The Thirteen Dimensions

Partner Trauma Model

2005-2012

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This is Dr. Minwalla's Original Grounded Theory Model that's started in 2006 as the Sex Addiction-Induced Trauma Model - which later evolved into Deceptive Sexuality Trauma and the 22 traumatic sequences called DST-22. The original acronyms and language have been preserved to allow a historical record and all readers to see how the model evolved over time.

Thirteen Dimensions of Sex Addiction-Induced Trauma (SAIT) Among Partners and Spouses Impacted by Sex Addiction ©

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The Sex Addiction-Induced Trauma Model© (SAITM©) articulates thirteen dimensions of trauma relevant to the clinical impacts, injuries and symptoms among intimate partners of sex addicts, based on both qualitative research and clinical application with partners and spouses impacted by sex addiction and compulsivity. Each dimension is a cluster of traumatic impacts, traumatic processes, and post-traumatic symptom sequences. Not all clusters or dimensions may be relevant for every partner or spouse (Jason, 2009). Trauma is subjective and individuals are completely different and unique (Jason, 2009).

Dr. Omar Minwalla first studied sexual trauma among partners (Dimension 8) in 2005 and 2006. From 2008- 2009, Silvia Jason, MFT, CSAT joined Dr. Minwalla and authored the first seven dimensions in concept, along with articulating emotional abuse and specifically gaslighting in a sex addiction-compulsivity and partner and spouse trauma context (Jason, 2009). Dr. Minwalla and The Institute for Sexual Health (ISH) went on to further develop and refine the thirteen dimensions of sex addiction-induced trauma among partners and spouses through direct clinical application and grounded-theory research methodology (Minwalla, 2012).

The following is derived from the victim's perspective, **from the bottom looking up, NOT just from the top looking down.**

Thirteen Dimensions of Sex Addiction-Induced Trauma (SAIT) among Intimate Partners and Spouses Impacted by Sex Addiction-Compulsivity©:

1. Discovery Trauma
2. Disclosure Trauma
3. Reality-Ego Fragmentation
4. Impact to Body and Medical Intersection
5. External Crisis and Destabilization
6. SAIT Hypervigilance and Re-Experiencing
7. Dynamics of Perpetration, Violation and Abuse (SAIP)
8. Sexual Trauma
9. Gender Wounds and Gender-Based Trauma (GBT)
10. Relational Trauma and Attachment Injuries
11. Family, Communal and Social Injuries
12. Treatment-Induced Trauma
13. Existential and Spiritual Trauma

Dimension 1:

Discovery Trauma

Dimension 1 is discovery trauma, which is defined as the traumatic intrusion(s) and resulting post-traumatic symptoms from the intersection of the partner's pre-existing reality-ego (PRE) with the deceptive, sexual/relational compartmentalized reality-system (Minwalla, 2012). Discovery is a critical traumatic incident or event (Steffens & Rennie, 2006; Jason, 2009; Minwalla, 2011), as well as an ongoing traumatic process and system (Jason and Minwalla, 2009). To reduce the clinical conceptualization of discovery trauma to a singular traumatic episode is often diagnostically incomplete and inaccurate and serves to diminish both reality and the actual traumatic experience of the partner.

The impact of a discovery includes ego-reality turbulence, disturbances and ultimate ego-reality fragmentation (Dimension 3), originally described as a "shattered self" in the context of partners (Jason, S., 2009). A discovery induces the experience of reality incongruence, which destabilizes ego structures, on which psychological stability, organization and function, depend and are based. The change in ego structures causes or "induces" fear into the system, as often occurs when important structures or functions of the ego are threatened. Thus, a discovery introduces fear into the psychological system, often inducing "flight", "freeze", or "flee" mechanisms based in human survival.

The induction of fear into the psychological and relational system is one of the specific traumatic symptom processes of discovery trauma.
A discovery does not in any way mean a full awareness of reality or the truth for the partner or spouse. It means a degree of awareness that there is reality incongruence and the open possibilities of a deceptive, compartmentalized, sexual or relational system, with no ability to confirm the extent or nature. This can often induce severe panic, terror, and intense fear, horror, or helplessness. It opens up an entire world of actual possibility, with no reliable source of reality, as it has been systematically denied and withheld from the intimate partner, with intention.

It is important to consider each single discovery as a trauma-inducing event, and different than any other discovery incident. A partner will often experience multiple and various forms of discovery trauma incidents and processes, sometimes hundreds. As with all traumatic incidents that repeat many times and have a similar theme (Jason, 2009), this then constitutes a form of complex-PTSD and will often induce many symptoms of C-PSTD well before initial discovery, often causing symptoms covertly in an intimate partner for years (Herman, 1997; Jason, 2009; Minwalla, 2012). Thus, many partners impacted by sex addiction-compulsivity disorders experience both PTSD events and also C-PTSD symptom systems as part of discovery trauma in a SAIT clinical context.

It is important to note that what occurs and ensues after a discovery incident, or what does not happen after a discovery incident, for example defensive tactics that constitute forms of emotional abuse (Jason, 2009), is also related to the traumatic experience of discovery trauma (Jason and Minwalla, 2009). Thus, discovery trauma is both discovery incidents and processes that may exist over many years. How fear is metabolized and how the sex addict-compulsive may, or may not, respond, particularly in terms of abusive responses (SAIP; Dimension 7), in the various contexts of relational rupture (Dimension 10) will impact traumatic process and symptomology significantly.

The configurations of traumatic discovery experiences can vary. Discovery can be a first awareness, a slow evolving consciousness, or an intuitive sense. It may involve a subtle awareness of reality incongruence. The introduction of fear involved in discovery trauma can be an evolution process, like “a drop of ink in water”. Discovery trauma can also often be a sudden and direct collision of the partner’s pre-existing ego-reality (PRE) with the SAC-deceptive-compartmentalized reality, “like a car accident”, often constituting an actual traumatic event (Steffens, 1996) inducing PSTD around a single episode, with the ensuing aftermath constituting the resultant complex trauma and C-PTSD symptoms. Discovery trauma requires clinical intervention and specificity that supports the necessary indicated clinical metabolization and regulation of traumatic memory towards ego-reality reformation and relational safety.

Dimension 2:

Disclosure Trauma

Disclosure trauma (Steffens, B. A., & Rennie, R. L., 2006; Jason, 2009) is a specific type of traumatic discovery incident and traumatic process, and may also occur many times in a partner's experience. Each disclosure is a critical trauma-inducing incident and traumatic process. A disclosure is the process of being told about some aspect of the deceptive, compartmentalized reality-system (factual or not). There can be many disclosures, spontaneous or forced disclosures, and professionally guided disclosures, which is a clinical treatment process (Jason, 2009). All of these are conceptualized as trauma-inducing, to the extent that ego-reality disturbance and fragmentation ensues as a direct response and symptom of reality incongruence that develops due to the critical intersection of original or pre-existing ego-reality with SA-deceptive-compartmentalized reality-system (Minwalla, O., 2012).

The induction of fear into the psychological and relational system is one of the specific traumatic symptom processes of disclosure trauma in a SAIT context. Disclosure can be one of extreme and sudden ego disintegration ("car accident" metaphor) and/or can be a subtle and slow evolution or dissolve of ego structures ("ink in glass of water" metaphor). The overwhelm to the ego from a single disclosure often induces the fragmentation of the ego dramatically, thus often causing severe and clinically significant symptoms, as first research via quantitative methodology indicates (Steffens, B. A., & Rennie, R. L., 2006).

Both dimensions one and two, both discovery trauma and disclosure trauma (Jason, 2009) result in some form of ego disturbance if not complete annihilation of a partner's reality-ego, requiring clinical intervention and immediate stabilization, as indicated per rate of trauma resolution in partner, not at the rate of the sex addict's demand or treatment demand. It is also important to understand the overlay of discovery trauma and disclosure trauma of the partner or spouse as a complex and nuanced traumatic process, often involving many experiences of acute trauma (PTSD) and chronic and pervasive systems of trauma-inducing psychological and emotional abuse and covert harm (SAIP) involved in the inter-relationship between discovery and disclosure trauma (Dimension 1 and 2) causing and relating to reality-ego fragmentation (Dimension 3).

Dimension 3:

Reality-Ego Fragmentation

Reality-Ego Fragmentation is conceptualized as one of the critical injuries of SA-Induced Trauma (Minwalla, 2011). The dynamic inter-relationship between reality and ego becomes traumatized and "shatters" (Jason, 2009), and the ego experiences turbulence towards eventual fragmentation (Minwalla, 2012). The SAITM understands the ego as the organized conscious mediator between the psyche and reality, specifically the function in both the perception of and adaptation to reality. The ego and our ability to both perceive and adapt to reality adequately is essential for psychological health and stability. The greater the disparity between perceived reality (pre-existing ego-reality) and SA-deceptive compartmentalized reality, often the greater the traumatic impact and consequence on ego infrastructure (Jason, 2009).

Reality-Ego that fragments from the intrusion of the SA-deceptive-compartmentalized-sexual system often includes the most foundational structures on which many critical cognitive and psycho-emotional schemas and systems of functioning, including relational functioning, are necessarily dependent. Ego-reality fragmentation then becomes one of the critical injuries of SAIT, and from this many SAIT symptoms and trauma-inducing dynamics evolve. The metaphor of "the foundation of a house fragmenting, slowly or suddenly or both" applies in order to conceptualize ego destruction and damage.

A traumatized, fragmented, and injured ego causes functional impairment, similar to brain injury. The actual ability to utilize the ego towards initiating and effectively implementing health attempts becomes compromised and diminished (Minwalla, 2012). The ego seeks repair and integration by attempting to utilize itself to repair and adapt (Minwalla, 2012). Traumatic ego-reality dissolution and fragments manifest as traumatic memories, body experiences and traumatic coping patterns and intrusions seeking clinical metabolization and integration. Symptoms of ego fragmentation among partners and spouses often include alterations in consciousness, alterations in self-perception; amnesia or hypermnesia, transient dissociative episodes, depersonalization, de-realization, and "reliving traumatic experience" either through PTSD symptoms or through the process of ruminative preoccupation (Herman, 1997).

According to the diagnostic system of C-PTSD, alterations in self-perception includes symptom clusters around a sense of helplessness or paralysis of initiative; shame, guilt and self-blame; sense of defilement or stigma; sense of complete difference from others – utter aloneness, sense no one could understand, and a sense of a nonhuman identity (Herman, 1997).

Ego fragmentation often results in significant traumatic loss cycles (Jason, 2009) in which the survival coping reactions to the original impact/trauma creates a new set of feelings, reactions and way one relates to self and others. This is “like waking up one day and you are a different person" and this "sudden different identity" becomes a second fragmentation of ego-reality trauma to original fragmentation trauma (Jason, 2009). These cycles of grief and loss from original self and ego-reality due to trauma symptoms and manifestation of traumatized self as applied to partners impacted by sex addiction was developed and described by Silvia Jason (2009). It is critical to note and link (Dimension 11) the reality that the sudden loss of “self” and “becoming someone different”, due to traumatic ego-reality fragmentation, is also traumatic for children within the mother-child bond/attachment and dependency, causing ego disturbances and sudden shifts in children, family members, and any human being related intimately or in dependence to the partner or spouse impacted by SAIT.

Dimension 4:

Impact to Body and Medical Intersection

This dimension and symptom cluster focuses on SAIT and the body of the partner or spouse; physical impacts, medical concerns and physical traumatic experiences (Jason, 2009). This involves the trauma to one's physical body, which can be significant for partners. This could include the impact on body image, triggering of eating disorders, weight loss or weight gain, vomiting, shaking, hair loss (sometimes extreme), defecation, insomnia and sleep disturbance, psycho-emotional dissociation, crying episodes, physical expressions of rage, hyper-vigilance, muscular constrictions, stomach sickness, falling to the ground, fetal position, vaginal spasms, aversion to physical or sexual touch, sharp pains, uncontrollable primal screams and screaming sounds. These are simply some of the hundreds of physical and medical symptoms of trauma and SAIT among partners, as it is clear that psychosomatic traumatic manifestations are profound.

Some partners may be also dealing with pre-existing medical concerns or physical health concerns such being pregnant or dealing with breast cancer and rounds of chemotherapy when suddenly impacted by sex addiction-induced trauma. Due to the fact that some medical conditions are highly sensitive and relate directly to disturbances to the body associated with trauma and SAIT specifically, nurses, medical and healthcare professionals need to be educated on how to screen, assess and treat sex addiction-induced trauma medically, particularly as it relates to other medical health concerns. In fact, even children who are in episodes of SA-induced ego-reality fragmentation causing psychotic breaks and SAIT-related dissociation and trauma symptoms are being hospitalized, for example, and the medical team will often determine no diagnostic or clinical explanations, when clearly SAIT pertains both in terms of diagnosis and treatment. Gynecologists should be versed in sex addiction-induced trauma. The lack of recognition among medical professionals, and the lack of intersection between people experiencing SA-induced trauma symptoms and medical knowledge or insight is a serious problem.

It is critical that the harmful impacts to a person's body is taken into treatment account and viewed as important in terms of clinical metabolization in the service of healing. It is also critical to develop integration of bodily impacts into an overall traumatic narrative and treatment process. For example, sexually transmitted disease and infections testing, which due to finances being used for the sex addict's treatment (Dimension 5 and 9), the partner may need to use insurance only, and also may encounter treatment harm based on gynecological insensitivity rooted in the lack of awareness in the physician of SAIT, etc. (Dimension 4 and 12).

Dimension 5:

External Crisis and Destabilization

External crisis and destabilization means all the practical changes, sudden or long-term external changes, and the overwhelming chaos that ensues and often endures as a direct result of the sex addiction, particularly post-ego fragmentation, and as a result of all the associated dynamics of abuse and violation (SAIP) in "the aftermath and fallout of the car accident / ink in water" (Minwalla, 2012). These dynamics are a significant source of stress that alone often can cause functional impairment. This can include concerns related to finances, moving, separate sleeping arranging, changes in routine, sudden shifts in residence, childcare routines changed, co-parenting dynamics altered, impact on family system, disclosures, what to say to whom, or how to find treatment, being stalked by others, etc. This includes practical concerns that may impact trauma, such as people who are poor and who definitely cannot afford treatment. Medical and psychosomatic conditions are likely (Dimension 4), yet the lack of resources is also likely (Dimension 12), leaving many partners in medical despair.

Furthermore, it is imperative to note that because the addict is the "identified patient", the partner or spouse often may end up "holding down fort" and being "the together one" in the early stages of the process. This may result in a profound submerging of trauma, a form of extreme traumatic constriction based on survival. It may only be when the conditions have stabilized, or there is actual increased safety or functionality in the sex addict or family system, and the perpetration and abuse (SAIP) stops, before a partner could ever contact or metabolize her traumatic fragmentation and dissociative experiences. This SA-induced traumatic submergence is a characteristic of this dimension of trauma and needs to be accounted for in both conceptualization and clinical intervention and treatment.

The omission of recognizing the external and practical stressors that the injured partner may have to manage, such as "holding down fort", while traumatized, often induces or exacerbates SAIT. The seeming assumption that the partner is "functional and obligated" becomes disorienting in light of the partner's subjective and actual experience of self. This is often linked with ego-fragmentation, which both perceives and adapts to reality. Thus, essentially, it is often during a critical injury of ego trauma, that the partner is then implicitly mandated to perform gender-based or parent-based obligations. This can sometimes link to gender wounds in that often women are taken for granted for this "work" (gender-based trauma) and in the context of experiencing SAIT, this "normal work" can become a source of trauma exacerbation and/or include traumatic incidents and processes (Minwalla, 2012) based on external crisis and destabilization (Jason, 2009).

Dimension 6:

SAIT Hypervigilance and Re-Experiencing

According to The Diagnostic and Statistical Manual of Mental Disorders, (Version 5), PTSD is often characterized by heightened sensitivity to potential threats, including those that are related to the traumatic experience (American Psychiatric Association, 2013). The DSM-V describes the symptom of re-experiencing as covering spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress. It then also describes the symptom of arousal as being marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance or related problems. The current manual emphasizes the "flight" aspect associated with PTSD; the criteria of DSM-5 also accounts for the "fight" reaction often seen in trauma symptom sequences (American Psychiatric Association, 2013).

Hyper-arousal and re-experiencing is a well-established symptom of trauma in which specific internal/external, and objective/subjective stimuli, perceptions, thoughts, feelings or sensations will remind the psyche of the trauma and the system will react to the stimulus – causing psychological, cognitive and emotional changes related to fear, panic and feelings associated with traumatic memory (American Psychiatric Association, 2013). SAIT reactivation and re-experiencing among partners and spouses can become crippling in terms of clinical and functional impairment due to intensity, frequency and pervasiveness of reactivation cues. Triggers can be so nuanced and different for every partner; bill boards, magazines, other women, cell phones, blond hair, texting, computers, cities, massages, intimacy, sexual positions, Hispanic women, etc. Agoraphobia, panic attacks; dissociative and fear-based perceptual lens will pervade and the consequent psychological-cognitive defensive systems of protection will emerge and be present.

Hyper-arousal, hypervigilance, re-experiencing and the symptomology of trauma reactivation based on cues is a well-established science in the field of trauma (American Psychiatric Association, 2013), and clearly applies to partners and spouses impacted by sex addiction-induced trauma (Jason and Minwalla, 2009). However, diagnostic terms such as “snoopervising” have emerged and are used among traditional sex addiction therapists to actually reframe traumatic re-experiencing and behavioral correlates of hypervigilance. Instead of the more accurate diagnostic concept of hypervigilance and understanding a partner’s behaviors as post-traumatic “safety-seeking behaviors” (Steffens, 2006), many sex addiction therapists reframe a partner’s “safety-seeking attempts” (Steffens, 2006) as “pathological co-sex addiction slips that define and demonstrate the partner’s unmanageability (Carnes, 1991, pg. 361) and proof and confirmation of her insanity”. The clinical and professional utilization of terms such as “snoopervising”, “pain shopping”, or “playing victim” to describe people in traumatic hypervigilance reactivity, (Jason, 2009) is a form of professional perpetration (Dimension 9 and 12), according to the SAITM, and further have no legitimate or ethical place in clinical practice or within any professional realm.

Dimension 7:

Sex Addiction-Induced Perpetration (SAIP)

Policy makers and clinical researchers give psychological and emotional abuse considerably less attention than physical abuse, based on traditional definitions of domestic violence. However, psychological and emotional abuse can impact a human being just as much as physical abuse, in terms of harm, symptoms, and traumatic impacts (O'Leary, 1999; American Psychological Association, 2007; Intimate Partner Abuse and Relationship Violence Working Group, 2001). Sex Addiction-Induced Perpetration (SAIP) includes emotional abuse, psychological abuse, family and relational domination, covert management of deceptive-compartmentalized-reality, sexual abuse and coercion, child neglect and abuse, and other patterns of harm to human beings and violations of human rights, termed "sex addiction-induced perpetrations" (SAIP) (Minwalla, O., 2011; Minwalla, O., 2012). Clinical terms such as perpetration, victimization, abuse and trauma (PTSD, C-PTSD, RTS) are appropriate terms based on clinical standards of care and recommendations by the American Psychological Association related to the diagnosis and treatment of psychological and emotional abuse (Intimate Partner Abuse and Relationship Violence Working Group, 2007; American Psychological Association, 2007)

Silvia Jason, MFT, CSAT was the primary author who initially articulated patterns of emotional abuse utilized by sex addicts against partners in covert management (Jason, 2009). Jason also contributed the concept of gaslighting, as applied in the context of partners and spouses impacted by SAIT and articulated the patterns of emotional abuse – such as threats, sidetracking, blaming the partner, gaslighting, and covert emotional abuse that results in emotional trauma and wounding (Jason, 2009).

Gaslighting (Gass, 1988; Dorpat, 1994; Dorpat, 1996; Jason, 2009) is the process in which the addict intentionally manipulates a partner's reality in order to protect reality and the truth from becoming known or discovered by the partner. This is a form of psychological manipulation and covert psycho-emotional abuse and perpetration (Jason and Minwalla, 2009). The serious damage that can often result from gaslighting a person is that it erodes or ruptures the person's relationship between their psyche and their intuition or "gut instincts" (Minwalla, O., 2012). This is actually one of our most important relationships because it helps us navigate decision-making essential for adaptive survival. Our connection between our psyche and our intuition is needed for survival and in order to make effective decisions on the most fundamental levels.

The impact of chronic patterns of psychological manipulation, over time, is the slow erosion or weakening of one's relationship between the victim's psyche and their intuition. Sometimes there can be a progressive reliance and eventual dependency on the perpetrator's reality as the victim's adapted "survival instinct" (Minwalla, 2012; Herman, 1997). Thus, if the ability to utilize one's own intuition is so compromised and abused, and/or if the victim has been manipulated into deep dependency and reliance on the perpetrator's definition and mandate of reality, then the victim may be not be able to generate emancipation impulses, based on instinctual self-generation. The idea of "just leaving" is not reality-based for certain partners and spouses who have been victimized and abused via gaslightling, which constitutes a specific type and form of psychological abuse and torture, and a significant SAIP, often highly relevant to sex addiction disorders and a partner's traumatic clinical configuration.

There are many abusive attitudes employed by others and society against partners and spouses. There are agendas that are enacted, ways of managing the addictive system, and other dynamics of abuse, violation and perpetration that fall under the umbrella term of SAIP, Sex Addiction-Induced Perpetration. SAIP can include marital rape and sometimes does (Minwalla, 2013). SAIP can include dynamics of coerced sex with a partner or sexual manipulation (Minwalla, 2013). SAIP may include collusion in acting out with the partner's friend, or may include the other people whom she honored and trusted who may have known and colluded in denial and silence or even supported the acted out.

SAIP can include impacts on children, including parentification, using children post-trauma as self-soothing objects, objectification of children based in SAIT responses; post-traumatic unhealthy alliances within family systems; sex addict blaming child for own sexual acting out; permitting and allowing misrepresentation of truth socially; etc. SAIP is most often a system of thoughts, feelings and behaviors. All forms of SAIP should be identified and integrated into clinical treatment and management paradigms. Indeed, sexual acting behaviors are, but only one form of SAIP.

Dimension 8:

Sexual Trauma

There can often be trauma to a partner's sexuality, inclusive of traumatic incidents and ongoing traumatic patterns that traumatize a partner's sexuality. Ongoing systems of sexual and gender domination, control and utilization and violation of a partner's body and sexuality may sometimes exist within intimate partnerships impacted by sex addiction or compulsivity disorders. The sexuality of a partner is often impacted by sex addiction in a similar way that women who have been raped or sexually traumatized are impacted in terms of symptom similarities (Minwalla, 2009). The sexual symptoms that partners often experience correlate with symptoms of rape trauma syndrome (RTS)(Minwalla, 2006; Minwalla, 2009).

Symptoms of SAIT on a partner's sexuality may include avoidance or lack of interest in sex, sexual shutting down, collapse and numbing; somatic genital and sexual symptoms (ex. vaginismus; vulvic pain and reproductive/gynecological impacts); sexual traumatic constrictions; fear and panic about having contracted a disease or infection of a sexually transmitted disease; psychological sense of "being dirty and feeling contaminated"; confusion around self-blame; post-trauma-induced-hypersexuality; impulse to hide in context of shame; fear and anxiety when reminded of sexual SAIT intrusions; internalized obligatory sexual pressure (as a victim), varied aversions to touch or intimacy, aversion to physical holding, physical contact and sexual activity (sometimes with any human being and sometimes more specific to perpetrator); SAIT reactivation and re-experiencing via visual; auditory; cognitive or actual experiences of sexuality, and deep gender wounding and gender-based trauma (Dimension 9).

There are various impacts that relate to sexual trauma that some partners experience. Fear or actual contraction of a sexually transmitted infection or disease is not uncommon for partners. Such infections sometimes lead to the loss of pregnancies or induced abortions and other serious gynecological trauma and physical consequences to a partner's sexual body and reproductive system. Often sexual acting out is discovered in the context of fertility treatments, which creates an intersection between fertility treatment trauma and sex addiction-induced discovery trauma, for example.

The more one studies female sexual realities, the more one becomes aware of our modern day human atrocities, yet unveiled. Sex addiction-compulsivity problems and disorders, not always, but can sometimes, include sexual rape, inclusive of marital rape. This is a serious problem that is rarely discussed, in and out of the professional realms, and need to be. Some partners of sex addicts are raped as an ongoing system of sexual domination and violation, sometimes in the name of various constructs of marriage, religion or gender expectations and obligations. Rape and pressuring around anal sex exist. Forms of dissociation and detachment, during or around sexuality, is a vital symptom and coping strategy utilized by many partners to endure sex in which their true will is not being honored. In such cases, symptoms of Rape Trauma Syndrome (RTS) will likely emerge and intersect with SAIT and will require specific, gender-based clinical context and consciousness, with appropriate clinical nuance, with both differentiation and integration. The Sex Addiction-Induced Trauma Model rejects, on both academic and ethical grounds, the diagnostic and clinical conceptualization or use of “sexual anorexia” (Dimension 12).

Dimension 9:

Gender Wounds and Gender-Based Trauma (GBT)

To the extent that there is gender subservience as a mandate of repression, then there exists gender-based violence as a factor that serves to maintain the subservience. There are myriads of dynamics informed by gender-based violence causing symptoms of gender-based trauma (GBT) in all of us and in humanity. Partners and spouses often experience significant gender-based trauma based on patterns of gender-based violence and abuse associated with sex addiction-compulsivity patterns and perpetrations, including the harm they may endure from clinical treatment interventions (Dimension 12). Trauma disorders and symptoms are known to be traditionally misdiagnosed and under-observed or attended to by psychological interventions, particularly when it comes to trauma symptoms among girls and women (American Psychological Association, 2007).

Partners are often profoundly impacted at the core of their gender (Jason, 2009) and gender identity (Minwalla, 2012), which often includes damage to ego structures (Dimension 3) and core gender constructs such as wife, mother/father, female/male, sexual being, worthy being, body image, and core gender esteem, worthy human, etc. The impact of gender wounding (Minwalla, 2012) and gender esteem on overall psychological health and functioning is often not recognized and often rendered unconscious. However, gender identity and gender esteem is a primary and core dynamic in self-construction, core self-esteem, and self-worth and is foundational to global psychological functioning and adjustment. It is very closely related to sexuality, yet in a clinical system of traumatic injuries, it is delineated in order to more fully appreciate and understand the traumatic wounding in service of repair and integration of regenerated gender fragments, gender esteem and the reconstruction of gender identity in a post-SAIT clinical content.

Included under this dimension (Dimension 9) is the context and dynamics of gender-based violence that infuse and inform many of the dimensions, including treatment-induced trauma (Dimension 12), as the co-sex addiction model propagates a psychology of victim blaming as a derivative of gender-based violence (Minwalla, 2012). Also included in this dimension are the all the victims who are women of color, women who may not have legal status, female domestic employees, domestic nannies and babysitters, homeless or poor girls and women, sex traffic victims and sex industry victims, and pornography victims who are directly or indirectly impacted by sexual acting out disorders and sex addiction (SAIP). Gender wounding and gender-based trauma is considered to be a critical injury for many partners impacted by SAIT.

Dimension 10:

Relational Trauma and Attachment Injuries

Healthy and secure attachment to human beings is essential to psychological health (Bolby, 1979). Disconnection from human beings results in pain, dys-regulation, and disease. Rupture from what was experienced as a secure attachment, which included psychological and emotional dependency, is a traumatic and critical event and dynamic in itself (S. Johnson, 1996). Relational trauma and attachment injuries, inclusive of attachment rupturing and the traumatic relational dysregulation within the system of the coupleship or relationship is another critical injury of SAIT, according to the SAITM. The SAITM asserts clearly that sex addiction-induced trauma is not to be reduced to "relational trauma" or "attachment trauma" only, but included as one important clinical traumatic source and yet only one of the critical injuries, along with Dimensions 3, 9, and 12 (Minwalla, 2012).

Sex addiction-induced trauma impacts the partner or spouse, but SAIT also profoundly impacts the relationship as a "separate, third, entity". The relationship, the "us" itself, is traumatized. The relational ruptures, attachment injuries, and relational dis-connection and inability to re-establish healthy or even regulatory attachment becomes a source of traumatic experience (Johnson, S. 1996). The lack of ability for re-attachment creates an ensuing form of C-PTSD-inducing conditions and symptoms, often resulting in traumatic reactive escalation or erosion and eventual loss of relational stability and basic dependency. Relational trauma, in this context, often causes significant symptoms of trauma and defensive coping adaptations in both partners. The SA-induced relational trauma and patterns of relational coping and disorientation is in itself a traumatic process, involving myriads of injuries in dependency, trust, loss, grief, dissociation and traumatic symptom sequences. The significant instability in each person, and between each person, is a source of trauma, as are the attempts for re-attachment with chronic or pervasive failure.

The heart of the relationship is often "shattered and is hemorrhaging" and according to the model, requires immediate clinical assessment, stabilization and the couple needs clinical intervention around safety and functionality. This is explicitly not "couples therapy" in any way. The traditional sex addiction's model of "stay on your side of the street" for couples is often harmful (Minwalla, 2012). The degree of relational disturbance, attachment rupture and relational trauma will dictate the first phase of clinical needs for the coupleship or relationship. The SA-Induced Trauma Model asserts a systemic and relational model, between the partner, the sex addict, and the relationship ("Three Plates Spinning"©) (Minwalla, 2012).

Dimension 11:

Family, Communal and Social Injuries

While trauma impacts a partner's interior world, and primary adult attachment, it also has far reaching implications for other relationships, including the parent-child bond, the social world, the experiences of being in public, the sense of communities that provide stabilization and dependency, and relationships to others in general, and all human beings. It is common for many of these often extremely painful dynamics to go unacknowledged and excluded from discussions on sex addiction. However, these consequences on social functioning and interpersonal functioning can be a significant source of trauma, and may involve multiple attachment injuries, significant grief and loss over many relationships, and profound, sudden and prolonged shifts and alterations in the ways a partner relates to other human beings on the most basic level.

Sex addiction-induced trauma impacts children. To have relationships impacted such as the mother-child bond, the family, the home invaded, or for any parent to bear witness to the profound traumatic impacts on a child, children or a family system is trauma inducing for a partner. These losses of realities, and the ongoing reality of others being impacted and harmed, will no doubt provoke deep instinctive reactions, and biologically-based protective paternal instincts and reactivity, as often reflected in nature (ex. "Mama bear", "hornet's nest", etc.). Extreme rage may be expected when one's home, children, or family system is threatened and altered, outside of planned intent. For a partner to witness her young children having trauma symptoms due to sexual acting out in the family system, even in the midst of recovery, can often be a reminder and a significant source of traumatic re-experiencing (Dimension 6), inducing episodes of rage, for example.

Often a family system is invariably impacted by sex addiction. Partners may end up holding secrets from loved ones and family, experiencing a loss of integrity with others she had always cherished. Partners may lose friends, may find out their friends colluded or also violated her. The trauma may also cause social constriction and avoidance, causing significant changes to how the partner relates to her social reality, community, public space, and to human beings in general, including agoraphobic symptomology or loss of faith in humanity.

Dimension 12:

Treatment-Induced Trauma

The term, "treatment-induced trauma" was formulated and articulated by Dr. Omar Minwalla (2011), to describe symptoms being presented in clinical context among partners and spouses impacted by sex addiction (2005 - 2014). Treatment induced trauma involves both the induction of trauma and the traumatic symptom sequences experienced by the partner or spouse (Minwalla, 2012). Treatment-induced trauma is a clinical or medical intervention, which causes harm, a parallel re-injury, to the patient or client, and the traumatic consequences that ensue from the clinical interventions, or serious clinical omissions, perpetrated by therapists and medical professionals (Minwalla, O., 2012). Treatment-Induced trauma is another trauma inducing critical injury of SAIT. Often this dimension of trauma is caused by clinical interventions that are fundamentally organized on the traditional co-sex addiction model (COSA), or single-concept codependency model (CODA), and other traditional interventions, such as sex positive therapy, based in the omission of recognizing or treating SAIT among partners. Many "sex positive" counselors and educators will prescribe, "date nights or sex nights", for traumatized and sexually abused partners and couples impacted by SAIT, for example.

To reach out for help and be "let down" or "let go" or "hurt instead of helped" is of the utmost of serious violations in both medicine and human ethics and attachment relationships – to do no harm (American Psychological Association, 2010). It is the serious diagnostic mislabeling of well-established trauma symptoms (both PTSD and CPTSD) as an "addiction based in core wounds", and propagated by a foundational psychology of gender-based violence inherent in the model, that causes and inflicts damage and trauma to not only the partner, but also the addict, the couple, the children, the family system and society at large (Minwalla, 2012). In fact, the traditional sex addiction treatment model, which promotes co-sex addiction as the primary clinical diagnosis and clinical paradigm for treating partners, is a collusion with perpetration that is harmonious with the exact perpetration of the sex addict and sex addiction (SAIP) and is considered a specific sub-category of Dimension 7, Sex Addiction-Induced Perpetration (SAIP). Indeed, this may often present among the first concern that may need to be clinically addressed, and stabilized, in order to access other SAIT trauma experiences in the service of optimal treatment opportunities for the intimate partner or spouse.

Dimension 13:

Spiritual and Existential Trauma (Dimension 13):

One healthy dependency relationship for the human psyche, indeed an archetype of connection, is with the Universe, God, that which is beyond self or ego. This capacity for and established connection to transpersonal energy serves as vital stabilization for many people, including many partners. The vital relationship to "that which is beyond" (transpersonal) and that which supports us and protects us, (divine) systems of meaning (Herman, 1997), can be impacted by this specific type of structural ego-reality damage and injury (Dimension 3). Indeed, existential trauma or spiritual trauma is a form of ego fragmentation, possibly representing a foundational structure on which much of the psyche may be organized. The traumatic shattering of a person's existential reality and their relationship with divine systems of benevolence or protection (Herman, 1997) can be altered. This can result in ego destabilization, ruptures with benevolent or omnipotent attachment and core psychic reliance on God, faith, humanity, love, and life itself. Foundational components of spiritual conceptualization and meaning may be significantly altered. To the extent that spirituality, religion, faith, and existential factors impact and relate to our experience, and hold us up ultimately, is the extent that a partner may be traumatized by SAIT on this dimension, and fall and collapse deep within her soul.

"The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient's present symptoms and the traumatic experience is frequently lost." (Herman, J., 1997)

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