**Disclosure of Extramarital Sexual Activities by Persons with Addictive or Compulsive Sexual Disorders: Results of a Study and Implications for Therapists**

**by**

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Despite religious and cultural precepts that forbid sexual activities outside marital relationships, such behaviors have continued in most societies and are common in the United States. Fifty years ago, Kinsey and associates found that one in two husbands (Kinsey, Pomeroy, & Martin, 1948) and one in four wives (Kinsey, Pomeroy, Martin & Gebhard,1953) had engaged in extramarital sex. During the peak of the "sexual revolution" 20 years later, the reported numbers of unfaithful women increased (Tavris & Sadd, 1975), and categories of affairs were defined on the basis of approval or disapproval and knowledge or lack of knowledge by the spouses about the affair (O'Neill & O'Neill, 1976; Rubin & Adams, 1986). In surveys published in the United States in the past two decades, more than 50% of men and women admitted they had engaged in marital infidelity at some time in their marriage (Glass & Wright, 1992; Hatcher, et al, 1990; Thompson, 1983).

Psychotherapy of married couples wishing to address adultery traditionally seeks to explore motives for the behaviors and effects upon the marriage and family. In attempts to understand extramarital sexual behavior, clinicians and researchers have utilized various typologies and definitions. Pittman (1989) defines infidelity as “a breach of the trust, a betrayal of a relationship, a breaking of an agreement. . .We might define adultery as a sexual act outside the marriage, while we might define infidelity as a sexual dishonesty within the marriage" (p. 20). In his practice, Pittman found that affairs fell into four groups: (a) *accidental infidelity* -- unplanned sex acts that "just happened"; (b) *romantic affairs* -- the person truly believed he or she was in love; (c) *marital arrangements* -- efforts to maintain a distance that is required by one of the partners; and (d) *philandering* , "that habitual sexual activity that seems natural to the philanderer, and is motivated more by fear of and lust for the 'opposite sex' than by any forces within the marriage or the immediate sexual relationship" (p. 133).

Moultrup (1990) defines an extramarital affair as "a relationship between a person and someone other than his [sic] spouse that has an impact on the level of intimacy, emotional distance, and overall dynamic balance in the marriage" (p.

11). His therapy is based on the assumption that the role of an affair is to create emotional distance in the marriage, and he emphasizes that "the critical principle is to consider the possibility of unconscious emotional benefits gained by the noninvolved spouse" (p. 37). The goal of therapy is to resolve the intimacy problems in the couple relationship so that an affair will no longer be "needed." This model does not consider the possibility of accidental affairs nor those that arise out of individual pathology or habit rather than relationship difficulties.

Brown (1991) classifies affairs as (a) conflict avoidance strategies, in which couples who cannot discuss their differences use affairs to make it clear that there are significant problems; (b) intimacy avoidance, where "it feels safer to keep things stirred up a bit" (p. 33); (c) empty nest affairs, in which the marriage feels empty; (d) out the door affairs, in which the affair gives one or both partners the impetus to leave the marriage, and (e) sexual addiction, in which people "deal with their emotional neediness by winning battles and making conquests in the hope of gaining love" (p.35).

A particularly egregious type of betrayal of the primary relationship occurs when a physician, psychotherapist, or clergy person embarks upon a sexual relationship with a patient, client, or other person with whom he or she has a fiduciary relationship. Such relationships are expressly forbidden by their professional associations, and in at least a dozen states they are considered felony crimes. Gabbard and Lester (1995) presented a typology of sexually exploitative psychotherapists. Their disorders consisted of: (a) psychotic disorders, such as the manic phase of bipolar illness; (b) predatory psychopathy and paraphilias, a category which includes antisocial personality disorder, severe narcissism, and various paraphilias which are repeated acted upon, involving many victims; (c) "lovesickness," which is believing they are madly in love with the patient or client, and (d) masochistic surrender, which describes therapists who appear to pursue humiliation and victimization in their work and often in their private lives, and eventually succumb to patients' sexual entreaties despite the costs to themselves.

Another typology of sexually exploitative health care professionals was presented by Irons & Schneider (1994), who found that 55% of 137 consecutive sexually exploitative professionals assessed in a multidisciplinary inpatient program had a paraphilic or nonparaphilic addictive sexual disorder. Smaller numbers fell into three other categories: (a) naivete, or failure in education about appropriate professional boundaries, (b) situational stress, such as marital, professional, or health problems, and (c) other Axis I or II diagnoses listed in the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV) (American Psychiatric Association, 1994) such as bipolar illness or antisocial or narcissistic personality disorder.

All these various typologies have some common categories, including (a) infidelities related primarily to difficulties within the marriage such as poor communication skills and fear of intimacy, or the need for an excuse to terminate the marriage; (b) accidental infidelities; (c) infidelity as a resolution to situational

stresses not related primarily to the marriage, such as job difficulties, deaths, health problems; (d) infidelity as a component of a primary personality disorder or psychosis, and (e) infidelity as an expression of an addictive sexual disorder . A "true love" affair may result from several of the above categories. Of note is that the latter two categories do not arise primarily out of relationship difficulties, but rather out of individual pathology of one of the partners. In many cases the partner who has not strayed outside of the marriage has her or his own pre-existing emotional difficulties, and in almost all cases the couple relationship is affected by the infidelity, however, it is erroneous to assume that every case of infidelity requires a primarily relationship-centered treatment approach.

**Sexual Addiction**

Several authors cited above believe that sexual disorders with compulsive or addictive features may be implicated when sexual infidelities recur in ritualized patterns. There is disagreement among professionals about whether compulsive sexual behavior should be viewed as an addiction (cf. Carnes, 1991; Shaffer, 1994; Schneider, 1994; Schwartz & Masters, 1994). In many cases the addiction model is beneficial in helping people stop unwanted, compulsive sexual behavior, in treating the disorder, and in preventing relapse.

Key concepts for understanding addictive sexual disorders were reviewed by Irons & Schneider (1997, 1999). An addictive sexual disorder is considered to be present when (a) there is loss of control over one or more sexual behaviors -- that is, when the person has been unable to stop despite attempts and promises to oneself, (b) when the behavior is continued despite significant adverse consequences, such as loss of job or marriage, exposure to disease, risk to safety, or arrest or public humiliation, and (c) when a great deal of time is spent in fantasizing or obsessing about sex or a particular sexual activity.

Some ritualized sexual activities are classified in the DSM-IV (American Psychiatric Association, 1994) as paraphilias because they are seen as being outside the boundaries of what society considers normal sexual behaviors. These include exhibitionism, voyeurism, and frotteurism (inappropriate touching). However, any sexual activity may become compulsive and result in significant adverse consequences, including those which are normal and healthy for most people (e.g., masturbation and use of pornography). A more recent and burgeoning example is cybersex, which can be defined as any form of sexual activity involving the computer. This can include viewing and downloading pornography, exchanging sexual talk online, and videostreaming, in which two persons participate in real-time sexual activities online while cameras attached to each participant's computer transmit images to the other showing what each one is doing. An increasingly popular activity, cybersex is used in a "recreational" fashion by about 85% of users, whereas about 15% find themselves involved in these activities compulsively, with adverse consequences for their relationships, jobs, etc.(Cooper et al [1999], Schneider [2000a, 2000b], Schneider & Weiss [2001]).

An analogy may be made to the consumption of alcohol, which is a pleasant and positive experience for most people but causes significant life problems for approximately thirteen percent of the population (Regier et al, 1990). The key differentiating feature is not the frequency of the behavior, but rather the consequences to the person and to others. Although recovery from alcohol dependency usually requires total abstention from alcohol consumption, recovery from an addictive or compulsive sexual disorder consists not in avoiding sex altogether, but rather in learning what are healthy sexual activities for the person. An analogy can be made with compulsive overeating, in which recovery comprises learning how to eat in a healthy and non-compulsive manner and to cope with anxiety or stress in healthy ways.

When secret extramarital sexual activities intrude on a primary committed relationship, on question inevitably surfaces: should one disclose the infidelity to the partner? Some authors have asserted the need for honesty and disclosure (Pittman, 1989; Subotnik & Harris, 1994; Vaughan, 1989), and some even give advice about what and when to tell (Subotnik & Harris, 1994; Wallerstein and Blakeslee, 1989; Vaughan, 1989). In contrast, many clinicians hesitate to recommend full or even partial disclosure because of the client's fears that the uninvolved spouse may choose to leave the relationship. Many partners who have suspected the existence of extramarital sexual activities have in fact threatened to leave should their suspicions be confirmed; on the basis of such threats, both the involved spouse and the therapist may consider it too risky to disclose. The concern is exacerbated when there has been a long-standing pattern of infidelity, as typically exists when one partner has a compulsive sexual disorder.

When an addictive disorder is present, the marriage and family therapist must recognize the special importance of the role of honesty as a component of the most widely-accepted treatment of addiction. One of the fundamental principles of the most widely used approach for addiction treatment –- that based on Alcoholics Anonymous – is that honesty is essential for recovery. The addict is repeatedly told of the importance of being rigorously honest about his or her behavior. However, because disclosure of sexual activities will pain to the partner (not to mention pain to self), being honest presents a real dilemma for both the addict and the therapist. This is particularly true when not telling could do greater harm, as when the unfaithful person has exposed the partner to HIV infection, or when sexual misconduct has occurred that could result in legal charges, loss of professional license, and financial adversity for the family. These same considerations also exist when the extramarital sexual activity did not result from an addictive or compulsive disorder.

**A Study of Disclosure of Extramarital Sexual Activities**

Few published studies have addressed whether disclosure is advisable and how the therapist might facilitate the process of disclosure so that it may be healing to both the couple and the individuals involved. Relationship issues resulting from addictive or compulsive sexual problems have long been an interest of the

authors. (Schneider, 1991, Schneider & Schneider 1989, 1990a, 1990b, 1990c, 1996; Corley & Alvarez, 1996). as have relationship problems resulting from sexual exploitation by a professional member of the couple (Irons & Schneider, 1999). Because of the compulsive nature of the behaviors, there is usually an extensive history of sexual infidelities. The emphasis on honesty in the patient's recovery process results in pressure to disclose infidelities to partners despite fears of the consequences. For that reason, such a group can be expected to be particularly informative for studying issues of disclosure.

Using an anonymous, self-administered survey, Schneider, Corley & Irons (1998 and 1999) carried out a qualitative study addressing the consequences of choice of timing, extent, and manner of disclosure of the extramarital sexual behavior to the partner. Separate surveys were constructed for addicts and partners. The survey contained closed, multiple-choice (with a 5-point, Likert-like scale), and open-ended questions. Examples of open-ended questions were those related to the meaning of disclosure to both the addict and the partner, what each individual identified as helpful or unhelpful actions or advice by the therapist, and what was the outcome of the disclosure for the couple relationship. The survey took approximately 1-1.5 hours to complete. A convenience sample of American and Canadian psychotherapists who treat sex addicts and their partners was asked to distribute surveys to current and former clients. Additional surveys were sent to five contact persons within the sex addiction recovery community for distribution to self-identified recovering sex addicts and partners

The respondents therefore consisted primarily of persons and partners (or former partners) of persons who had been diagnosed by a professional as having an addictive or compulsive sexual disorder (Sexual Disorder NOS in the DSM-IV) and a few who were self-identified as sex addicts or partners (or former partners) of sex addicts. Originally surveys were distributed to persons who were members of a couple. A subsequent mailing specifically targeted persons whose primary relationships had ended as a result of sexual compulsivity problems and who were now separated or divorced.

A total of 161 surveys were returned following the initial mailing, a return rate of well over 16.0% of those actually distributed. Of the total, 81 addicts and 80 partners responded. Of the partners in this group (group A), 4 out of 78 (5%) were separated or divorced. In addition, the second mailing of 120 surveys directed to therapists working with persons who were separated or divorced yielded 36 responses (30%), consisting of 20 addicts and 16 partners (group B).

Of the entire group, half the respondents were male, and half female; 75% were currently married or in a committed long-term relationship, whereas 25% were separated or divorced. The mean age of the respondents was 43.8 years ( SD =9.1), with a range of 26-70; the mean age of the addicts was 45, and the partners' mean age was 42.6 years. Among the addicts, 93 (91.2%) were male; among the partners, 88 (93.6%) were female. As to sexual orientation, 91.7% of the

respondents identified themselves as heterosexual, and 8.3% were homosexual or bisexual.

The occupations of the respondents are summarized in **Table 1.**

The licensed health professionals included physician, nurse, psychologist, social worker, physical therapist, and clergy. Other regulated professionals included lawyers, professors, and teachers. The great majority of respondents were employed, and most had received higher education.

Of 100 sex addicts who specified their compulsive behaviors, 91 (91%) had engaged in sexual activities with other people outside the marriage. Many had engaged in multiple behaviors including affairs with opposite- or same-sex persons, having sex with prostitutes, visits to massage parlors, frequenting pornographic bookstores or theaters, or engaging in sexual activities with patients or clients. Among the nine persons whose sexual activities had not involved contact with other people, several had engaged in illegal behaviors such as voyeurism or exhibitionism. The survey did not ask specifically about sexual involvement with patients or clients in a professional setting. However, several addicts stated that their compulsive sexual behaviors did involve crossing professional boundaries. The study was done before widespread use of the Internet for sex, so it did not address this emerging problem.

Persons with addictive disorders often have more than one type of addiction or compulsive behavior. Only 42% of the 102 sex addicts in this study stated they had no other addiction; 49% reported were also recovering from addiction to alcohol, other drugs, and/or nicotine (3 persons identified nicotine as their only drug of addiction); 25% identified an eating disorder; 12% were compulsive spenders; and the remainder identified other addictions and compulsions. Among the partners, 29% reported having an eating disorder and 17% were in recovery from chemical dependence (of whom 3 identified nicotine as their only addictive drug).

Among the addicts, the median time in recovery from sex addiction was 3.4 years, with a range of from less than 1 month, to 16 years; 35% had less than 2 years, 33% had 2 to less than 5 years, and 32% had at least 5 years recovery. A majority of the partners had attended self-help programs based on the Al-Anon model. Nearly all (90.8% of the respondents saw or were seeing a professional counselor or therapist; 59.2% of the entire group had seen more than one type of professional. In other words, this population had received both professional and peer support in their recovery process.

*Threats to leave before the disclosure*

Long before disclosure took place, many partners suspected correctly that affairs or other extramarital sex was occurring. Over half of the partners (52.8%) were suspicious enough to confront their spouses. Most (84%) of the addicts who were confronted denied any wrongdoing. Before the first disclosure, 29 out of 77

partners (37.7%) in the still-married group (group A) threatened to leave because they had some suspicions, as did 7 of the 16 (44%) of the divorced/separated group (group B). Among the addicts, 44.4% of group A and 60% of group B recalled receiving such threats. Understandably, this might have given pause to the offending partners about the wisdom of disclosing that these activities had actually taken place. Threats to leave were common whether or not the couple eventually stayed together.

*Threats to leave after disclosure and outcomes of the threats:*

In group A, 47 (60.2%) of the partners reported threatening to leave after hearing the disclosure. However, of the 47 marriages where threats to leave occurred after disclosure, only 11 (23.4%) of the couples actually separated. In 34 cases (72.4%) the couples stayed together throughout. **Table 2** summarizes the data for 45 partners of group A who responded. It is notable that of those spouses who threatened to leave, one one-quarter actually did so, only temporarily.

When the partners who did not leave despite having threatened were asked for an explanation, half (36.2%) of the 45 who had threatened to leave stated that they stayed because one or both went to therapy and 12-step programs (those based on the Alcoholics Anonymous model) and were working actively on their recovery. An equal number of partners (36.2% of the 45 who threatened to leave) were unable to take effective action, changed their minds, or decided to "give him another chance.."

In group B, consisting of 16 former partners who did leave the marriage, 10, or 62.5%, threatened to leave at the time of disclosure. Compared with the 60.2% of partners from group A who threatened to leave, there is clearly no difference. Thus, a threat to leave did not predict the eventual outcome.

*Adverse consequences of the disclosure:*

When asked, "Did you experience any adverse consequences as a result of the disclosure?" the vast majority of both groups, as expected, said they had - - 97.3% of the addicts and 92.2% of the partners. The most common consequences for the addicts were compromise of the relationship (40.8%), followed by emotional problems and depression (25%). Among the partners, 59.4% reported emotional problems and depression, and 23.4% felt their relationship was compromised. Of course, many of these consequences can be considered secondary to the behavior rather than to its disclosure. Other adverse consequences included damage to other relationships such as with children, parents, and friends; legal consequences such as arrests; and financial consequences such as job loss and costs of treatment.

*Disclosure during inpatient treatment*

In several cases, disclosure to unsuspecting spouses was done over the telephone. The wife of one physician who had had sexual relations with several

patients reported, “My husband phoned me from the psychiatric hospital, where he was surrounded by nurturing caring professionals and fellow addicts. I was in our bedroom painting furniture, surrounded by our five small children. I never would have believed for a minute he would actually have sex with anyone outside the marriage. I was absolutely shocked y the seriousness and extent of his behaviors. There never would have been an easy way to disclose all this stuff, but I should have been given the same supportive environment as my husband. The spouse needs just as much guidance and support as the addict.”

A dentist who had multiple affairs and other forms of sexual acting out, had sex with a fellow patient during inpatient treatment for sex addiction. He phoned his wife and told her about this. He reported that it ended the marriage. “She was very angry. I wish I had told her in person, with the counselor present.”

Adverse experiences were also reported by partners who received disclosures of significant sexual activities during a therapy session at the inpatient facility and were then left to process the news alone and were not provided with referrals for follow-up back home: “After the disclosure, I should never have been allowed to return to my motel room. I truly believe God drove the car to the motel, because I didn’t even see the road. I needed 24-hour attendance. Since then I have felt loneliness and the lack of counselors in our city with the expertise I saw at my husband’s treatment facility. I still long for an opportunity to speak with other professionals’ wives who have common backgrounds as myself. I am recovering from a traumatic experience.”

*Public disclosure*

In cases when the extramarital sexual behavior is illegal (e.g. solicitation of a prostitute, professional sexual misconduct), the disclosure and its aftermath may be played out in the public arena. The wife of an exploitative professional may be seen as an accessory to the misconduct. A 49-year old health professional who had been married to a clergyman reported, “Because he was charged with a sexual offense against a minor and it was announced on the local radio, each member of our family suffered humility and loss of face in public. . . It was extremely difficult for any of us to walk down the street in our town. My husband and I were both well known in the community. When the disclosure came, many of our friends were stunned and pulled away; many have not contacted me to this day. The church as a whole avoided us. Even the friends who were ‘there’ for us pre-sentence fell away. Quite accidentally I discovered that they believed I had known all along about my husband’s secret behaviors and had not spared their children exposure; in other words, I conspired with my husband to lure their unsuspecting children to our home. . .I felt I had to leave the community for my sanity. I resigned my job, my husband and I separated, and I moved to another state.”

*Partial or sequential disclosure*

The study results suggested that it is tempting for an unfaithful partner to attempt damage control by revealing only some information initially. The adverse effects of staggered disclosure were described by several partners. One woman wrote of her feelings after her husband lost his job because of sexual misconduct. “He had to tell me something, because he was fired, and people in his profession are seldom fired for any reason other than gross malpractice or sexual misconduct. He told me he had sexually touched a subordinate at work. He said it was invited, which turned out not to be true. His revelations continued to dribble out over weeks as I continued to ask for information. Each new piece of information felt like a scab being ripped off.”

A man who was sent to prison as a consequence of his sexual behavior disclosed to his wife only some of his activities. She wrote, “Some of his past was reported to the pre-sentence investigator, and I received the report only after he’d been in prison for 3 months. When I read it, I felt immense pain and anger. Part of that was not having been told. I felt lied to and I didn’t trust any of the relationship.”

*Positive outcomes of disclosure*

Both addicts and partners reported significant positive aspects of disclosure. Honesty, an end to denial, and hope for the future were recurrent themes mentioned by addicts. Partners described the main positive outcomes to disclosure as clarity and validation, and hope for the future: "One of the most helpful things about it for me was that it confirmed my reality. My husband had repeatedly told me how crazy and jealous I was. Over time I had started believing him. Finding out I had not misread the situation helped me to begin trusting myself, that I wasn't as crazy as he said or as I had thought. " "It was the best and worst day of my life. I knew for once that he told the truth at the risk of great personal cost. It gave me hope that he could grow up an face life's responsibilities. It was the first time his words of love and his actions were congruent. I felt respected, relieved, outraged, sick. It gave me hope for our relationship. "

The responses of Group B, now separated or divorced, were similar. A career woman, now divorced, wrote, “I had been in such a crazy-making state for so long. Learning it had been a 12-month affair helped me put it all in perspective. I was angry, hurt, shocked -- and relieved.”

*How important is it to disclose to your partner?*

The survey asked addicts and partners whether they felt at the time that disclosure was the right thing to do, and how they feel about it now. At the time, 44 (57.9% of the addicts in Group A felt it was definitely or probably the right thing to do, but significantly more, 73 (96.1%) felt that way at the time of the survey ($P<0.01$). Nine (11.8%) of the addicts felt at the time that it was probably or certainly wrong, compared with only 1 (1.3%) of the addicts at the time of the survey.

In contrast, despite the pain of experiencing disclosure, a large majority of partners (81.3%) felt it was a right thing, even at the time, and this proportion increased even further with the passage of time (93%), although the difference was not statistically significant. Significantly more partners than addicts ($p<.01$) initially believed in the rightness of disclosure, but at the time of the survey, the difference between addicts and partners was no longer significant.

Among addicts who thought it was important to disclose, the primary reasons for this belief were that it was essential for one's own recovery, that the partner deserved and needed to know, that truth was needed for the couple relationship to be healthy, and that it was important because there were health and safety considerations.

Among partners who recommended disclosure, the chief reasons were that the offending partner needs honesty to begin healing and reduce the shame and guilt felt; the partner need to know in order to assess her health risk, to be able to make informed choices about the future, and to obtain validation.

Even among those who eventually divorced, the consensus was in favor of disclosure. A woman who is now divorced stated, “Should he fully disclose? Absolutely. As soon as possible. Within couples therapy so both partners are safe, or with two individual therapists present. Trust cannot be rebuilt until all the secrets are on the table.”

When asked, "Would you recommend disclosure to other couples?" 71% of the addicts in Group A and 82.7% of the partners said definitely or probably yes. The responses for Group B were similar despite the demise of their marriages: 65% of the 20 addicts and 87.5% of the 16 partners said definitely or probably yes.

Several partners felt strongly that in cases where the offending spouse is already in treatment or in counseling and is advised to disclose, consideration should be given to providing the partner with support to handle the disclosure.

Suggestions to therapists regarding the circumstances of the disclosure are beyond the scope of this paper and will be addressed elsewhere. Disclosure is often the crisis that brings a couple to therapy, but in those cases in which the disclosure can be planned, the needs of the partner should not be forgotten. Partners of sexually compulsive persons need peer and professional support during the disclosure process.

*Study conclusions: The threat and the reality of disclosure*

Disclosure of an affair or other extramarital sexual activity is often delayed because of fears of the partner's reaction, specifically, the fear that the partner will leave the relationship. Although the partners in this study often described their reactions to the disclosure in terms of despair, devastation, and hopelessness, and although most initially considered ending the relationship, most chose to stay and to work it through.

Threats to leave the relationship, a common expression of anger, are a frequent initial reaction by the partner to disclosure of extramarital sexual behavior: 60.3% of spouses stated they had threatened or considered leaving, and 51.3% of addicts reported that they knew of such threats or feelings by the betrayed partner. However, only one-quarter of partners actually followed through on their threats with separation. An interesting finding was that among those partners who ultimately stayed, there was no difference in the percent who threatened to leave (60.3%) compared to the percent among those who eventually did separate or divorce (62.5%). Thus, threatening to leave after receiving a disclosure is very common and is not a predictor of the eventual end of the marriage.

Initially, adverse consequences were inevitable. Addicts whose partners had threatened to leave "if I find out you had an affair" were fearful of the loss of the relationship. Many addicts reported feeling shame and loss of self-esteem at the time of disclosure. Both members of the couple reported significant emotional consequences. Many partners were angry, as reflected in their threats to exit the marriage. However, most of those who threatened did not actually leave, either because one or both partners went into counseling or other treatment, or because the consequences of leaving appeared to outweigh those of remaining in the relationship.

Most of the partners (81.3%) felt right from the time of the initial disclosure that the disclosure had been a good thing. A smaller majority of the addicts (57.9%) felt this way at the time of disclosure, but many more (96.1%) came around to this point of view after the passage of time. The majority of both groups (71% of addicts and 82.7% of partners) recommended disclosure to other couples. Addicts favored disclosure because it represented hope for the future, an end to denial, and a chance to come clean and put an end to secret keeping. Partners recommended receiving the disclosure because it provided validation for their perceptions and suspicions, which had frequently been discounted by the addict, because it provided hope for the future, and because it often led to a shift in focus from the addict's needs to their own. Both groups believed that honesty is an important healing characteristics, both for each of them and for the couple relationship.

Because the study subjects were not a random sample of all persons and partners of persons with addictive or compulsive sexual disorders, it was not possible to assess the statistical probability that a couple will separate or divorce following disclosure of the sexual acting out. However, the value of the particular study population selected is that the betrayal and lying involved was generally more egregious, longer-lasting, and involved more offenses than relationships in which disclosure of only one or two affairs was the issue. If such couples can work through the issues of restoring trust, forgiveness, and getting the marriage back on track, then other couples for whom addiction and recurrent betrayal is not present might be expected to recover with less difficulty. The experience of the couples reported here can provide valuable information for therapists who counsel all couples about disclosure.

One factor which is both a strength and limitation of this study is that the couples were sampled at varying times in the course of recovery from the betrayal and disclosure. The time period from the relationship crisis to the time of completion of the survey varied from a few weeks to many years. Many of these couples were still in the process of working through the consequences of the betrayal. The study therefore provided a cross-section of the recovery process at a particular time. Only a longitudinal study would reveal how many of the couples who were separated at the time of the study will ultimately reconcile, nor how many of the couples who were together will eventually separate.

**Implications for Therapists**

*To conceal or reveal a secret?*

Therapists often see clients only after the initial disclosure. If, however, disclosure is to be a part of the therapy process, then it is worth while to consider the reasons for disclosure. Recognition of each partner's motivation can influence the timing, nature, and extent of disclosure. Some legitimate reasons for immediate disclosure are:

The partner suspects and is asking questions

The partner is at risk for a sexually transmitted disease and needs testing and protection

The information is about to be revealed to the spouse by another person or agency, and the addict recognizes it would be much better for him (her) to tell the spouse directly

The relationship is being adversely affected by the secret

The addict's recovery is being adversely affected by his (her) dishonesty

On the other hand, disclosure might best be deferred if

The addict is disclosing out of anger, in order to hurt the partner

The addict is disclosing out of exhibitionism, e.g. "All these women want me."

The addict feels like "dumping" all the details of the sexual activities in order to assuage his (her) guilt

The partner is particularly vulnerable at the time– physically or emotionally fragile – and might be harmed by the disclosure

*Safety*

When the married person involved in extramarital sex is a woman, fears of the consequences of disclosure may be realistic. Schneider and Schneider (1990c) surveyed several husbands of recovering female sex addicts and learned that it was common for these men who had learned of their wives' affairs to fantasize harming the wife or the affair partner, and some reported destroying furniture and other objects in anger. Before a therapist recommends disclosure to any client, an assessment of the risk of domestic violence needs to be carried out. Another safety issue is that of the risk of acquiring sexually transmitted diseases (STDs): If the straying partner has had unprotected extramarital sex and has exposed the spouse to disease, then disclosure should not be delayed.

*Disclosure is a process*

Disclosure is usually a process rather than a one-time event (Schneider et al., 1998). Much of the time, the sexually compulsive person does not tell all at first, then comes back to reveal more. In particular, sexually exploitative professionals often initially minimize their misconduct, not only to licensing boards and assessment teams but also to their spouse. When a wife who has publicly supported her husband because she believed in his innocence eventually learns that he continued to lie to her about the allegations after they were made public, her public humiliation and sense of betrayal is compounded, and the healing is that much more difficult.

Even when the sexually compulsive person intends to give a full disclosure, it often happens that some material is omitted, only to come up later. One reason is that addicts, who typically participate in at least three categories of sexually compulsive behaviors and often more, may simply have forgotten some of their past behaviors. This is particularly true because addictive behaviors are often carried out in what addicts describe as a "trance" or "the bubble," and may not be recalled clearly in the person's more rational state. Another reason is that addicts may not initially realize that some behaviors constituted betrayal or infidelity and need to be revealed. Later in recovery, as they become more honest, they may recognize that these activities need to be disclosed. Finally, a slip or relapse to some extramarital sexual acting out will result in the necessity for additional disclosure.

Early disclosure and a willingness to answer the partner's questions honestly and fully provide the information requested are factors that will make it more likely that the relationship will survive the crisis. A therapist can help facilitate this process. When a partner receives a subsequent disclosure after believing (s)he has been told of everything initially, the impact can be devastating, setting the process of rebuilding trust back for months. The therapist partly forestall this by explaining to the clients that disclosure is not a one-time event, and that it is likely that additional disclosures will be necessary in the future.

*How much to disclose*

Spouses who believe they have received full disclosure are often significantly set back in the process of forgiveness and rebuilding trust if subsequent events prove that only partial disclosure has occurred. In our study, deliberately staggered disclosures – initially revealing only the most benign behaviors, or only those behaviors which the spouse already suspects – is very damaging to the couple's efforts to rebuild the relationship. On the other hand, the betrayed partner often wishes to know "everything," in the false believe that increased knowledge will provide increased control over the addict's behavior. In reality, however, details about the nature of the sexual activities, the number of times and places, etc. may be replayed over and over again in the partner's head and may interfere with recovery. We have found that what is most helpful for the restoration of the relationship is for addicts initially to disclose at least the broad outlines of *all* their significant compulsive sexual activities, rather than holding back some damaging material. However, because early on, the partner tends to want 'all the details,' we recommend that the partner discuss with a counselor or therapist what details are really important to know and what the likely effect will be on the partner. One effective tool is to ask the partner to write a list of every question to which (s)he wants a detailed answer, and elicit a promise from the addict to reply fully at some particular time in the future, say one or three months. The therapist then puts the list away and retrieves it at the later session. By that time, it is hoped, the couple will have made some progress and the partner's need to know "everything" will have abated.

A precaution is in order here: When a sexually exploitative professional has had a sexual relationship with a patient or client, the professional must take care to respect that person's confidentiality to the largest extent possible during disclosure to the spouse. Ideally, the patient's identity is best kept confidential. In reality, however, if the patient has complained to the professional's licensing body or to legal authorities, her identity is likely to be known already.

*Special issues for sexually exploitative professionals and their spouses*

In any marriage, disclosure of infidelity by one person creates an immediate personal crisis for the other. Partners of sexually exploitative professionals have additional factors to contend with. The professional's misconduct is often made public, and the spouse's reaction is closely observed -- by the professional's patients or clients, by the congregation, or by the public. It is traditional for the wife to "stand by her man" in such situations. The professional's wife typically plays out this scenario no matter what her inner turmoil. Later she may experience additional anger over having been "forced" to assume this role.

Another factor for professionals' spouses is often their very real financial dependence on the professional. The professional's lost income, the cost of psychological assessment and therapy for the misconduct, legal costs of defending against lawsuits arising from the misconduct, and the recent decisions by medical and psychological malpractice insurance carriers to exclude from malpractice coverage the cost of fighting sexual misconduct lawsuits, all may combine to create a financial crisis for the family. It is understandable that many

spouses choose to defend the exploitative professional rather than leave, no matter what their feelings.

The sexually exploitative professional's spouse is often seen by the victim(s), the media, and by the professional's patients or clients as an extension of the perpetrator rather than as a secondary victim. Spouses of exploitative ministers have related being ostracized by their congregation because of their husbands' behavior (Legg & Legg, 1995). At the time that the spouse most needs a support system, her community tends to cut her off and isolate her. Her only support, in fact, seems to be her husband.

Faced with the knowledge of her husband's betrayal, compounded by isolation from the community, the spouse's fears of abandonment from childhood become reactivated at this time. To protect herself, she may view this as the time to fight for the survival of her marriage and her lifestyle by suppressing her own needs, fears, and anger, and actively supporting her husband, rather than asking for the emotional support that she so badly needs. For example, she may be too invested in protecting her husband to be willing to open up and reveal their real problems and marital difficulties, much less her own negative feelings, during family therapy sessions (Irons & Schneider, 1999).

**Conclusions**

Following disclosure of extramarital sexual behaviors, threats to leave are common and are part of the way partners cope with their distress rather than a realistic outcome for most couples. Threats to leave the relationship in the aftermath of affairs or extramarital sexual activities are often not carried out, even when the betrayal has been extensive. Inpatient facilities, and therapists in general, are advised to assist the betrayed partner as well as the compulsive person with the disclosure as part of a process of healing. Disclosure is a process rather than a one-time event. Nonetheless, it is most helpful if the initial disclosure includes at least a broad outline of *all* the discloser's sexual behaviors.

Sexually exploitative professionals face particular issues related to the fiduciary nature of their professional relationships and their high status in the community. Consequences of their behavior often involve the humiliation of public exposure, loss of community status, loss of career, and at times loss of freedom. The spouse is expected to publicly support the perpetrator and to keep the family together while the perpetrator is receiving treatment or even is incarcerated. Spouses of sexually exploitative professionals need recognition by treatment professionals that they too need a great deal of support and healing.

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## Table 1: Occupations of Respondents [N=191]

Licensed helping professionals 46 (24.%)

Other regulated professionals 40 (21%)

Other employed (CEOs, trades, etc.) 82 (43%)

Non-wage earners 23 (12%)

**Table 2 : Outcome of threats to leave (n = 47)**

Never left: 34 (75.6%)

Partner did not follow through with threat 17 (37.8%)

Addict and/or partner got help 17 (37.8%)

Left: 11 (24.4%)

Reconciled: 7 (15.5%)

Divorced or still separated 4 (8.5%)