Journal of Sex & Marital Therapy, 37:45–55, 2011
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ISSN: 0092-623X print / 1521-0715 online
DOI: 10.1080/0092623X.2011.533585

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Disputing the Notion of Psychopathology Among Women Married to Hypersexual Men Using the MMPI-2-RF

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This article offers a report disputing the notion that women who are married to hypersexual men exhibit a constellation of pathological symptoms, although it is likely they experience marital distress. The authors measured psychopathology using the Minnesota Multiphasic Personality Inventory-2-Restructured Form and marital satisfaction using the Revised Dyadic Adjustment Scale. The authors failed to find evidence supporting a common belief that wives of hypersexual men have their own pathology. Wives of hypersexual men, however, were significantly more distressed about their marriages compared with the controls in this study. Overall, these findings contradict a characterization of wives of hypersexual men as being more depressed, anxious, chemically dependent, or otherwise dysfunctional.

Women who are married to hypersexual men are often distressed about the discovery or disclosure of their husband's sexual behavior (Reid & Woolley, 2006). Beyond this, however, some reports note that wives of hypersexual men may be distressed because of their own preexisting psychopathology (e.g., Schneider, Corley, & Irons, 1998). These findings raise questions about the primary source for distress among this population of women. The present

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study explores psychopathology and marital distress among women married to hypersexual men, compared with a group of control participants, to clarify that relation and to provide additional insights about this population.

Defining Hypersexual Behavior

Hypersexual behavior has been discussed from several perspectives, including sexual addiction (Goodman, 2001), sexual compulsivity (Coleman, 1991), sexual impulsivity (Gabbard & Bennett, 2005), and hypersexuality (Kafka, 2001; Reid, 2007). The phenomenon of hypersexuality can encompass socially deviant or normal expressions of sexual behavior and can manifest in solo or relational sexual activities. Examples include compulsive masturbation; protracted promiscuity; pornography dependence; multiple extradyadic relationships; excessive online sexual pursuits; solicitation of commercial sex workers or use of escort services, strip clubs, or other venues associated with the adult entertainment industry; and telephone sex (Kafka, 2001; Reid & Carpenter, 2009b).

Men—whose spouses were the subject of this study—were identified as *hypersexual* if they experienced the following symptoms for a period of 6 months or more: (a) repetitive and intense preoccupation with sexual thoughts, urges, and behavior; (b) multiple unsuccessful attempts to control sexual thoughts, urges, and behavior; (c) adverse consequences causing clinically significant distress or impairment in occupational, interpersonal, or social areas of functioning related to the intensity or frequency of sexual thoughts, urges, or behaviors, (d) the presenting symptoms experienced by the men could not have occurred exclusively within the context of another Axis I disorder (e.g., manic phase of bipolar), be substance induced, or occur as a direct result of a neurological insult, head trauma, or degenerative brain disorder; (e) their symptoms must have been observed as distinct and separate from the phenomenon of persistent sexual arousal syndrome, in which an individual experiences persistent sexual arousal in the absence of desire. The symptoms experienced by the men could include solo or relational sexual activities and could also occur comorbidly with paraphilic tendencies (Reid, Karim, McCrory, & Carpenter, 2010; Reid & Carpenter, 2009a).

In the present study, we used the label of *hypersexual behavior* in an effort to place the focus on sexual behavior and its consequences without assuming causal mechanisms or associated features still under debate which are inherent in perspectives derived from other models (e.g., sexual addiction). Nonetheless, there are a number of parallels between hypersexuality and addiction models that have been important in shaping both theory and interventions for this population of individuals.

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Women Married to Hypersexual Men

Following the discovery of the husbands' hypersexuality, wives report diminished intimacy, a loss of self-worth, and tendencies toward self-blame for their husbands' sexual choices (Matheny, 1998; McCarthy, 2002). These women may feel confused, betrayed, powerless, trapped, and hopeless about their marital situations (Manning, 2006; Schneider, 2000; Tripodi, 2006). Some researchers have reported that wives of hypersexual men experience disproportionate rates for eating disorders and chemical dependency (Manning & Watson, 2007; Schneider et al., 1998), whereas others describe wives' reactions to the discovery or disclosure of hypersexual behavior as a traumatic event (Steffens & Rennie, 2006). As these investigations have been carefully reviewed, a number of methodological limitations have been noted particularly as it pertains to sampling and statistical methods used in these studies (Reid, Carpenter, Draper, & Manning, 2010). For example, a number of these studies relied entirely on wives who have entered treatment while failing to include those who have not.

The current literature often paints an unfavorable portrait of women married to hypersexual men suggesting that they exhibit various psychopathology including clinical depression, anxiety, chemical dependency, eating disorders, and suicidal ideation (Wildmon-White & Young, 2002). These observations can inadvertently suggest that these are dysfunctional women who, along the course of their challenging lives, chose dysfunctional husbands. This implication potentially moves the focus from the marital dyad and from the consequences of having an unfaithful hypersexual spouse, instead placing it on the wives themselves. Although these findings are possibly true for some, it contradicts our clinical experience, which led us to question whether a more representative sample of wives would exhibit these attributes disproportionately when compared with controls.

The purpose of the present investigation was to examine psychopathology among a group of women married to hypersexual men, compared with a group of controls, to determine whether wives, on average, are significantly different across these attributes, as measured by the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF). We also wanted to compare levels of marital distress between the groups. We hypothesized that wives would not experience greater levels of psychopathology when compared with controls, however, they would be more distressed about their marriages.

METHOD

Participants

Participants in this study consisted of wives ($n = 49$) who were recruited from an outpatient mental health clinic in the Midwest that specializes in

the treatment of various sexual issues including hypersexuality. Some of the wives ($n = 31$) sought help along with their husbands, whereas others ($n = 18$) were specifically invited to come into the clinic for some couples' sessions with their husbands. The latter group did not seek clinical services nor were they attending any support groups. We obtained a high response rate of 96% from the wives in treatment and 93% from wives contacted by the primary therapist to participate in our study. Age of the wives ranged from 20 to 53 years ($M = 33.5$, $SD = 9.1$), and all were Caucasian. Relationship status included first marriage ($n = 39$), remarried ($n = 5$), and separated ($n = 5$).

The wives in this study were included because their husbands met the criteria for hypersexual behavior (described earlier). Consequences related to hypersexuality affected various facets of the hypersexual husbands' lives, including academic pursuits, parenting, friendships, employment, personal interests, and their marriages. These men experienced legal problems (e.g., arrests for solicitation of sex), financial losses, sexually transmitted diseases, loss of professional licensure, and psychological distress. Wives were selected consecutively on the basis of (a) husbands' Hypersexual Behavior Inventory scores ≥ 53 (Reid & Garos, 2007); (b) husbands' disorder was not paraphilic ($n = 3$ excluded); and (c) wives' willingness to participate ($n = 3$ excluded).

Control participants ($n = 44$) were drawn from a sample of (a) married female college students and (b) women in the community who were married to male students but not attending a university themselves. We specifically recruited participants for this sample through evening classes because these wives were often part-time, nontraditional students (or spouses of such students) and were more characteristic of women dwelling in the community. In addition, the controls were matched with the wives on the basis of similar demographic composition (determined by drawing participants with zip codes from the same area). Age of the controls ranged from 19 to 60 years ($M = 28.4$, $SD = 10.1$), with predominantly Caucasian representation (only 1 Hispanic woman and 1 Asian woman). Relationship status included first marriage ($n = 40$), remarried ($n = 3$), and separated ($n = 1$).

The controls were given a brief questionnaire that asked whether their husbands consumed pornography, engaged in telephone sex, had ever been unfaithful, or patronized strip clubs or venues associated with the adult entertainment industry. The questionnaire also asked whether the wives suspected their husbands of any sexual promiscuity or excessive tendencies of masturbation. In addition, wives married to men with any known paraphilic tendencies were screened. College women who endorsed any of these items ($n = 5$) were excluded from our sample.

Procedures

All men seeking help for hypersexual behavior were screened using the Hypersexual Behavior Inventory and required a cutoff score of 53 for their wives

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to be eligible for inclusion. Wives who did not accompany their husbands were recruited through a phone call by the primary therapist. All women completed a brief demographic survey, the MMPI-2-RF, and the Revised Dyadic Adjustment Scale.

Controls were recruited from a university and community sample. Students received extra course credit for their own participation or the participation of their wives. All data were collected ensuring confidentiality and anonymity of participant responses. All participants were given informed consent, and the study was approved by the university review board for research with human participants.

Measures

Hypersexual Behavior Inventory

The Hypersexual Behavior Inventory (Reid & Garos, 2007) is a 19-item self-report measure comprising three factors: control, coping, and consequences. These three domains of hypersexual behavior relate to (a) control over sexual thoughts, urges, and behavior; (b) consequences associated with hypersexual behavior; and (c) the extent to which an individual uses sex to cope with uncomfortable or unpleasant affective experiences. Items are reported on a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*very often*), with possible scores ranging from 19 to 95. Higher scores reflect greater hypersexuality, with 53 regarded as the cutoff for those experiencing difficulties with hypersexuality. Reliabilities have been high in varied clinical populations (control, $\alpha = .91$; coping, $\alpha = .91$; consequences, $\alpha = .89$), and the measure discriminates well between controls and hypersexual patient samples (Reid, Carpenter, & Lloyd, 2009; Reid, Harper, & Anderson, 2009).

MMPI-2-RF

The MMPI-2-RF is a substantially shortened version of the MMPI-2 and is linked conceptually and empirically to theories and models of personality and psychopathology. The measure includes five sets of scales: Validity, Higher Order (H-O), Restructured Clinical (RC), Specific Problem (SP), and Interest, as well as the Personality Psychopathology Five–Revised (PSY-5R) scales. The MMPI-2-RF technical manual provides extensive reliability and validity data for this instrument that match or exceed those found with the previous version, the MMPI-2 (Ben-Porath & Tellegen, 2008).

Revised Dyadic Adjustment Scale

The Revised Dyadic Adjustment Scale (Busby, Christensen, Crane, & Larson, 1995) was developed to measure facets of marital distress and captures elements of dyadic consensus, satisfaction, and cohesion. The scale consists of

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14 items (e.g., "How often do you and your partner quarrel?") scored on a 6-point Likert-type scale ranging from 1 (*always disagree*) to 6 (*always agree*). Two additional sections of the measures require endorsements ranging from *never* to *all the time* or *more often*. Scores can range from 0 to 69, with higher scores reflecting higher marital satisfaction. It was validated using confirmatory factor analysis on a sample of distressed and nondistressed couples ($N = 242$). The Revised Dyadic Adjustment Scale showed adequate criterion validity, internal consistency, and split-half reliability, and it demonstrated concurrent validity with other measures of marital adjustment and satisfaction (Busby et al.).

RESULTS

MMPI-2-RF Comparisons

MMPI-2-RF scores for wives of hypersexual patients were similar to those of control wives. Results of all variables compared are provided in Table 1. More systematically, these comparisons were grouped into several analyses. First, groups were compared on the demoralization subscale as an index of

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TABLE 1. Group Comparisons of Client Spouses Versus Control Spouses on Study Variables

	Wives ($n = 49$)		Controls ($n = 44$)			Effect size
	M	*SD*	*M*	*SD*	*F*	η^2
Dyadic Adjustment Scale–R	42.11	8.70	50.95	7.37	11.81*	.24
MMPI-2-RF RC Scales						
RCd: Demoralization	53.98	10.43	54.30	9.28	0.02	.00
RC1: Somatic complaints	54.96	9.45	57.23	12.16	1.02	.01
RC2: Low positive emotions	58.96	10.63	51.95	11.90	8.99*	.09
RC3: Cyncism	50.18	13.19	47.84	8.73	1.00	.01
RC4: Antisocial behavior	46.71	8.07	48.93	9.62	1.46	.02
RC6: Ideas of persecution	53.18	10.38	52.98	9.44	0.01	.00
RC7: Dysfunctional negative emotions	53.29	11.05	51.48	9.27	0.72	.01
RC8: Aberrant experiences	49.35	11.06	51.50	8.08	1.13	.01
RC9: Hypomanic activation	44.53	11.42	45.70	10.05	1.41	.02
Higher order scales						
Emotional/internalizing	54.12	12.27	51.91	11.35	0.81	.01
Thought	49.92	11.30	50.68	9.00	0.12	.00
Behavioral/externalizing	47.49	10.77	48.30	9.24	0.15	.00
Other MMPI-2-RF scales						
Helplessness/hopelessness	50.06	11.41	46.20	13.12	2.30	.02
Self-doubt	51.45	12.01	51.52	14.90	0.00	.00
Stress/worry	54.16	11.47	57.80	11.40	2.34	.03
Substance abuse	45.80	6.92	47.41	7.40	1.18	.01

Note. MMPI-2-RF = Minnesota Multiphasic Personality Inventory-2-Restructured Form.
*$p < .01$ (two-tailed).

overall distress and pervasive life dissatisfaction. Patient spouses ($M = 53.98$) did not differ from control spouses ($M = 54.30$), $F(1, 91) = .02$, *ns*.

Second, a multivariate analysis of variance comparing the groups on the remaining RC scales was significant, Wilks's lambda = 0.807, $F(8, 84) = 2.51$, $p < .05$. To clarify this group difference, the univariate *F*s were inspected, revealing that none of the RC scales was even close to significance, except for RC2, low positive emotionality, such that patient spouses ($M = 58.96$) scored significantly higher than did control spouses ($M = 51.95$), $F(1, 91) = 8.99$, $p < .01$. Cohen's d for the group difference on RC2 is .70, a medium effect size. Repeating the analysis with RCd as a covariate had little effect. A similar analysis of Personality Psychopathology Five–Revised scales yielded a similar result, with a difference arising only on the introversion/low positive emotionality scale (which is conceptually similar to RC2).

Third, using a multivariate analysis of variance, the groups were compared on the three higher order scales, revealing no meaningful differences, Wilks's lambda = 0.988, $F(3, 89) = .364$, *ns*. Univariate *F*s are presented in Table 1.

Fourth, groups were compared on specific scales most reflective of other dysfunctional patterns proposed by other researchers reviewed earlier. The MMPI-2-RF scales helplessness/hopelessness, self-doubt, stress/worry, and substance abuse were identified as meeting this criterion. As shown in Table 1, these additional scales yielded no meaningful differences.

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Marital Adjustment Comparison

Groups were also compared on the Revised Dyadic Adjustment Scale as a comparison point, emphasizing situational distress over the marriage, as opposed to the more pathology-based distress of the MMPI-2-RF scales. Because not all participants completed the Revised Dyadic Adjustment Scale, the sample sizes are somewhat smaller. Patient spouses ($M = 42.11$) scored significantly lower than did control spouses ($M = 50.95$), $F(1, 37) = 11.81$, $p < .01$. These mean values parallel fairly closely the norms of Busby et al. (1995) for distressed ($M = 41.6$) versus nondistressed ($M = 52.3$) couples. Using the cutoff score recommended by Busby et al. (distressed <48), 14 of the 19 spouses of hypersexual men (74%) fell into the distressed range, whereas only 4 of the 20 control spouses (20%) had scores in the distressed range, $\chi^2(1) = 11.30$, $p < .01$.

It is interesting to note that the score on the Revised Dyadic Adjustment Scale is more predictive of group membership than is RC2 ($r = .49$ vs. $r = .30$). Also, if the Revised Dyadic Adjustment Scale is first regressed onto group membership, RC2 add no additional predictive power to the regression equation (partial $r = .15$, $t = .89$, *ns*).

DISCUSSION

The findings derived from comparisons between the samples in this study provide important insights about women married to hypersexual men. We remind the reader that methodology used to obtain the group of wives of hypersexual men used in this study provided a more representative sample of this population as compared with earlier studies (e.g., Schneider et al., 1998; Wildmon-White & Young, 2002).

In exploring significant differences among the subset of wives of the hypersexual men, we found support for our hypothesis that, on average, they would not exhibit greater psychopathology than controls as measured by the MMPI-2-RF. This was true for all of the higher order scales, eight of the nine RC scales, and the four additional scales reflecting some of the reported correlated features of this population in the literature. Although the wives showed higher elevations than the controls on RC2, low positive emotions, this is not overly surprising given that they were as a group, more distressed about their marriages. Although this scale can be a marker for major depressive disorders, it tends to reflects social isolation, a paucity of interest (e.g., anhedonia), and some pessimism. Given the nature of the situation for the wives, some diminished elements of positive emotion should be expected. For example, anhedonia may have been evident in their lack of desire for sexual relations with their husbands.

Our findings of differences in marital distress are significant in that they are congruent with and support previous research findings using different samples (Reid, Carpenter, et al., 2010). For example, studies on the effects of hypersexuality on the family found hypersexual behavior to be (a) a predictor of decreased marital satisfaction, (b) a predictor of decreased marital intimacy, and (c) a major contributing factor to separation/divorce of the couples surveyed (Schneider, 2000). What this suggests is that hypersexual behavior is consistently being associated with serious and negative effects on the marital relationship and creating levels of personal distress, which clinicians should address when working with this population. It is also plausible, given research noting higher rates of demoralization, alexithymia, and emotional disturbance among hypersexual men (Reid, 2010; Reid & Carpenter, 2009a; Reid, Carpenter, Spackman, & Willes, 2008), that the marital distress in wives found in this data is related to the dynamics that exist when someone is married to an individual with such affective disturbance.

The MMPI-2-RF inquires about feelings and behaviors without reference to timeframe, intentionally avoiding any distinction between enduring and transient dysfunctional patterns. Thus, these data do not allow conclusions about whether the conditions were preexisting (which would make them more plausible as contributors to the spouses hypersexuality). We can only conclude that at the time of assessment—when, for the spouses of hypersexual men, they were aware of their husbands' behavior—the wives were,

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on the whole, psychological healthy, although admitting low positive emotions. We consider the elevation in low positive emotions of the wives of the hypersexual men to be most parsimoniously explained by their elevated marital distress.

Limitation and Future Research

This study was limited in several ways. This study is correlational and therefore does not address whether hypersexual behavior exerts a causal or interactive affect on marital distress. This study also possesses the limitations commonly associated with and found in studies in which self-report measures are used. In addition, results may differ from studies using samples defined by other perspectives, such as sexual addition.

Inferences about our findings beyond those listed in this study should be made with caution, in part because our sample was predominantly composed of Caucasian, heterosexual couples. We also did not screen for mental health disorders among the college sample, which could have affected the present results. In addition, a more diverse ethnic representation among participants in our sample would have been ideal. Although we made efforts to have a more representative sample and match on age and marital status (e.g., number of remarriages, separations), we acknowledge that some of our differences may have been the result of an age effect, and therefore, it is also possible that we failed to find some differences given that our controls were younger, on average, compared with the wives of hypersexual men.

Several findings from this study might prompt future research. In particular, it would be ideal to ensure more representative sampling when considering wives of hypersexual men. Future studies might also seek further understanding about what factors motivate wives in their decisions to accompany their husbands to treatment. The field also needs research exploring differences on the basis of subtypes of hypersexuality (e.g., solo vs. relational sex or modalities of hypersexuality) and whether the hypersexual behavior was discovered or disclosed. We would also encourage researchers to consider replication studies using other measures of psychopathology or structured diagnostic interviews. The findings from this study should be extended to broader family systems by investigating how children are affected as well as partners of hypersexual gay and lesbian couples.

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