how their approach positively or negatively impacts UWs' recovery. This interview will take about 60-90 minutes and your responses will be transcribed and recorded so that I get an accurate account of your experience. If at any time you need me to clarify a question or you need a break, please feel free to let me know. If at any time you wish to withdraw from the interview, please let me know and I will delete your information. I want to remind you that your experience will be strictly confidential. Your recording will be protected on a password protected computer and the written transcription will be kept in a locked safe. As we go through the interview, please answer the question at the level you feel most comfortable with.

First, I'm going to ask you some demographic questions just so that I can describe my participants to stakeholders interested in our study.

1. What race/ethnicity best describes you?
    a. African American/Black (non-Hispanic)
    b. First Nations/Inuit/American Indian/Alaskan Native Asian (non-Hispanic)
    c. Asian (non-Hispanic)
    d. Native Hawaiian and other Pacific Islander Hispanic/Latina
    e. Hispanic/Latina
    f. Caucasian (non-Hispanic)
    g. Other
2. Which relationship status best described you when you discovered your spouse's out-of-control sexual behavior?
    a. Married 3 years
    b. Married 4-5 years
    c. Married 5-10 years

d. Married 10-15 years

e. Married 15-20 years

f. Married 20-30 years

g. Married 30-40 years

h. Married 40-50 years

3. Which age range best describes you?

a. 21-29

b. 30-39

c. 40-49

d. 50-59

e. 60 or older

4. Which education status best described you at the time of discovery?

a. Under 12 years of school.

b. High School graduation

c. College 4 years

d. Masters

e. Doctorate

f. Post-doctorate 4+years

5. Which employment status best described you at the time of discovery?

a. Homemaker

b. Unemployed

c. Part-time employed

d. Full-time employed

6. Which parental status best described you at the time of discovery?
    a. Children between the ages of 5-20
    b. Children between the ages of 21-25
    c. Adult children
    d. No children
7. Which faith statement best described you at the time of discovery?
    a. Atheist
    b. Agnostic
    c. Non-practicing
    d. Christian
    e. Jewish
    f. Other

Now I'm going to ask you some questions about your experiences with your discovery and the support you sought from mental health professionals. Psychologists, social workers, professional counselors, therapists, and marriage and family therapists are considered mental health professionals. Ok, let's begin.

8. How long ago did you discover your spouse's out-of-control sexual behavior?
    a. How did your discovery impact other aspects of your life? Explain.
    b. How is the impact of your discovery impacting your life today? Explain.
9. Can you tell me about what it was like when you discovered your SAS OCB?
10. What was the experience like for you and your spouse when you made the discovery?
11. Who if anyone did you tell?
    a. How did you make the decision about who or not to tell?

b. What was the most memorable reaction you received from those you told?

12. What was it like seeking help from mental health professionals?

    a. How many help-seeking attempts did you make to find a professional counselor?

    b. How did you determine which mental health professional (s) to go to?

    c. How soon after discovery did you begin with a mental health professional?

    d. How did you find your counselor(s)?

    e. Did your mental health professional(s) have a specialty?

        i. Was your mental health professional(s) a certified CSAT counselor?

        ii. Was your mental health professional(s) a certified APSAT counselor?

        iii. Was your mental health professional(s) a trauma specialist?

    f. How easy or difficult was it for you to find a counselor that met your needs? Explain.

13. How would you describe your experience with couple's counseling?

    a. What details can you provide about the nature of the therapy?

    b. What thoughts and feelings do you have about your experience with your couple's counseling as it relates to the discovery of your spouse's sexual addiction?

    c. What, if anything, did your professional mental health counselor say or do that felt helpful or not helpful?

14. How would you describe your experience with disclosure?

    a. Did you and your spouse participate in a professionally led disclosure?

    b. If yes, what process was used?

c. In what ways was disclosure helpful or unhelpful to your healing?

15. What messages did you receive from a mental health professional about sexual addiction?
16. Can you recall messages conveyed through words, body language, or facial expressions that you received from your mental health professional about your experience? What was that like?
    a. What was said or conveyed by your mental health professional that was helpful? Explain.
    b. What was said or conveyed by your mental health professional that you found unhelpful? Explain.
    c. What was said or conveyed about your sexually addicted spouse that you found helpful? Explain.
    d. What was said or conveyed about your sexually addicted spouse that you found unhelpful? Explain.
    e. How did you determine which information from your mental health professional was going to be helpful? Explain.
17. Are you still seeing the mental health professional for issues related to your discovery?

    a. If yes, what are the current benefits of the work you are doing?

    b. If not, what made you stop working with the mental health professional?

18. Is there anything else that you would like to share about your experience with mental health professionals after discovering your spouse's out-of-control sexual behavior?

Thank you so much for your time and participation today. Next, you can expect to receive an email from me within one week with your transcription....if you have any questions or concerns about my transcription, please contact me via e-mail with your concerns and I will schedule a fifteen minute follow-up phone call to make the corrections. Similarly, if have a question about the accuracy of your transcription, I will reach out to you bey e-mail and request a fifteen-minute follow-up phone call to make the necessary changes. Please be assured that all of your information is strictly confidential, and you will be the only one able to access your information.

APPENDIX F: Journal

1. April 7, 2022

As I prepare to interview my first participant, I pray that God will give me the focus to hear her story and honor it when I report on my findings. It's been a stressful time waiting for IRB approval and striving to complete this study in time to graduate this year. Because technology is my nemesis, I pray there are no glitches in zoom and the recorder. Similar to counseling, I need to set aside my worries and anxieties to be present for my participant because she has taken time from her busy day to be available to me. The first experience is always the hardest, so I pray that I am fully present. I pray my participant appreciates that while I am a student trying to finish my studies, I am grateful that she is willing to share her story with me.

After the interview: I am amazed at how my participant was willing to share her story with me, someone she has never met. I hope I was safe for her. I hope when I said few words, she didn't interpret that as indifference. I need to figure out how to be objective while conveying that I am empathic and attuned to what the participant is telling me.

2. April 7, 2022

As I think about the questions in my manual and how they shaped the first interview, I wonder if I am overreaching in what I am asking. I noticed that with my first participant, I got engrossed in what she was telling me. I pray that I honor my client's story by being present and picking up nuances in her voice and in her words.

After the interview: I was overwhelmed by the participant's emotions and felt protective of her. Yet, if this study is to have credibility, I must bracket personal feelings toward my participants and their experiences. As I put on my rationale "hat," it helps me reflect on her

contribution to this study and how suspending personal reactions will help me to tell her story. I want to set aside any preconceptions about where the data will take me so that I can follow the procedures for a phenomenological study.

3. April 8, 2022

As I prepare to meet my third client, I am feeling anxious that this process is rushed. I would have liked to have more space between the interviews. I am exhausted. However, I am grateful that I have the online version of Microsoft Word so that I don't have to manually transcribe the recordings. I feel like I have read too much about sex addiction and intimate betrayal trauma. I pray that I continue to bracket myself so that what I have learned about this phenomenon doesn't "leak" into the interview.

After the interview: There were some similarities between me and the participant. Yet, there were a lot of differences in her story as well. I wonder how our similarities in age positively or negatively impacted her willingness to share her experience with me. I am so grateful for her generosity of spirit.

4. April 10, 2022

The opportunity to learn from women all over the country adds an interesting dynamic to the process. By the time I interview this client, I feel that I have put in a full day's work because of the time difference. I pray that God not only gives me the mental and emotional stamina to remain present with this participant, but that I suspend what I have experienced as a betrayed partner and heard from my clients and the other participants. I pray that each personality of my participants will emerge as I share what I have learned from them.

After the interview: My participant is amazingly courageous….and funny! Is it okay to enjoy the participants as much as I do? I find it interesting that the participants grieve their losses

(about their relationship differently). I have such admiration for my participant and I look forward to telling her story.

5. April 11, 2022

As I prepare for my fourth interview, I am noticing that the participants are becoming very real to me….so much so that I think about their stories during my "down time." Interviewing these women seems therapeutic as they recount how they have had to fight to get the answers they needed about their husband's addiction. Today I revised my script slightly so that I could inform my participants that this is a phenomenological study and therefore, the data comes from the information they share.

After the interview: I felt more relaxed telling this participant that I wanted to hear as much about her experience as she wanted to share, and that I didn't intend to interrupt. Exploring the phenomenon through the transcendental approach has made me more aware how the power of bracketing or restraining from interjecting helps the client's story come through. I am trying to prompt the participant with encouragers such as, "Can you tell me more?"

6. April 13, 2022

On one hand, I am happy to be getting more familiar with the Zoom, recording, and transcribing process. My computer is rebelling though. Just when I need it to perform, the Zoom freezes or the computer overheats. I am praying that my gracious God makes my path straight so that I can complete the interviews. I am praying that I don't seem like I am going through the motions. I find myself reminding myself to bracket what the participants are sharing so that each interview feels fresh to me.

After the interview: I was moved by the beauty of this participant. While I am looking very plain these days, her make-up, jewelry, and hair were beautiful—a stark contrast to the way

I am looking. It's interesting to look into her beautiful home as a backdrop to the chaos she experienced a few years ago. Her dates are similar to mine and I resonated with her determination to learn about what she had stumbled upon. When I feel drawn into the story, I scribble a note and remind myself to bracket my interpretation of what she is saying. Gratefully, her husband's issues are different than mine…I was also taken by her comment that she expected me to be her daughter's age. By God's good grace I will finish this work.

7. April 14, 2023

I am especially grateful to this participant for rescheduling. After working with a failed system, we had to reschedule. Because she has a demanding job, I feel privileged that she took time out to meet with me. Since I have already met her, I am anticipating time spent with her. She is another older woman, married for some time who had no idea about her husband's behavior. I hope I can tell my participants' stories well.

After the interview: I was a little "star struck" when I learned that my participant worked with a prominent professional and that he was her counselor. It has been a discipline that has taken some effort…..I need to remain non-reactive as I learn bits of the participant's story that incite a personal reaction from me.

8. April 18, 2023

While I have been encouraged to do more work in this area by the women I have met, I need to focus on completing this study for now. While I have enjoyed hearing the stories of my participants, I am eager to start analyzing the data and see what I find. I pray that this experience generates a quality paper and sparks an interest in the mental health community to learn more about partners in committed relationships with sexually addicted individuals.

After the interview: I am in awe of the work this woman has done and how important her faith has been to her. God has so blessed her with a redeemed marriage. As I think about the interviews, I want to know more about the women who did not participate in the study.