How Much Will Hypnotherapy Reduce Trauma Symptoms of Partners of Sex Addicts?

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Abstract

Though partners of sex addicts experience significant distress in response to the betrayal behaviors of sex addicts, little research attention has been directed to these clients. They often present with trauma symptoms and many qualify for Posttraumatic Stress Disorder. This article explores the use of hypnotherapy to treat trauma symptoms. Research results show that a combination of Cognitive-behavioral Therapy and hypnotherapy is effective in reducing the frequency and intensity of trauma symptoms. Therefore, this dual approach could be an ideal treatment for partners of sex addicts.

Key Terms: Sex addiction, partners of sex addicts, hypnotherapy, posttraumatic stress
Dedication

This article is dedicated to partners of sex addicts. The hope is that this article will increase awareness for this growing addiction in the United States, encourage more mental health professionals to treat these clients, and stimulate more research in effective treatment protocol for intimate partners of sex addicts.
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How Much Will Hypnotherapy Reduce Trauma Symptoms of Partners of Sex Addicts?

Sex addiction is a growing problem in the United States. Carnes (1991) estimates that one in four adults struggle with sex addiction. Just as chemical dependency clinicians recognize the damage drug and alcohol addiction causes to family and friends of addicts, so must psychotherapists consider the damage done to those close to sex addicts. The fall-out of sex addicts’ behavior is particularly damaging to their intimate partners. And if the majority of these addicts are in a committed relationship, then the number of partners impacted by this addiction could be as high as 25% of the adult population.

Sexual addiction is a relatively new field in research. Hagedorn (2009) observes that little research has been done to find empirically based training protocol for psychotherapists even though there is enough literature to show the legitimacy of this disorder. Even less research attention has been directed to diagnosing and treating the distressing symptoms of the partners of sex addicts (POSA). Partners suffer repeatedly and intensely from the sexual acting out behaviors and dysfunctional belief systems of sex addicts. Many clinicians diagnose them as co-addicts or codependents. Rather than labeling POSA as codependents, it is important to diagnose their distressing symptoms according to the DSM and treat them accordingly.

The purpose of this literature review is to examine the effectiveness of hypnotherapy in reducing the severity and frequency of the distressing symptoms presented by partners of sex addicts. To accomplish this purpose, these questions were used as a guide in this research. How does acting out behaviors of sex addicts impair POSA? How much will hypnotherapy reduce the severity and duration of trauma symptoms in POSA?

This article will examine hypnotherapy, posttraumatic stress, and partners of sex addicts. In the first section, the history of hypnosis is examined. The author will also explore how
hypnotherapy works and the ailments it treats. The second section focuses on posttraumatic stress. What is trauma? What damage does trauma cause? What are effective techniques for treating trauma? The final section takes an in-depth look at partners of sex addicts exploring these topics: What is sex addiction? How does the sexual acting out behaviors of addicts cause trauma for POSA? How does the addiction and trauma treatment models compare? How do clinicians effectively treat the distressing symptoms of POSA?

**Hypnosis**

If one brings the term “hypnosis” up in casual conversations, most likely the responses will be polarizing. Some will love it while others fear it. Despite its long history, its world-wide use and the many research studies that have examined it, hypnosis is still cloaked in mystery for many people. Some fear that the hypnotist can take control of their mind like a Jedi in the movie *Star Wars*. There is no doubt that those who use stage hypnosis to entertain by influencing audience members to quack like a duck reinforce this perception. Despite its controversy, hypnosis has endured from ancient times to modern day because it enables individuals to heal their bodies and minds (Gezundhajt, 2007; Saudi, 2005). To demystify hypnosis, the researcher will recount key historical markers of hypnotherapy, explain how clinical hypnosis works, and document its benefits.

**History of Hypnosis**

Hypnosis has a long, multicultural, and controversial history. Knowing the historical perceptions of hypnosis will help mental health professionals address misconceptions clients may have of this technique. Exploring its historical uses details the diverse ailments hypnosis has been used to treat prior to modern medicine. Understanding its history may also help clinicians
have an idea how hypnosis may be used in the future (David Wark, personal communication, June 2, 2011).

According to Gezundhajt (2007), trance induction can be traced as far back as 3,000 years ago. At that time, Egyptians used it to cure a “broken forehead” (David Wark, personal communication, June 2, 2011). There is evidence of hypnotic experiences in the ancient religious texts of Jews, Muslims, and Christians (Gezundhajt, 2007). In medieval times, written record of the use of hypnosis shifted from the Middle East to Europe. Italians, Germans, and Swiss continued its use for spiritual purposes and to cure ailments (Gezundhajt, 2007). During this era, hypnosis was also given a dark reputation. Christian leaders in Europe defined trance-like states as evil. These spiritual leaders believed that evil spirits possessed those in trance and thus required exorcism (Gezundhajt, 2007). Despite the negative stigma, the practice of hypnosis in Europe continued because of its curative power.

In the midst of the Scientific Revolution, Franz Anton Mesmer (1734-1815) was the first to examine hypnosis from a scientific and medical perspective (Gezundhajt, 2007). Trained as a physician, he opposed the common belief of his time that sickness was caused by demon possession. He rejected the belief that those stricken with disease needed exorcism. Instead, Mesmer believed the source of illness lies with electromagnetism. Electromagnetism is “magnetism developed by a current of electricity” (Merriam Webster, 2011). Mesmer believed an imbalance of electromagnetic fluid within the nervous system caused sickness (Gezundhajt 2007). From this theory, his concept of “animal magnetism” was birthed which also became known as “mesmerism.” Though Mesmer’s theory of animal magnetism was influenced by the science of his time, he in fact traded one superstition with another to explain the origin of sickness and disease.
The focus of treatment for Mesmer’s sick patients was to bring the fluids back into harmony by redistributing them (Gezundhajt, 2007). In order to balance out the fluids, he put patients in magnetically charged tubs of water and influenced them to shake violently while hypnotized. The eccentricity of Mesmer and the bizarre shaking of his patients drew the attention of medical and scientific authorities. After investigating animal magnetism, the medical communities in Vienna and Paris banned Mesmer’s practice. The investigators found no scientific evidence that electromagnetic fluid existed and credited human imagination for those who were cured during Mesmer’s treatments.

Though Mesmer’s practice was shut down, treating sickness with hypnosis continued. The Marquis de Puysegur (1751-1825), a disciple of Mesmer, developed what he called “magnetic somnambulism” (Gezundhajt, 2007). Somnambulism is defined as “an abnormal condition of sleep in which motor acts (as walking) are performed” (Merriam Webster, 2011). Rather than inducing convulsions like Mesmer, de Puysegur induced a deep state of relaxation through the use of calming techniques (Gezundhajt, 2007). Along with relaxation, the success of magnet somnambulism required establishing trust of patients and complete submission to the hypnotizer. He adopted Mesmer’s idea that magnetism played a role in healing the sick. But for de Puysegur, magnetism was produced within his mind and transferred to his patients through his fingertips. Under hypnosis, the “magnetized patient” was directed to diagnose his/her problem, determine treatment, and predict prognosis. Though eventually magnetism theory was discarded, de Puysegur’s therapy more closely resembled modern day hypnotherapy with its focus on building rapport, deep relaxation, and having clients direct the experience.

Soon after Mesmer and de Puysegur, the medical community in the West took a more concentrated interest in hypnosis (Gezundhajt, 2007). In the mid 19th century, John Elliotson and
James Esdaile, used it as an anesthetic to numb patients during major surgery. James Braid, a Scottish surgeon, is credited for rebranding trance induction from the name mesmerism to hypnosis. His inspiration came from the Greek word for sleep, *hypnos.* Braid described hypnosis as “a powerful adjunct that could cure all kinds of ailments” (Gezundhajt, 2007, p. 188).

As the medical community experimented with hypnosis to treat physical ailments, some were applying the technique to the psyche. Jean-Martin Charcot (1825-1893) was the first to use hypnotic trance to treat patients with hysteria (Gezundhajt, 2007). He identified three levels of hypnosis: lethargy, catalepsy, and somnambulism. Two of Charcot’s students went on to play key roles in using hypnosis to treat mental illness: Pierre Janet (1859-1947) and Sigmund Freud (1856-1939). Janet focused his work on “simultaneous psychological existences” which is now termed Dissociative Identity Disorder. He used the somnambulism stage of hypnosis to “replace the hysterical personality with a healthy second one.” Like Charcot and Janet, Freud also used hypnosis to treat hysterical patients, but he took it in a different direction. Freud used the trance technique to recover memories of distressing nature that were believed to be repressed by clients.

Though Europeans played a key role in developing hypnosis for medical and psychological treatment, Saudi (2005) claims the American, Milton Erickson (1901-1980), as the father of modern hypnotherapy. A physician, psychiatrist, and psychologist of the 20th century, Erickson spent his lifetime practicing self-hypnosis, treating his patients with it and teaching the technique to thousands. He rejected the idea that the hypnotic state was a form of sleep and defined it as “…one of intense focusing and concentration” (Saudi, 2005, p. 38). From his belief that therapy should be efficient and effective in reducing troublesome symptoms, he developed brief hypnotherapy. He agreed with his predecessors in assessing hypnosis as a powerful tool in relieving suffering. So convinced of this therapeutic technique, Erickson invested his
professional life in developing and teaching it to other clinicians. He founded the American Society of Clinical Hypnosis, established the American Journal of Clinical Hypnosis, published 300 scientific papers, wrote several books, and treated 30,000 people using hypnotherapy.

**How Does Hypnotherapy Work?**

Exploring the historical background of hypnosis helps in identifying modern day apprehensions of this therapeutic technique. Many of these apprehensions are due to a lack of understanding of what clinical hypnosis is. In an attempt to demystify trance-like states, the author will attempt to define hypnosis, identify the techniques hypnotherapists use to lead clients into trances, and analyze it through scientific means.

Milton Erickson defined hypnosis as a “trance state served to provide a special psychological state in which patients could re-associate and recognize their inner psychological complexities and utilize their own capacities in a manner in accordance with their own experiential life” (Saudi, 2005, p. 39). Hypnosis connects the conscious mind with the resources stored in the unconscious mind. Erickson viewed the unconscious as an endless vault of information where experiences and conclusions of those experiences are stored as well as solutions to current problems (Edmunds & Gafner, 2003).

Barabarsz, Olness, Boland, and Kahn (2010), describe hypnotic trances as imagination combined with suggestions for “focused attention, relaxation, and calmness” (p. 1). They also described hypnosis as “…controlled dissociation, and dissociation, in turn, as a form of spontaneous self-hypnosis” (Barabatsz et al., 2010, p. 45). Self-trance is an ability most people have and utilize usually without knowing it. Common examples of self-trance are day dreaming and highway hypnosis (Delle Jacobs, personal communication, June 2, 2011). Highway trance is driving to a routine location without recalling how one got to the destination. Another example
of trance is racing to the bus stop without being aware of an irritated blister on the heel caused by a pebble in the shoe.

The role of the therapist is to guide clients into a trance and then offer suggestions that invite them to utilize their own inner resources to produce the desired change (Saudi, 2005). The key to hypnosis’ effectiveness lies with calming the brain down and suggesting the change clients seek. Unlike entertainment hypnosis, in clinical hypnotherapy clinicians do not control clients. Therapists are simply guides to the door of their clients’ unconscious minds. Once the door is open, clients are invited to take the lead. Clinicians should always consult with clients prior to trance induction on what result clients want from each hypnosis session. It is important that clients be in control of their hypnotic experience.

This technique will not succeed without first establishing good rapport. As de Puységur observed, developing good rapport with clients is necessary for guiding them into trance (Gezundhajt, 2007). Because their defenses are lowered, clients are in a vulnerable state during hypnosis. Building trust and educating clients on clinical hypnosis is vital. Clients also become more suggestible, the more they trust their therapists (Jack Rusinoff, personal communication, June 2, 2011).

The first thing clinicians should do before using this technique is to ask clients what knowledge and experiences they have of hypnosis (Peggy Trezona, personal communication, June 2, 2011). It is a good idea to address fears and misconceptions of hypnosis before guiding people into trance. Common misconceptions of clinical hypnosis are:

- hypnotist is in control, not client
- people can be forced to act against their will
- hypnosis is a “truth serum”
• people can get lost in trance and not come out
• people will experience lack of awareness, loss of consciousness, or sleep
• real hypnosis produces amnesia
• hypnosis is for the weak-minded and gullible

Therapists should be prepared to explain the difference between entertainment hypnosis and clinical hypnosis. Entertainment hypnotists are in control of the trance experience from start to end. They chose audience members who are highly hypnotizable to go into a deep trance with the goal of entertaining the rest of the audience. These entertainers may unintentionally cause psychological harm to those with a history of severe trauma because the control they have over their subjects may mimic the control abusers had over them (Peggy Trezona, personal communication, June 2, 2011).

In clinical hypnosis, Peggy Trezona (personal communication, June 2, 2011) says clients can expect to be in control throughout the trance, come out of trance whenever they want, and to have a relaxing, calming experience. It is helpful to explain to clients that they can expect to have part of them observe themselves in trance while another part experiences relaxation and trance. Clients decide what suggestion they want to receive while in trance. To further demystify hypnosis, therapists can give examples of common self-trance experiences they may already unknowingly utilize such as highway trance and day dreaming.

For clients who are new to hypnosis, Barabasz et al. (2010) recommend describing the hypnotic experience “as being very much like the experience one may have when absorbed in a good book, a movie, or even watching cloud shapes change in the sky” (p. 3). The author recommends giving clients an introductory hypnotic experience by guiding them into trance for about 10-15 minutes with the only suggestion being to calm the mind and body. The purpose of
this initial hypnotic session is to give clients a pleasurable experience and to demonstrate the power of their mind to produce a relaxed state in a short amount of time. The introductory experience can also give them an opportunity to test clinicians to see if they are trustworthy when in a vulnerable state. After each hypnotic session, it is important to debrief with clients. Clinicians should ask what their overall experience was. Knowing what was helpful or not helpful during their trance experience can help clinicians tailor future hypnosis sessions to meet the individual needs and preferences of clients as well as sharpen the skills of therapists.

Trance can be induced in limitless ways. A hypnotic trance can be induced by looking at one’s hands and noticing the lines of the fingerprint or noticing one’s breathing pattern. The most well-known trance induction is watching the pocket watch swing back and forth. Another example of trance induction the author has found to work well for most people is incorporating multiple senses. Clients would be directed to focus on an object in the room observing its shape, color, and depth. Then, clients can be guided to focus on a sound noticing its volume and pattern. Finally, clients are asked to focus on an inner sensation and describe it in their minds.

When guiding others into trance, it is important for clinicians to be aware that each client will have differing hypnotizabilities (David Wark, personal communication, June 2, 2011). Some will be highly hypnotizable entering into trance quickly and easily. Others will have mild to moderate hypnotizability and may take longer for them to calm their minds. Barabatsz et al. (2010) mention reports done by Bryant, Guthrie, Moulds, Nixon, and Felmingham (2003) that clients suffering from Posttraumatic Stress Disorder tend to be moderately high in hypnotizability. Clients suffering with phobias, eating disorders, and sleep problems are also tend to be highly hypnotizable (Shep Myers, personal communication, June 3, 2011). Those with schizophrenia, General Anxiety Disorder, and Obsessive Compulsive Disorder tend to have
lower hypnotizability (Shep Myers, personal communication, June 3, 2011). Though it may take longer for clients with mild to moderate hypnotizability to enter trance, they can be guided into hypnosis if they trust the clinician.

Charles Tart (1970) developed a susceptibility scale to measure how deep clients are in trance (Shep Myers, personal communication, June 3, 2011). The Tart Scale is a 11 point scale with zero being awake and alert and 10 meaning one can do anything suggested (Shep Myers, personal communication, June 3, 2011). While in trance, clinicians ask clients to rate how relaxed they feel. Therapists can also look for change in skin tone, breathing, and response to suggestions to determine how deep in trance clients might be (Shep Myers, personal communication, June 3, 2011). For mild to moderate hypnotizable clients, clinicians can do deepening technique to guide clients into a deeper state of hypnosis. A commonly used deepening technique is asking clients to imagine a staircase with the clinicians counting each step the clients walks down (Mark Weisberg, personal communication, June 3, 2011).

After they are in a state of relaxation and calmness, then clinicians can introduce suggestions clients have requested or invite clients to go wherever their unconscious minds wants to take them. Balugani (2008) found that the hypnotic experience is more effective if the imagery within the trance is tailored to clients’ knowledge and ability. “…The more he/she is familiar with the imagined precept, the more vivid his/her representation” (Balugani, 2008, p. 35).

There is considerable support from research demonstrating the effectiveness of hypnosis (Barabasz et al., 2010). So what actually happens in the brain when one is hypnotized? In an effort to answer this question, Fingelkurts, Fingelkurts, Kallio, and Revonsuo (2007) studied the brain of a 39-year-old woman while under hypnosis using an electroencephalogram (EEG). The
subject’s brain was examined before hypnosis, during trance that did not involve suggestion, and after induction. The results of the study showed that hypnosis markedly reorganized brain activity with the majority of the neural activity occurring in the right hemisphere (Fingerlkurts et al., 2007). The right side of the brain stores memories of what one does or sees and tries to fit the pieces of information into a whole picture (Centre for Neuro Skills). This study shows that hypnotherapy reorganizes brain activity. However, more research is needed to explain the significance of the neural activity changes.

**Benefits of Hypnosis**

The benefits of hypnosis are diverse. It has been used to treat a multitude of ailments from physical illness to mental disorders. Hypnotherapy can effectively and efficiently get to the root cause of psychological ailments with minimal resistance from clients (Edmunds & Gafner, 2003). Research proves hypnotherapy reduces pain (Millings, Kirsch, Allen, Reutenauer, 2005). Hypnosis is a useful tool in reducing stress and anxiety (Barabasz et al., 2010). It is effective in calming the mind and body in a short amount of time (David Wark, personal communication, June 2, 2011). Hypnosis’ ability to create calmness and relaxation so quickly can create a sense of control over one’s own mind and body. It can shift clients from a negative to positive state and access their inner resources to create change (Delle Jacobs, personal communication, June 2, 2011). Another asset of hypnosis is that can be taught to clients so they can use it on their own to manage their mental and physical heath long after psychotherapy ends.

The conditions hypnotherapy can treat are widespread. Erickson used hypnotherapy for “psychosomatic disorders, sexual problems, speech, pain, terminal illness, panic, obstetrics, pediatrics, migraine, depression, autohypnosis, sports performance issues...” (Saudi, 2005, p. 42). Hypnosis can be used to improve job performance such as taking exams (David Wark, Personal
Hypnotherapy can tap into the body’s natural healing ability to treat these other medical conditions: asthma, cystic fibrosis, irritable bowel syndrome, fibromyalgia, hemorrhage in surgery, hemophilia, insomnia, and warts (David Wark, Personal Communication, June 2, 2011). It has been used to change behavior patterns such as smoking cessation and anxiety with public speaking (David Wark, Personal Communication, June 2, 2011). This technique has also been used to treat victims of childhood sexual abuse and Posttraumatic Stress Disorder (Edmunds & Gafner, 2003; Wai-ling Poon, 2007; Barabatsz et al., 2010).

Clinicians can use hypnosis to prepare clients to process traumatic events. It aids in creating a safe environment where clients feel in control as well as strengthening weakened psyches (Kingsbury, 1992; Wai-ling Poon 2007). Trances can tap into their past successes and inner strengths to increase a sense of empowerment. While hypnotized, clients control where they go within their unconscious realm (Degun-Mather, 2001). When they acquire enough resources, hypnosis can enable clients to face traumatic memories that need to be processed as well as transform those troublesome memories (Wai-ling Poon, 2007; Edmunds & Gafner, 2003).

Self-hypnosis is common, universal, and often practiced unknowingly. Any practice that leads to a deep state of relaxation and focused concentration can be a form of self-hypnosis (Saudi, 2005). When Milton Erickson was a teenager he unknowingly used self-hypnosis to cure his paralyzed body. After contracting polio at the age of 17, he was told by his doctor that he would die the next day (Saudi, 2005). Not only did Erickson defy death, he also used his mind to empower himself to walk again. Describing that day, Erickson said,
I lay in bed without a sense of body awareness. I couldn’t even tell the position of my arms or legs in bed. So I spent hours trying to locate my hand or my foot or my toes by a sense of feeling and I became acutely aware of what these movements were (Saudi, 2005, p. 41).

Ten years later, Erickson could walk without a limp (Saudi, 2005). Through his own experience with self-hypnosis, he was convinced that the human mind has the power to reduce pain and to heal the body and mind even when the odds are against it.

Summary of Hypnosis

The natural healing ability of the human body and mind is tapped into by hypnosis. The key to the usefulness of clinical hypnosis is that lowers defense mechanisms that can get in the way of healing. By tapping into the vast resources of their unconscious minds, people may have the potential to overcome physical and emotional suffering and to restore the body and mind to an improved state of health.

Whatever method leads to intense focusing and concentration could lead one into a hypnotic state. There are constructive means of trance induction, like self-hypnosis, prayer, mediation, and yoga. There are also dangerous methods such as drug use and abuse (Spiegel, 1988). The methods for entering into trance are endless.

The concepts associated with hypnosis share common ground with the Adlerian technique of early recollections and the concept of the purpose of symptoms. Adler viewed early memories as reminders of important conclusions drawn from specific experiences (Griffith & Powers, 2007). Like hypnosis, the technique of early recollections can be used to transform painful and traumatic memories by helping clients re-narrate them (Susan Brokaw, personal communication, April 22, 2010). Instead of traumatic experiences being the central focus of their
lives, early recollections and hypnosis can re-process those experiences so that they become just one chapter in the story of their lives. Milton Erickson aligns with Adler’s belief that symptoms have a purpose. Adler saw symptoms as providing a purpose of avoiding something or protecting one’s self-esteem (Mosak & Maniaci, 1999). Similarly, Erickson believed that the behaviors of clients could be part of the problem; he used hypnosis to uncover the unconscious motive for choosing particular behaviors or symptoms (Saudi, 2005).

The case studies of Kinsbury (1992) and Wai-ling Poon (2007) in treating trauma victims with hypnosis are worthy of attention. The research of Fingerlkurts et al. (2007) show a promising finding of how hypnosis changes the brain. However, these studies need larger sample sizes and control groups to provide more conclusive data on the helpfulness of hypnotherapy in treating trauma.

Hypnotherapy is a powerful tool that has the potential to reduce painful symptoms and relieve suffering for a variety of conditions. It is also an effective method of reducing stress and anxiety. Once trust is established with clients, hypnosis has the potential to produce change quickly (Barabatz et al., 2010). Despite these assets, Wai-ling Poon (2007) identifies a limitation of hypnosis worth noting—not all people are hypnotizable. For those who are highly dissociative, there may be limitations as well. Though they are highly skilled at self-trance, they are more likely to fear not being able to come out of trance. Highly hypnотizable people may also feel a lack of control when being guided into trance because they so easily dissociate. Another limitation could be previous negative experiences with hypnosis, such as with entertainment hypnosis.

As powerful as it is in bringing healing and restoration to many who can be guided into trance, it can be equally destructive. Clients put themselves in a vulnerable place when
hypnotized because their defenses are lowered. It is important to remember that defenses are employed for survival and preservation purposes. If hypnotists abuse their power and cross ethical boundaries when clients’ defenses are lowered, they could cause serious damage. Allowing clients to control the pace and direction of hypnotherapy will avoid the abuse and misuse of hypnotized clients. To use this technique ethically, clinicians should not pressure hesitant clients to experience hypnosis. And for clients who are comfortable with it, therapists should always consult with them asking what specific suggestion they want to receive while in trance.

Throughout history and in the present time, many have relied on self-hypnotic trances as survival mechanisms when traumatized. The next section of this article will seek to explain what constitutes as a traumatic event. The distressing symptoms caused by trauma which individuals seek to dissociate form will also be examined.

Posttraumatic Stress

Trauma is common. Eighty-nine percent of Americans have been exposed to trauma (Solomon & Johnson, 2002). Nearly everyone will experience trauma during their lifetime. Many who encounter mild to moderate trauma often have the resources to independently recover. However, severe trauma can cause chronic distressing symptoms that require professional intervention in order for healing to take place. To better understand trauma, the author will explore what trauma is, the damage it causes, and effective treatment for it.

What is Trauma?

Kingsbury (1992) defines trauma as experiences that overwhelm a person’s coping mechanisms. “One may talk of the defenses being breached or adaptive behaviors being inadequate, but the basic concept is that the person is overwhelmed” (Kingsbury, 1992, p. 86).
When defense mechanisms fail to adequately address traumatic experiences and a sense of safety is not restored, traumatic stress symptoms are unconsciously implored for survival. Because they are overwhelmed, trauma survivors often separate the trauma from their conscious mind, or dissociate. Despite the attempt to avoid the distressing event, trauma victims still seek out resolution for the trauma, which results in nightmares and flashbacks as their unconscious mind tries to process the turmoil.

Spiegel (1988) adds another component to the definition of trauma. He defines the traumatic experience as one of objectification. “Trauma can be understood as the experience of being made into an object: the victim of someone’s rage, of one’s own limitations, of nature’s indifference” (Spiegel, 1988, p. 18). For traumas caused by people, the objectification of victims discounts their intrinsic worth as a human being. Their rights to set safe boundaries for themselves are violated as perpetrators invade them. For example, rape victims are made into sex objects and combat vets into killing machines (Spiegel, 1988). “The essence of the trauma experience is that it leaves people in a state of unspeakable terror” (Van der Kolk, 1988, p. 282).

Severe cases of trauma may result in Posttraumatic Stress Disorder (PTSD). To receive a PTSD diagnosis, the first qualifier is the person must be exposed to a traumatic event. The exposure could be direct or second-hand. The DSM categorizes trauma into one of three categories: 1) directly experiencing a distressing event that involved death, threatened death or serious injury, 2) witnessing another person experiencing a traumatic event as described in category one and 3) learning about a traumatic event as described in category one that happened to a close friend or family member (APA, 2000). Symptoms that qualify for a PTSD diagnosis include:

1. Feelings of intense fear, helplessness or horror
2. Re-experiencing traumatic event through dreams or flashbacks
3. Persistent avoidance of whatever reminds one of the distressing event
4. Increased arousal such as sleep problems, irritability or anger outburst, hyperalertness, difficulty concentrating, or exaggerated startle response (APA, 2000, p. 468).

These symptoms must be present for more than one month and cause obvious distress or impairment at work or socially (APA, 2000).

Traumatic experiences can range from mild to severe. Though one can recover independently from mild trauma, it is not the case for those experiencing severe or repetitive trauma (Kingsbury, 1992). People with severe trauma most likely will need professional intervention in order to heal. Examples of events that are commonly understood to cause severe trauma are “domestic violence, combat, rape, child abuse, accidents, terrorism, and disaster” (Solomon & Johnson, 2002, p. 948). Other traumatizing events could be the diagnosis of a life-threatening illness, the sudden death of a loved one, kidnapping, job loss, divorce, home break-in, witnessing murder, assault, and bullying. Any threatening event or experience that overwhelms a person’s coping mechanisms resulting in the inability to restore a sense of safety can result in psychological trauma.

**Damage Caused by Trauma**

The damage trauma inflicts can be devastating. Traumatic events can seriously harm the mind and body. Without intervention, those severely traumatize may suffer lifelong with “…poor affect regulation, hyper-arousal, intrusive experiencing, self-destructive behaviours, unmodulated sexual involvement and other psychological as well as psychiatric problems” (Wai-
ling Poon, 2007). As a result of the traumatic event, they often suffer from shame, guilt, sadness, anger, and fear (Ehlers & Clark, 2008; Spiegel, 1988).

Unresolved trauma can cause significant social impairment. Spiegel (1988) says it is difficult for trauma suffers to develop and maintain intimate relationships. Intimacy may trigger the intense emotions associated with the traumatic event. “The development of intimacy involves stirring strong feelings of love and hatred” (Spiegel, 1988, p. 20). They have decreased capacity to balance intimate relationships becoming too dependent or too independent (Van der Kolk, 1998). Victims of trauma also struggle with discerning if demands from others are appropriate or inappropriate (Van der Kolk, 1998). In some cases trauma sufferers may act out their extreme anger projecting it unto their loved ones resulting in domestic violence. The impairment trauma causes may also result in social isolation (Spiegel, 1998).

Traumatic experiences also cause cognitive impairment (Van der Kolk, 1998). “The increased physiological arousal of traumatized individuals decreases their capacity to adequately assess the nature of current challenges, and interferes with resolution and integration of the trauma” (Van der Kolk, 1988, p. 284). Trauma victims tend to tolerate stress poorly. They tend to have an all-or-nothing reaction. And they tend to respond to stressors with high anxiety and with social and emotional withdrawal.

A recent study was done on the effect of stress on the brain. Yale researchers that found even healthy individuals experiencing stressful events have reduced brain function (Hathaway, 2012). Using magnetic resonance imaging scans, they examined the brains of 103 healthy subjects who had experienced a distressing event such as death of a loved one, job loss, divorce, or loss of home due to natural disaster. They discovered “…markedly lower gray matter in portions of the medial prefrontal cortex, an area of the brain that regulates not only emotions and
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self-control, but physiological functions such as blood pressure and glucose levels” (Hathaway, 2012, para. 4).

The physical damage traumatic stress causes can be widespread. Psychological trauma can suppress the immune system and increase stomach acids and tumor growth (Van der Kolk, 1998). It can cause an imbalance in hormones resulting in chronic noradrenergic hypersensitivity, chronic low serotonin, and high cortisol, which may contribute to feeling a loss control over one’s life (Van der Kolk, 1998). Chronically high levels of cortisol causes “…high blood pressure, insomnia, anxiety, depression, frustration, anger, tension, depress the immune system and increase risk of heart disease, diabetes and stomach ulcers” (Steffens & Means, 2006, p. 98). Because of its destructive effect on the body, trauma sufferers are likely to present with physical health problems with some being chronic.

Trauma symptoms are grouped into two clusters: intrusive and avoidance (Kingsbury, 1992). The two clusters of symptoms are opposing forces. The avoidance symptoms seek to dissociate from the trauma, while the intrusive symptoms seek to process it (Kingsbury, 1992). To avoid places, people, or things that trigger the traumatic experience, clients will choose denial, go to great lengths to physically stay away from triggers, or push the trauma memory into the unconscious mind in an attempt to forget. Another way victims dissociate from trauma is by the avoidance of emotional expression (Spiegel, 1988). Because trauma victims desperately seek to separate themselves from the cause of their intense fear, helplessness, or horror, it leaves their unconscious mind to try to make sense out of the trauma. This results in intrusive nightmares and flashbacks.

Though victims employ traumatic stress symptoms in an attempt to create a sense of control and safety, the symptoms not only become troublesome but also destructive. For
example, the avoidant behaviors of trauma victims could increase intrusive dreams or flashbacks (Ehlers & Clark, 2008). These disturbing dreams and flashbacks can keep trauma sufferers in a heightened state of anxiety and stress reducing their overall quality of life. Intrusive symptoms keep them stuck in a cycle of re-experiencing the disturbing event. These distressing symptoms can also lead to a loss of control over one’s own mind, resulting in more severe psychological conditions such as amnesia or fugue and, in extreme cases, can cause Dissociative Identity Disorder (Spiegel, 1988).

If these traumatic experiences are not reprocessed and worked through, trauma suffers can be mentally and emotionally frozen in time. Sounds, symbols, or visual cues may trigger the traumatic event resulting in involuntary arousal as if one is experiencing the distressing event again (Van der Kolk, 1988). Experiences that trigger the trauma will bring victims back to that moment in time when their defenses were breached and they were objectified. They relive the past trauma as if it is occurring in the present. In addition, new traumatic experiences can also trigger past trauma. Even after clients effectively process past traumas, the intense emotions associated with them can resurface when new trauma occurs.

**Treatment for Trauma**

In order to effectively treat the pervasive damage trauma causes, it is important for clinicians to first assess for current and past traumatic experiences. Clinician Administered PTSD Scale for DSM-IV (CAPS) is a diagnostic tool designed to assess for the 17 features of PTSD (Blake, Weathers, Nagy, Kaloupek, Klauminzer, Chamey, Keane, & Buckley (2000). It is considered the “gold standard” in assessing trauma (S. Greene, Personal Communication, January 2012). In the CAPS’ manual, Blake et al. (2000) instruct clinicians to start the assessment by giving clients the Life Events Checklist. It lists 16 events commonly understood
to cause trauma such as assault, serious accident, and natural disasters. Clients are instructed to rate the three worst events. For each of these three events, clinicians ask in-depth questions for each of the four criteria of PTSD. The next step is to measure the frequency and intensity of each of the 17 features of PTSD (Foa & Tolin, 2000).

As with any assessment tool, CAPS has strengths and weaknesses. An important strength of this tool is its high reliability in diagnosing PTSD in the civilian and veteran population (Blake et al., 2000). It also measures symptom severity so it can be used to track therapeutic change. In addition to PTSD, it can diagnosis a less severe condition, Acute Stress Disorder. A weakness of the CAPS assessment is that it is time-intensive for both the clinician and client (Foa & Tolin, 2000).

After assessing clients with traumatic stress, treatment can begin. To recover from traumatic stress, three elements are needed: a sense of safety, a sense of control, and reprocessing the traumatic event. Creating a sense of safety and control is vital for healing from trauma (Kingsbury, 1992; Solomon & Johnson, 2002). Building a safe therapeutic environment means counselors need to be patient in developing trust with victimized clients. It could also mean helping clients get out of unsafe situations whether that be living arrangements, jobs, and relationships. If clients are unwilling or unable to get out of unsafe situations, it may be best to wait to start reprocessing the trauma event until they can be in a safe environment (H. Laube, Personal Communication, April 2011).

The second key component to treating trauma is restoring a sense of control. Spiegel (1988) says the traumatic event robs victims of a sense of control over their lives. That loss of control leads to the anxiety and intrusive symptoms of PTSD (e.g. sleep problems, increased arousal, angry outburst, etc.). Though traumatic events are significant experiences, resolving
psychological trauma means clients shift these events from the main story line to just one chapter of their lives. In therapy, a sense of control can be restored by helping clients integrate traumatic experiences into their larger life stories (Spiegel, 1988).

Some practical ways of creating a sense of control for trauma sufferers are psychoeducation, hypnosis, utilizing strengths, and shifting their focus on what they have control over. Educating clients about trauma can help them recognize the source of their troubling symptoms as well as the process for recovery. “Ironically, hypnosis, a technique long associated with fears of losing control, can be especially effective in helping such patients regain control over traumatic memories and their effects” (Spiegel, 1988, p. 18). When clients feel their distressing symptoms are in control of them, clinicians can guide them through hypnosis to go to a place where they feel a sense of control. This practice could help clients experience the power within themselves to tap into inner resources when faced with trauma. Hypnosis is also a useful tool in reacquainting clients with their strengths and inner resources they have that can help them to process the trauma.

Integration of the traumatic event happens by incorporating the third element needed for treating trauma—reprocessing the distressing event in a way that does not re-traumatize clients. Regardless of technique, Solomon & Johnson (2002) says PTSD sufferers will not recover if they do not emotionally process their trauma memory in a sustained way. Treating the trauma symptoms is an important aspect of creating a sense of control. However, symptom management will not provide lasting relief. Reprocessing psychological trauma is vital for recovery. Spiegel (1988) says recalling the trauma and expressing emotions associated with it is not enough for restoration; clients must also put the trauma into proper perspective.
…most trauma victims blame themselves inappropriately for bringing the traumatic event upon themselves. Therefore, teaching them in psychotherapy to accept responsibility for the event only further reinforces their denial of the absolute helplessness they experienced at the moment of trauma, and reinforces rather than relieves inappropriate guilt related to the trauma” (Spiegel, 1988, p. 18).

For clients to stop taking responsibility for the harmful event means accepting the reality that other forces are capable of violating their sense of safety and inflicting an immense amount of destruction on them. And it will help shift their energy unto recovery.

The traumatic event constitutes a huge loss. To recover, it is important for clients to find meaning in the loss (Spiegel, 1988; Botella, Osma, Palacios, Guillon, Banos, 2008). As with any significant loss, grief work can help clients find that meaning. Though each person will have a unique grief journey, there are five characteristics common to all who experience loss: denial, anger, bargaining, sadness or depression, and acceptance (Kubler-Ross & Kessler, 2005). Educating clients on these five stages helps them recognize when their trauma is surfacing and when attention needs to be given to process it. Assisting clients in identifying the varying forms of denial is particularly important since the avoidance cluster of symptoms play a central role in traumatic stress. A common form of denial is victims blaming themselves for the disturbing event; it serves the purpose of avoiding the intense feeling of helplessness (Spiegel, 1988). Acting as if the event happened to someone else could also be a form of denial (Spiegel, 1988). Another example could be avoiding anything and anyone that reminds the person of the disturbing event.

Solomon & Johnson (2002) say several therapeutic approaches treat PTSD. These therapies include cognitive-behavioral approaches (e.g. exposure therapy, cognitive processing,
eye-movement desensitization and reprocessing, and anxiety management), psychodynamic, hypnotherapy, group therapy, crisis intervention, and drug therapy. They found that most of these approaches are helpful in reducing trauma symptoms. Cognitive and psychodynamic approaches were most effective in reducing the avoidance cluster of symptoms, while exposure through imagination and hypnosis are most effective in treating the intrusive symptoms (Solomon & Johnson, 2002).

In their research, Solomon & Johnson (2002) found cognitive and behavioral approaches to have the strongest evidence based support for treating PTSD. The cognitive approach is useful in identifying mistaken beliefs associated with trauma (Solomon & Johnson, 2002; Spiegel, 1988). Because irrational thoughts fuel the troublesome symptoms, identifying these mistaken beliefs is vital to treating PTSD. As mentioned earlier, a common mistaken belief for trauma survivors is that they are responsible for the disturbing event (Spiegel, 1988).

Solomon & Johnson (2002) also point out that among all the treatment approaches to PTSD, cognitive-behavioral therapy (CBT) has received the most research attention. As part of CBT, exposure therapy can be a useful technique, but it can also re-traumatize those who are living in unsafe situations such as domestic violence or those regularly working in crisis situations, such as emergency personnel. It is also important to note that none of the approaches have been studied to determine long-term effectiveness.

Ehlers & Clark (2008) advocates trauma-focused CBT as the most effective treatment for PTSD. They found the techniques of prolonged exposure, cognitive reprocessing, and eye-movement desensitization and reprocessing to be superior to hypnotherapy. Sixty-seven percent of trauma sufferers who complete trauma-focused CBT treatments experienced reduced symptoms so much that they no longer met the criteria for PTSD. However, they also
acknowledge that 25-33% of clients drop out of therapy because CBT techniques were too difficult to tolerate.

Though research done by Solomon & Johnson (2002) and Ehlers & Clark (2008) support CBT as the most effective PTSD treatment, others advocate for hypnotherapy as the treatment of choice. Spiegel (1988) says hypnosis treatments are particularly effective when they are applied soon after the traumatic event. Those suffering from PTSD are often highly hypnotizable because they have previously employed dissociation as a coping mechanism (Kingsbury, 1992; Edmunds & Gafner, 2003; Degun-Mather, 2001; Spiegel, 1988; Barabasz et al., 2010). One enters an alternate state of consciousness in hypnosis as one does when dissociating from psychological. “Hypnosis is thought of as controlled dissociation, and dissociation, in turn, as a form of spontaneous self-hypnosis” (Barabasz et al., 2010, p. 45). Hypnotherapy allows clients to utilize their dissociative ability in a controlled way so that they can process their trauma without being re-traumatized (Kingsbury, 1992; Spiegel, 1988).

The split screen technique of hypnotherapy is often used to create a sense of control while working through trauma (Spiegel, 1988; Wai-ling Poon, 2007; Barabasz, 2010). Clients are asked to visualize a safe place while in trance. Once that safe place is established and clients are relaxed and have a sense of control, they simultaneously visualize the trauma and a safe place. The split screen technique allow trauma sufferers to process it a portion at a time. Kingsbury (1992) says hypnotherapy can eliminate the troublesome nightmares and flashbacks. As clients work toward resolution of their trauma, these distressing symptoms are no longer needed and so their intrusive symptoms decrease. Using a hypnosis technique like the split screen can enable clients to restore a sense of control over their minds (Spiegel, 1988).
Hypnosis can also strengthen the self-concept along with building a sense of control. A key asset to hypnotherapy is that it can internally strengthen trauma survivors in preparation for working through the trauma event. To strengthen their self-concept, Edmunds & Gafner (2003) say clients can be given a suggestion while in a trance like this, “You have the strength needed to successfully face challenges.” Before beginning the work of reprocessing the trauma, establishing a sense of control is necessary to avoid overwhelming their coping mechanisms. Hypnotherapy allows them the freedom to go at a pace they can handle.

In addition to building safety, establishing a sense of control, and strengthening the self-concept, hypnosis can also transform or restructure trauma memories (Edmunds & Gafner, 2003; Spiegel, 1988). “Trance allows patients freedom to tailor the message within the story to the most helpful and personalized conclusion” (Edmunds & Gafner, 2003, p. 217). Through hypnosis, the conscious and the unconscious can join forces to re-narrate the conclusions drawn from the trauma. While hypnotized, clients can employ inner resources that can help see the trauma from a different, more empowering perspective. Another asset of hypnotherapy is that therapists can teach self-hypnosis so that they can continue to process their trauma outside of therapy (Spiegel, 1988). When practiced regularly, self-hypnosis has the potential to provide symptom relief quicker and speed up the recovery process.

Edmunds and Gafner (2003) reported a study done by Brom, Kleber and Defares (1989) that found hypnosis to be as equally effective in treating trauma as psychodynamic therapy and anxiety management. The benefit of hypnotherapy over some other trauma techniques, such as exposure therapy, is it addresses trauma symptoms in a gentler way and thus gives clients a greater sense of self-control (Edmunds & Gafner, 2003). Because hypnosis gently explores overwhelming emotions, it may encounter less client drop-out rates compared to CBT.
Because of the two cluster symptoms of PTSD, trauma victims most likely will need a dual approach in therapy. A potent treatment approach for these clients seems to be a combination of CBT and hypnotherapy (Degun-Mather, 2001; Wai-ling Poon, 2007). Research done by Kirsch, Montgomery, and Sapirstein (1995) shows hypnosis to be 70% more effective when combined with CBT. Together CBT and hypnosis treat both useful with intrusive symptoms. Wai-ling Poon (2007) used CBT and hypnotherapy to treat a woman with PTSD suffering from childhood sexual abuse. Hypnosis was used “for grounding and stabilizing the overwhelming emotions; for addressing the negative self-schema; and also for re-processing the traumatic memories in a safe and controlled way” (Wai-ling Poon, 2007, p. 30). CBT was used to teach the client affect management training by identifying her feelings, connecting them to experiences, and teaching her how to resume a calmer state (Wai-ling Poon, 2007). The result of combining these two approaches was a significant reduction of her symptoms so that she no longer met the criteria for PTSD (Wai-ling Poon, 2007).

**Summary of Posttraumatic Stress**

Fortunately, there are several approaches that successfully treat trauma. The most effective treatment for PTSD appears to be a dual approach. Hypnosis alone may be insufficient in treating trauma. But, when combined with CBT, hypnotherapy can be an ideal approach. Hypnosis treats the intrusive clusters symptoms and utilizes dissociative ability of trauma sufferers, while CBT is useful in treating the avoidant symptoms and identifying mistaken beliefs that perpetuate PTSD symptoms. Hypnosis allows clients to dissociate in a control way in order to create a sense of safety and control while reprocessing the traumatic event. Another asset to hypnotherapy is that clients can be taught self-hypnosis and use it between sessions and long after therapy ends for prolonged symptom relief.
The concepts of trauma may have its roots in Alfred Adler’s Individual Psychology. They align with the Adlerian concepts of mistaken beliefs, purpose of symptoms, and goal-directed behavior. Adler said mistaken beliefs get in the way of adaptive functioning (Griffith & Powers, 2007). As stated earlier, a common mistaken belief of trauma victims is that they are responsible for the traumatic event (Spiegel, 1998). This belief serves the purpose of avoiding a sense of helplessness (Spiegel, 1988). Irrational thoughts like this one keep clients stuck in a state of trauma long after the event is over. Adler believed people choose their symptoms, though often unconsciously, to avoid something or to protect their self-esteem (Mosak & Maniaci, 1999). PTSD suffers get caught between the two opposing forces of the cluster of symptoms. They desperately want to avoid the intense helplessness and horror associated with the trauma and thus unconsciously utilize the avoidance symptoms. Yet, their minds seek to reprocess the event, then leads to employing intrusive symptoms. Adler also believed behavior is movement towards a goal (Mosak & Maniaci, 1999). When trauma victims forget the memories associated with their overwhelming emotions or avoid whatever triggers their memories, their goal is to separate themselves from the trauma. But, the trauma remains with them until it is reprocessed. No amount of forgetting will give them long-term relief.

Though more research needs to be done to examine the long-term effectiveness of the various PTSD treatment approaches, Solomon & Johnson (2002) claim that any of the approaches mentioned in this article can shorten the duration of PTSD symptoms to three years. Those who do not receive treatment will suffer for five years or more. Left untreated, severe trauma victims could suffer from PTSD their entire life. Because trauma is a common human experience and can cause long-term damage, it is important psychotherapists request a complete trauma history for all their clients.
Though many clinicians are likely to detect trauma caused by a diagnosis of life-threatening disease, murder, sexual assault, and combat, they may miss less obvious ones like those in an intimate relationship with a sex addict. With sex addiction becoming a growing epidemic, more and more partners are suffering from relational trauma caused by betrayal and emotional abuse. The final section of this literature review will explore sex addiction and the damage it causes.

**Partners of Sex Addicts**

With the ease of access to online pornography, a gateway into sexual compulsivity, more people are getting hooked into sex addiction. Compared to the numbers affected by this addiction, there is an insufficient amount of psychotherapists and clinics trained to work with this condition. Partners of sex addicts (POSA) are those in a committed relationship with someone who has an addiction to sex. To better understand the emotional damage they suffer from, the author will seek to define what sexual addiction is, explain how betrayal causes trauma for POSA, compare the addiction and trauma treatment models, and explore effective treatment for POSA.

**What is Sex Addiction?**

Turner (2009) references Kasel (1989) in associating drug addiction to sex addiction. Both chemical use and sexual compulsion are utilized by addicts as coping mechanisms to numb painful emotions (Carnes, 1991). In fact, sex addicts often struggle with other addictions, though sex is usually the primary one (Turner, 2009). Sex is used as a tool to gain power and control when the addict is feeling powerless or stressed. “The need to prevail in adult relationships is a result of suffering profound powerlessness from childhood and subsequent immense amounts of
shame” (Turner, 2009, p. 285). The powerlessness many sex addicts experienced in childhood is often caused by trauma, such as physical and sexual abuse and neglect (Carnes, 1991).

Unresolved trauma, lack of constructive coping skills, and shame fuels the cycle of sex addiction. Addicts are often unaware of the connection between their sexual compulsion and childhood events (Turner, 2009). They dissociate from overwhelmingly painful emotions caused childhood trauma. Sex is a survival mechanism for them. “Without sex the addict’s world unravels” (Carnes, 1991, p. 22). Though the sexual acting out behaviors provides temporary relief from pain, like any other addiction it ends up causing more harm to the person. Their sexual behaviors often contradict their values. As a result, they become afflicted with shame (Tripodi, 2006; Bergner & Bridges, 2002). And because addicts lack constructive coping mechanisms to address painful emotions like shame, they repeat sexual behaviors in attempt to numb themselves from the shame (Carnes, 1991).

Sex addiction is difficult to diagnose. “Typically, other problems, such as discord, infidelity, and generic sexual difficulties are presented before sex addiction surfaces thereby obscuring an accurate assessment” (Turner, 2009, p. 283). This addiction coexists with other mental illnesses like anxiety, depression, pathological lying, sociopathy, narcissism, obsessive compulsive disorder, PTSD, substance abuse and dependence, and personality disorders (Turner, 2009; Gonyea, 2004). Because addicts are afflicted with shame, they become masters at hiding their compulsive sexual behaviors. Their pattern of lying and giving partial truths, adds to the challenge to clinicians in identifying this addiction.

To help clinicians identify this disorder, it is important to know common warning signs of sex addiction. One warning sign is family history. “The family history of a sex addict frequently reflects little intimacy, inconsistent rules, inadequate supervision, high expectations,
and an intergenerational history of addictions” (Turner, 2009, p. 284). Another sign is that the addicted person started using sex to cope with emotional or bodily pain in adolescence prior to substance use (Turner, 2009). Sex addicts often develop additional addictions though sex compulsion remains the most deeply rooted (Carnes, 1991; Turner, 2009). Though the addiction often begins in early adolescence, sex addicts often suffer long into adulthood before receiving professional intervention (Turner, 2009). As a result, their acting out behaviors can cause significant damage to themselves and their partners.


1. A pattern of unmanageable behavior
2. Severe negative consequences due to sexual behavior
3. Ongoing desire or effort to limit sexual behavior
4. Inability to discontinue the behavior(s) despite severe consequences
5. Persistent quest for self-destructive or high-risk behaviors
6. Sexual obsession and fantasy as primary coping mechanism
7. Tolerance or the need for increasing amounts and varieties of sexual experience to attain the desired effect
8. Severe mood changes regarding sexual activity
9. Inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual consequences
10. Neglect of important social, occupational, or recreational activities because of sexual behaviors (p. 289).
In his book *Don’t Call it Love*, Carnes (1991) created a self-assessment for sex addicts. It is a useful tool in identifying a sexual compulsion as well as educating clients on the symptoms of sex addiction.

When the signs of sex addiction are present, clinicians should also inquire about withdrawal symptoms. Carnes (1991) says sex addicts experience “…dizziness, body aches, headaches, sleeplessness, and extreme restlessness” (p. 25). These withdrawal symptoms mimic the symptoms of cocaine withdrawal. Recovering sex addicts who also struggled with chemical addiction say the physical withdrawal symptoms of sex addiction was more prolonged and painful compared to withdrawal of chemicals.

Carnes (1991) says an unfortunate scenario that often plays out with sex addicts is a significant increase in sexual acting out behaviors after becoming sober from alcohol. For those with multiple addictions, quitting chemical use is markedly easier than ceasing sexual compulsions (Carnes, 1991). “People who experience dual dependencies like chemicals and sex often make this striking observation: chemical abuse is easier to stop than sexual addiction” (Carnes, 1991, p. 34). In addition to alcohol, other addictions may be nicotine, caffeine, and illegal substances (J. Truer, personal communication, February, 2011).

Sex addiction is an intimacy disorder. Sexual interaction with an intimate partner can be threatening for sex addicts because they risk being rejected (Gonyea, 2004; Carnes 1991). “Addicts are not able to accept real intimacy because of a core certainty that they will be rejected” (Carnes, 1991, p. 91). Intimacy may also trigger their unresolved childhood traumas (Van der Kolk, 1988). To regain power and control when they are feeling powerless and inadequate, they sexually act out to numb their emotional pain. These sexual compulsion sabotages intimate relationships.
Turner (2009) says the acting out behaviors of sex addicts has a wide range of behaviors. With the easy accessibility to the internet, the most common outlet for sex addicts is online pornography. Other ways the addiction manifests is with other willing partners. Examples are anonymous sex, cybersex in chat rooms, prostitution, or getting paid for sex. The addiction may also evolve into illegal behaviors. Sex with involuntary partners includes voyeurism (spying on others in the nude or engaging in sex), exhibitionism (exposing themselves in public places), rape, and sexual abuse of children.

As with addicts of drugs and alcohol, sex addicts usually have a locus of control and responsibility outside of themselves. This perspective leads them to avoid taking responsibility for their behaviors. Often, they project their responsibilities unto their intimate partners. Addicts blame POSA for their sexual problems and their unhappiness (Schneider, 2000). This externally focused thinking pattern puts both addicts and their partners in a double bind. The longer addicts avoid taking responsibility for their behaviors, the deeper they may go into their addiction and unhappiness and thus the more damage they may inflict on POSA.

If POSA accept the role of being the source of the problem, it will lead to anxiety, depression, and/or health problems. Taking responsibility for what is not within their power to control does not produce the much desired change POSA seek. Like most trauma victims, they often struggle with the mistaken belief that they caused their partner’s unhappiness (Tripodi, 2006). This irrational thinking does not lead to a more stable and safe relationship that they desperately want. The sex addiction is the problem. And until the true problem is acknowledged and sex addicts pursue recovery, it is likely that the distress of POSA will increase if they stay in the relationship.
How Betrayal Causes Trauma to Partners of Sex Addicts

Partners of Sex Addicts (POSA) suffer intense emotional damage as a result of sex addicts’ infidelities (Bergner & Bridges, 2002; Schneider, 2000; Tripodi, 2006). “Sex touches at the most intimate part of a person’s existence, and violations of this can be damaging for many years to come” (Tripodi, 2006, p. 272). The sexual betrayal is usually not the cause of the severe damage done to POSA; it is the betrayal of intimacy. Partners of sex addicts often say the worst part of learning of the betrayal is the loss of trust in their partner (Gonyea, 2004; Bergner & Bridges 2002; Schneider 2000). The trust that built the relationship crumbles as one secret after another is uncovered. Whether the acting out behaviors consists only of pornography or progresses to live encounters, the damage done to POSA is the same (Schneider, 2000; Bergner & Bridges, 2002). Bergner & Bridges (2002) say “the discovery is traumatic in the sense that it confronts her with a new world that she finds devastating, confusing, and incomprehensible…” (p. 195).

Because sex addiction is an intimacy disorder, POSA are the casualties in the fall out of this addiction. Gonyea (2004) describes the impact of infidelity as “…energy drained from the primary relationship…” and causing “…deteriorating connection between partners…” (p. 382). Attention and energy addicts used to give to building connections of love and trust shifts to meeting the growing demands of their addiction. As the addiction escalates, addicts become more and more obsessed with meeting the demands of “their own pleasure at the expense of everyone else’s wellbeing” (Bergner & Bridges, 2002, p. 199). To cover up their behaviors, sex addicts perpetually lie to their partner eroding trust (Schneider, 2000). Along with lying, addicts detach emotionally from POSA as the addiction escalates (Schneider, 2000; Bergner & Bridges, 2002). Sexual interaction between couples no longer is an expression of love and intimacy.
Instead, POSA become objects of the sex addict’s pleasure (Schneider, 2000). Bergner & Bridges (2002) report that healthy romantic relationships include these characteristics: “(a) investment in the wellbeing of the beloved, (b) respect, (c) admiration, (d) sexual desire, (e) intimacy, (f) commitment, (g) exclusivity, and (h) understanding” (p. 196). The betrayal behavior of sex addicts violates all of these aspects of intimacy.

The self-concept of POSA is assaulted with objectification, rejection, and emotional abuse. Sex addicts compare them to unrealistic images in pornography leaving POSA feeling flawed and undesirable (Schneider, 2000). Schneider’s (2000) research shows that POSA feel like objects of the addicts’ pleasure rather than equal partners in a mutually satisfying relationship. POSA are afflicted with feeling unwanted and insecure as the addict avoids sexual encounters with them over masturbating to online pornography or sex with other partners (Gonyea, 2004; Schneider, 2000; Bergner & Bridges, 2002). Addicts cause further harm by manipulating their partners through emotional abuse to justify or hide their infidelities.

Sex addiction is about power and control (Turner, 2009). The addicts’ pursuit of power and control often leads to emotionally abusing their partners. They pressure POSA to perform sexual acts they are uncomfortable with or to join them in cybersex (Schneider, 2000). In response to this pressure, POSA report feeling “…angry, repelled, used, objectified, or like a prostitute” (Schneider, 2000). “The intrusive sex addict has a false sense of entitlement and takes from others without regard to their wishes” (Turner, 2009, p. 289). This sense of entitlement leads to a lack of remorse. The lack of remorse leads to repetitive destructive behaviors that harm POSA.

In an attempt to excuse their behaviors, sex addicts devalue their partners with emotional belittling or constant avoidance (Schneider, 2000). For example, they blame POSA for their
infidelities accusing them of not meeting their emotional and sexual needs (Tripoldi, 2006; Gonyea, 2004; Schneider, 2000). As a result, POSA get caught in the mistaken belief that they are responsible for their partner’s unhappiness and their infidelities. When POSA accept the blame for the addict’s emotional abuse it is a sign of traumatic stress (Van der Kolk, 1998). In response to the emotional abuse, POSA lose trust in their own intuitions (Tripodi, 2006). The lack of confidence in their hunches may contribute to a sense of helplessness to change the situation that is causing them so much damage.

To make matters worse, the concerns of POSA are often dismissed by mental health workers. When couples seek professional help, therapists who are untrained in identifying and treating sex addiction often minimize POSA’s concerns thus reinforcing their lack of trust in their own intuitions and causing further harm (Tripodi, 2006). Instead of providing the needed intervention and treatment for these couples, counselors may only treat symptoms instead of the root cause of the distress. Seeking professional help and not getting the treatment needed may perpetuate the feeling of hopelessness for both sex addicts and their partners. Because sex addiction is a growing epidemic, it is important for clinicians to have minimal knowledge of this disorder in order to assess it and refer addicts to specialists when needed.

The assault on their self-concept combined with the discovery of the addict’s secret life can lead to trauma for POSA. Tripodi (2006) reports that POSA suffer from “…despair, hopelessness, confusion, anger, and sadness…” (Tripodi, 2006, p. 272). Those who are aware of their partner’s sexual acting out behaviors and stay in the relationship experience a sense of loss of control and often choose to be in denial about the destructive behaviors (Tripodi, 2006). Schneider (2002) reports POSA fear catching a sexually transmitted disease from addicts, which could cause serious health problems and could be life-threatening. Tripodi (2006) also says
POSA experience intrusive thoughts of the addict’s sexually deviant behaviors. These thoughts are so disturbing that POSA may avoid sexual contact until the relationship becomes safe again (Tripodi, 2006). In response to the betrayal, POSA also suffer from anxiety, depression, difficulty concentrating, and hyper-vigilance (Steffens & Rennie, 2006; Tripodi, 2006).

The factors that increase trauma symptoms for partners of sex addicts include length of time in partnership, previous trauma, emotional abuse, and mistaken beliefs. Research from Steffens & Rennie (2006) show that the longer a couple is together the greater the likelihood for POSA to experience severe trauma symptoms in response to discovery of the betrayal. Previous traumatic experiences also increases the risk for severely distressing symptoms (Steffens & Rennie, 2006; Tripodi, 2006). “Fresh trauma of any kind nearly always hooks old trauma, even when we’ve done great recovery work” (Steffens & Means, 2009, p. 25). The degree of emotional abuse afflicted on POSA by sex addicts can also be an indicator of the severity of the trauma symptoms. If POSA get caught in the web of mistaken beliefs, their distress is likely to increase. The following are two common irrational beliefs of POSA: 1) believing they are responsible for the other’s acting out behaviors and 2) believing they are not attractive enough to keep their partner’s sexual interest.

The damage sex addiction does to POSA can result in complex relational trauma. “Relational trauma, often called attachment injuries, occur when one person betrays, abandons or refuses to provide support for another with whom he or she developed an attachment bond” (Steffens & Means, 2009, p. 11). Understanding this complexity will aid clinicians in recognizing and validating the distressing symptoms of POSA present with. Identifying the damage caused by betrayal is also the first step in providing effective treatment. How therapists define these symptoms will determine the focus of treatment.
Comparing the Treatment Models of Addiction and Trauma

There are two models of treatment for POSA: the addiction model and the trauma model. Each looks at the symptoms of POSA from a different perspective. The addiction model sees partners of sex addicts as co-addicts or codependents. Steffens & Rennie (2006) says this model views the source of distressing symptoms as the dysfunction and addiction of POSA. On the other hand, the trauma model views POSA as victims of an overwhelming event. The latter model views their symptoms as a response to a traumatic event—the disclosure of the betrayal. The two models approach treatment according to how they define the cause of the distressing symptoms. To better understand these treatment models, a deeper look at their strengths and limitations is valuable.

The advantages of the addiction model include peer support groups, addressing family systems, and identifying what POSA can and cannot change. Twelve step groups focused on sex addiction can provide a community of support for POSA with those of shared experiences. The addiction model takes into account family systems that might reinforce addiction rather than confront it. It focuses on identifying early childhood patterns developed from a dysfunctional family system (Tripodi, 2006). If POSA experienced abuse or neglect as a child, this model can help them understand the impact those painful experiences may have in current relationships. The addiction model also can empower POSA to shift their focus off of changing their partners and onto changing themselves (Bergner & Bridges, 2002). This shift in focus can help them discern what they do have control over—their thoughts, emotions, and behaviors—and what they do not have control over—other people’s thoughts, emotions and behaviors. Tripodi (2006) argues that this model allows POSA to acknowledge their role in their partner’s addiction.
Acknowledging unhelpful behaviors and taking responsibility for them is empowering because it can lead to healthy change for POSA.

Along with the strengths of the addiction model, it also has limitations worthy of consideration. First, in the addiction model, the trauma symptoms POSA suffer from is not the central focus of treatment (Tripodi, 2006). Instead, treatment is focused on uncovering the conscious or unconscious ways partners enable the addict. Second, the addiction model has greater potential for misdiagnose. If other clients present with the same trauma symptoms POSA suffer from but do not have sex addicts as intimate partners, mental health professionals would not consider a codependent diagnosis. Co-addiction and codependency are not DSM diagnoses and could distract clinicians from recognizing a legitimate mental illness that needs treatment. Third, the addiction model does not provide guidance on how to live with a sex addict (Tripodi, 2006).

If her husband continues to act out, dismiss or deny the destruction of his behaviors, or does not take actions to help restore safety in the relationship, the [wife of a sex addict] remains in a situation of perpetual threat until she finds ways in which she can develop self-protection skills and adaptive ways of managing the anxiety and stress (Steffens & Rennie, 2006, p. 262).

Processing emotional turmoil while living with the sex addict who is still acting out is likely to make recovery for POSA more difficult. They will need guidance from clinicians to restore a sense of safety and control.

A fourth limitation of the addiction model is that POSA resist being labeled a co-addict. Tripodi (2006) says many POSA feel others blame them for the acting out behaviors of sex addicts when labeled as codependent or co-addict. As stated previously in this article, Spiegel
(1988) says trauma victims often blame themselves for the traumatic event. Taking responsibility for the event seeks to protect them from the overwhelming helplessness they feel and keeps them in denial (Spiegel, 1998). The purpose of the self-blame may be to create an illusion of control over an out-of-control, intensely painful event. Like other trauma sufferers, POSA often fall into the trap of thinking they are to blame for their partner’s addictive behaviors (Tripoldi, 2006; Gonyea, 2004; Schneider, 2000). Counselors who label POSA as co-addicts and codependents could reinforce this mistaken belief, which could get in the way of their healing.

Bergner & Bridges (2002), Steffens & Rennie (2006), Turner, (2009), and Tripodi (2006) acknowledge that POSA suffer from trauma. Their response to the discovery of their partner’s sex addiction matches symptoms of PTSD. Steffens & Rennie (2006) did a study on 63 female POSA and found that 69.6% met the criteria for PTSD except for Criteria A1. Criteria A1 is directly experiencing a distressing event that involved death, threatened death, or serious injury (APA, 2000). However, if POSA suspect their partners gave them a life-threatening sexually transmitted disease this may qualify for Criteria A1. With over two-thirds suffering from PTSD, it is vital that psychotherapists look for signs of this disorder in clients who are coupled with sex addicts.

The advantage of the trauma model is that it addresses the common trauma symptoms that POSA suffer from. Early trauma intervention may reduce symptoms as well as encourage sex addicts to get the help they need (Steffens & Rennie, 2006). “Responding to the trauma-related distress for [wives of sex addicts] will enable her to begin a recovery process based upon empowerment and adaptive strategies for responding to a significant betrayal and traumatic threat” (Steffens & Rennie, 2006, p. 264). POSA need treatment for their traumatic experience
just like other trauma sufferers. They need safety, a sense of control, and guidance in reprocessing the traumatic event.

**Treating Trauma Symptoms of Partners of Sex Addicts**

It is well documented that POSA experience trauma in response to the discovery of their partner’s sex addiction. Therefore, a helpful treatment plan for these clients should include the core elements in treating any traumatized client—re-establishing a sense of control and safety and re-processing the traumatic event. But before treatment begins, clinicians should assess the severity of their symptoms.

Since Clinician Administered PTSD Scale for DSM-IV (CAPS) is an effective assessment tool for trauma, it is likely to be a helpful diagnostic instrument for POSA. In addition, CAPS also assesses a less severe condition—Acute Stress Disorder (Blake et al., 2000). As stated previously, CAPS measures the frequency and intensity for each of the 17 symptoms of PTSD (Foa & Tolin, 2000). It is important for clinical to know that relational trauma caused by sex addicts is likely to trigger past traumatic experiences (Steffens & Rennie, 2006). Therefore, POSA should also be assessed for past traumatic events even if clients have done recovery work for those experiences.

The sooner clients shift their focus off of their distressing symptoms and on to the steps, however small, they can take to restore a sense of control and safety, the sooner healing will take place and the less likely they are to develop PTSD (Steffens & Means, 2009). When POSA re-establish that sense of safety, the trauma work can begin (Turner, 2009). As documented previously in this article, combining CBT and hypnosis could be an effective therapeutic approach in addressing both the avoidance and intrusive symptoms of POSA. Hypnosis has been shown to be effective in creating a sense of safety and control (Speigel, 1998; Kingsbury, 1992;
Wai-ling Poon, 2007). Hypnotherapy can calm their minds when they experience high levels of anxiety and stress (Barabasz et al., 2010). This technique can also tap into their strengths and past experiences stored in the unconscious that may assist in addressing their current distressing experiences (Degun-Mather, 2001). In addition, therapy groups for POSA can provide an environment where self-love can grow as well as healthy protesting (Turner, 2009).

After the intensity and frequency of the distressing symptoms are reduced, Turner (2009) suggests educating POSA on sex addiction. Some helpful resources for clients are Your Sexually Addicted Spouse by Barbara Steffens and Marsha Means and Don’t Call It Love by Patrick Carnes. The former book focuses on the common experiences of POSA—details how sex addiction damages them and how to recover. The latter resource focuses on the sex addict—signs of addiction, the common cause, and the recovery process. Educating clients on sex addiction can help POSA put the betrayal trauma into perspective. Education gives “the individual a view of her partner’s addiction in which it is not about her, and in which it essentially had to do with childhood degradations from which her mate is trying to recover” (Bergner & Bridges, 2002, p. 202). POSA need to know that the sexual acting out behaviors are used as coping mechanisms to numb emotional pain (Turner, 2009). Clients also need to know that purpose of the addict’s lying, projecting blame unto them, and withdrawing from intimacy is to protect the addict from the intense shame they suffer from.

Along with educating POSA on sex addiction, it is also important to educate them on the grieving process (Botella et al., 2008). These clients need to know the five stages of grief—denial, sadness/depression, anger, bargaining, acceptance (Kubler-Ross & Kessler, 2005). To help POSA recognize when their trauma/grief surfaces, clinicians could ask them how they experience each stage of grief. To process their grief, Spiegel (1988) suggests teaching clients on
use the split-screen technique while doing self-hypnosis. Hypnosis is just one tool to assist in processing the five stages of grief. There are many other ways such as these:

- Journaling
- Listening to music
- Talking to friends and family
- Creating art
- Exercising
- Watching movies that reflect their grief

To prevent re-traumatizing them while processing trauma, setting boundaries for their grief can be helpful. Trauma is overwhelming. Therefore, it is important to process the loss one small step at a time. Setting boundaries for the trauma allows clients to process the trauma in manageable doses.

We can create boundaries between ourselves and the trauma by using self-soothing technique, changing cognitive distortions and negative self-talk to healthy self-talk, learning to ground ourselves if we begin to dissociate and using self-care activities to take responsibilities for meeting our own needs (Steffens & Means, 2009, p. 140).

Creating boundaries can establish healthy distractions from trauma, which can contribute to building a sense of control. When trauma needs to be processed, setting boundaries can help clients decide when, where, and how much to do. Processing trauma is not the only thing demanding the attention of POSA. They will need to set the trauma aside at times to attend to other demands like taking care of their children, working at their job, repairing their car, getting groceries, etc. Therapists can help clients explore ways to distract themselves in constructive ways from the trauma and grief.
Summary of Partners of Sex Addicts

Not enough research attention has been given to treating sex addiction. Even less has been directed to partners of sex addicts. Thus, there is a lack of evidence based treatment for POSA. More research attention is needed on effective treatment for the damage sex addiction causes to intimate partners. However, research has begun on analyze the distressing symptoms of POSA.

The studies done by Steffen & Rennie (2006), Bergner & Bridges (2002) and Schneider (2000) show that POSA suffer from traumatic symptoms in response to the sexual acting out behaviors of their intimate partners. The limitations of these studies are worth noting. All three studies involved 100 or less subjects of POSA with the majority being women. Their subjects did not represent a large sample size of this population and were not randomized. Because the research is heavily focused on women, we do not know if male POSA respond to infidelity similar to women. However, the strength of these studies is their accumulative findings on the traumatic responses of POSA.

It seems many of the mental health professionals that have training in sex addiction apply the useful concepts in treating sex addicts to POSA. It appears the addiction model has filled the gap in research in treating these clients. Though POSA have been helped by the addiction model, its limitations are worthy of attention. This model is insufficient in addressing their trauma symptoms. Labeling POSA as co-addicts or codependents could reinforce the mistaken belief that they are to blame for their partner’s behaviors. As a result, treating POSA with the addiction model could cause them further harm.

The trauma model appears to be a more effective approach. Intimate partners of sex addictions are not only victims of betrayal. They are also victims of emotional abuse and
objectification. The trauma model treats POSA like any other victim of trauma. It focuses on creating a safe environment and a sense of control in order to reprocess their trauma and rebuild their self-concept. In addition, these helpful concepts of the addiction model could be useful in their healing process: utilizing peer support groups and exploring family systems.

**Final Summary**

Though more research is needed to understand and treat the distressing symptoms of POSA, the limited research done to date agree that they suffer traumatic distress in response to the disclosure of their partner’s sexual acting out behaviors. Because trauma sufferers already utilize dissociation in attempt to survive the traumatic experiences, hypnotherapy could be an ideal form of treatment for POSA. It utilizes their dissociative ability in a way that can create a sense of control and safety so that the trauma can be reprocessed successfully. Combining hypnotherapy with cognitive behavioral therapy (CBT) could be effective treatment for POSA suffering from traumatic symptoms; Hypnosis treats the intrusive symptoms while CBT addresses the avoidant symptoms.

The dual approach of hypnosis and CBT may have a much higher success rate in treating trauma symptoms in POSA than any other treatment. Research has shown CBT to reduce symptoms among 67% of PTSD sufferers (Solomon & Johnson, 2002). However, CBT also has a drop-out rate of 25-33% because clients are not able to tolerate treatments like exposure therapy (Solomon & Johnson, 2002). Because hypnotherapy is a gentler approach in reprocessing trauma, it is better tolerated in comparison to exposure therapy. Substituting exposure therapy with hypnosis could eliminate CBT’s 25-33% drop-out rate. Therefore, this dual approach has the potential to reduce symptoms to below clinical levels for the majority of POSA.
References


