COUPLE RECOVERY FROM PROBLEMATIC PORNOGRAPHY USE:
A PHENOMENOLOGICAL STUDY OF CHANGE MOMENTS
AND COMMON FACTORS

by

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ABSTRACT

Couple Recovery from Problematic Pornography Use:
A Phenomenological Study of Change Moments
and Common Factors

by

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Utah State University, 2019

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A body of previous research has shown that problematic pornography use (PPU) is associated with harmful individual and relational outcomes resulting in clinically significant distress. However, the research regarding treatment of PPU is limited, testing a few models for their effectiveness in PPU treatment, yet lacking a broader approach to discovering what has been successful for clients. The present study utilizes a common factors framework to organize the existing PPU treatment literature and effectively examines gaps in that body of research. Then, I employed a phenomenological approach to understand the lived experience of 11 heterosexual couples who have achieved significant recovery from PPU. The major themes that emerged from the interviews are Catalysts for Recovery, Foundation of Support for Recovery, The Work of Recovery, Healing Perspective of Recovery and Meaning Making, and Hindrances and Recovery Cautions. In addition to these themes, separate recovery trajectories have emerged for the
recovering user and the recovering partner that ultimately make up the majority of the recovery of the relationship. Subthemes and specific examples are discussed (see Tables D-1, D-2, and D-3) as well as implications of how these themes, in connection with the common factors framework, account for some of the missing research gaps in the field of recovery from PPU.

(146 pages)
PUBLIC ABSTRACT

Couple Recovery from Problematic Pornography Use:
A Phenomenological Study of Change Moments and Common Factors

Travis J. Spencer

Pornography use has been reported to have harmful effects on relationships and individuals. However, research on effective treatment for problematic pornography use (PPU) is limited. This manuscript reviews the previous treatment literature for PPU and highlights the gaps that need further study. Then, I discuss how I performed a qualitative study of 11 couples who had successfully been treated for PPU in order to analyze the key mechanisms of change that were employed in their recovery process and address the missing gaps in this field of research. The five major emerging themes from this study are Catalysts for Recovery, Foundation of Support for Recovery, The Work of Recovery, Healing Perspective of Recovery and Meaning Making, and Hindrances and Recovery Cautions (see figure in Appendix E). These themes are outlined with associated subthemes and representative quotes. Key implications for clinicians and future research are discussed.
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Travis J. Spencer
CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>PUBLIC ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>vi</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>II. BACKGROUND – PREVIOUS PORNOGRAPHY RESEARCH</td>
<td>3</td>
</tr>
<tr>
<td>III. METHODS</td>
<td>23</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>44</td>
</tr>
<tr>
<td>V. DISCUSSION</td>
<td>79</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>91</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>115</td>
</tr>
<tr>
<td>Appendix A</td>
<td>116</td>
</tr>
<tr>
<td>Appendix B</td>
<td>123</td>
</tr>
<tr>
<td>Appendix C</td>
<td>125</td>
</tr>
<tr>
<td>Appendix D</td>
<td>126</td>
</tr>
<tr>
<td>Appendix E</td>
<td>137</td>
</tr>
</tbody>
</table>
### LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-1 Recovering User Recovery from Problematic Pornography Use</td>
<td>126</td>
</tr>
<tr>
<td>D-2 Recovering Partner Recovery from Problematic Pornography Use</td>
<td>130</td>
</tr>
<tr>
<td>D-3 Relationship Recovery from Problematic Pornography Use</td>
<td>134</td>
</tr>
</tbody>
</table>
**LIST OF FIGURES**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-1</td>
<td>137</td>
</tr>
</tbody>
</table>

E-1 Major themes of couple recovery from problematic pornography use...........137
CHAPTER I

INTRODUCTION

Rising prevalence and acceptance of pornography use has led to much research concerning how it affects its users (i.e. Carrol et al., 2008; Rissel et al., 2017). Though, there is some evidence that pornography can be helpful to some (i.e. Kohut & Fisher, 2013; Rissel et al., 2017), the majority of pornography effects research says that it can be harmful to individuals (i.e. Peter & Valkenburg, 2016) and relationships (i.e. Doran & Price, 2014; Leonhardt & Willoughby, 2017). Empirical research has implied that problematic levels of pornography use is associated with outcomes such as diminished work productivity (Gupta, 2017), social isolation (Young, 2008), relationship distress (Szymanski & Stewart-Rishardson, 2014), and diminished sexual satisfaction (Leonhardt & Willoughby, 2017; Zillman & Bryant, 1988). The focus on harmful effects of pornography use has even led to recent political platforms and state legislation that declares pornography as a public health crisis (Chen, 2016; Kopan, 2016; Taylor, 2018), making the arguments that mainstream pornography is degrading women, promoting sexually risky behaviors to hyper-exposed adolescents, and increasing risk of sexual child abuse (Taylor, 2018). There are, however, theoretical, empirical, and political criticisms of this legislation (Fisher, Montgomery-Graham, & Kohut, 2018) including the counterpoint that many of the deleterious effects of pornography use diminish when mediated by religiosity and/or moral incongruence with pornography use (i.e. Fisher et al., 2018; Grubbs, Exline, Pargament, Volk, & Lindberg, 2017b). Regardless of the academic, moral, and political debates on how pornography use affects individuals and
relationships, there remains individuals and couples who seek treatment for problematic pornography use (PPU).

Though PPU is commonly reported as a presenting problem in relationship and family therapy, many therapists feel unprepared in their training and ability to address this issue (Ayres & Haddock, 2009; Jones & Tuttle, 2012). Additionally, there is a sizeable lack of scholarly literature on treatment of PPU. Most of the available literature focuses on the effectiveness of a few specific models or techniques in treating PPU (i.e. Crosby & Twohig, 2016; Young, 2007), yet largely disregards the mechanisms by which change occurs, including client hope and motivation, the therapeutic relationship, and social support that play a significant role in change processes.

There remains a need for a broader approach to discover what common factors of change (Sprenkle & Blow, 2004) have been effective in the treatment of PPU and the process by which they are effective. The purpose of this study is to utilize the common factors of change framework to first organize the previous treatment literature of PPU and highlight the factors that have still been highly under investigated in the process of recovery from PPU. Then, I will outline the current phenomenological study (Groenewald, 2004), where I examined the lived experiences of couples who have achieved significant improvement in their recovery from PPU, particularly focusing on common factors of change and key change moments that were important roles in the treatment process. Results of the study and clinical implications of the findings will follow.
CHAPTER II
BACKGROUND – PREVIOUS PORNOGRAPHY RESEARCH

Prevalence and Acceptance of Pornography

Pornography is increasingly prevalent throughout many societies of the world (Price, Patterson, Regnerus, & Walley, 2016). Technological advances have streamlined the accessibility, affordability, and anonymity of pornography, creating a “Triple-A Engine” that is dramatically increasing its reach and impact (Cooper, Delmonico, & Burg, 2000). Still, precise pornography usage statistics fluctuate between studies due to varying types of survey questions asked and populations surveyed (Regnerus, Gordon, & Price, 2016). For example, one study of 813 college students from six universities across the United States found that 87% of emerging adult men and 31% of emerging adult women reported using pornography at least monthly (Carroll et al., 2008). Another study of 5165 adults under age 40 report that 69% of men and 40% of women use pornography in a given year, while 46% of men and 16% of women viewed pornography in a given week (Regnerus et al., 2016). A population study of Norway reports that 90% have viewed pornography at some point in their lives (Træn, Spitznogle, & Beverfjord, 2004). Despite the varying usage statistics between studies, we can safely conclude that pornography use at some level is highly pervasive among the citizens of our society.

The high prevalence of pornography use is strongly connected with increasing pornography acceptance (Carroll et al., 2008; Willoughby, Carroll, Nelson, Padilla-Walker, 2014) especially among youth and emerging adult generations (Leonhardt & Willoughby, 2018), adding acceptance as a fourth component to Cooper and colleague’s
(2000) “Triple-A Engine”. With intensifying accessibility, affordability, anonymity, and acceptance, it is little wonder that the pornography industry is a multi-billion-dollar industry in the US alone, still maintaining astronomical revenues despite the innumerable manifestations of free pornography that is so easily and readily available to consumers (Cowan, 2010; Makin & Morzcek, 2015). Due to the increasing prevalence of pornography and acceptance of its use, much research is being done to evaluate how pornography is affecting its users. The next section will review the potential effects of pornography found in scholarly research.

Potential Effects of Pornography Use

Potential Positive Effects

A great debate has developed as research shows both positive and negative outcomes for pornography use (Leonhardt, Spencer, Butler, & Theobald, 2018a). Some studies report that pornography can have educational benefits, asserting that increasing knowledge of sexual anatomy and sexual practices can increase individual and couple sexual satisfaction (Daneback, Traeen, & Mansson, 2009; Kohut & Fisher, 2013; Rissel et al., 2017). Other studies claim that pornography is primarily used for entertainment and has little effect on its viewers (e.g. Hald & Malamuth, 2008; Kohut, Fisher, & Campbell, 2017; Rissel et al., 2017) while also providing a safe place for an individual to explore sexuality (Attwood, Smith, & Barker, 2018; Goodson, McCormick, & Evans, 2001). Findings such as these may mitigate some of the concern regarding the high prevalence and acceptance of pornography.
Potential Problematic Effects

Although research has shown some possible positive effects of pornography use, this is only one side of the story. Many pornography users report their pornography use as having some level of a problematic effect on their lives (Hald & Malamuth, 2008; Kohut et al., 2017). Additionally, there is a sizeable body of scholarly literature that suggests that pornography use can be harmful to individual and relationship wellbeing (Leonhardt et al., 2018a).

Potential problematic individual effects. The majority of pornography effects research focuses on individuals. For example, pornography use has been associated with elevated risk-taking behaviors in men and negative mental health outcomes in women (Willoughby et al., 2014). Pornography use has been shown to predict lower marriage importance, higher relationship anxiety, and more permissive sexual attitudes for individuals (Leonhardt & Willoughby, 2018; Leonhardt et al., 2018b; Peter & Valkenburg, 2016). Earlier exposure to pornography was related to problematic outcomes such as earlier first sexual intercourse (Kraus & Russel, 2008), and elevated problematic pornography use later in life (Willoughby, Young-Petersen, & Leonhardt, 2018). Elevated or problematic use of pornography was also related with negative outcomes such as reduced neural plasticity, or the ability for the brain to change and adapt to stimuli and/or changing environments (Kühn & Gallinat, 2014), neurological and behavioral mechanisms similar to other behavioral and/or substance addictions (Gola et al., 2017; Kraus, Voon, & Potenza, 2016b), diminished work productivity (Gupta, 2017), reduced religiosity (Perry, 2017), and increased feelings of loneliness (Butler, Pereyra, Draper, Leonhardt, & Skinner, 2018; Yoder, Virden, & Amin, 2005), social isolation.
(Twohig, Crosby, & Cox, 2010; Young, 2007), and shame (Gilliland, South, Carpenter, & Hardy, 2011; Hook et al., 2015). Furthermore, use of pornography was connected with adult sexual dysfunctions (Hunt & Kraus, 2009), unrealistic sexual expectations (Doornwaard et al., 2017), and sexual objectification (Klaassen & Peter, 2015; Zurbriggen, Ramsey, & Jaworski, 2011).

**Potential problematic relational effects.** Research also shows that pornography use may also harmfully affect relationships. Szymanski and colleagues related pornography use with diminished trust and satisfaction in the relationship as well as increased psychological distress and reduced self-esteem in the user’s partner (Stewart-Richardson & Szymanski, 2012; Szymanski, Feltman, & Dunn, 2015; Szymanski & Stewart-Richardson, 2014). The user’s partner may respond to disclosed pornography use as a betrayal accompanied with trauma-like symptoms (Hentsch-Cowles & Brock, 2013; Schneider, Weiss, & Samenow, 2012; Vogeler, Fischer, Sudweeks, & Skinner, 2018). Furthermore, pornography use can lead to diminished availability, responsiveness, closeness, and intimacy, which can erode trust and lead to higher levels of couple distress (Szymanski & Stewart-Richardson, 2014; Zitzman, 2007; Zitzman & Butler, 2009). In one study, higher pornography use led to less relational commitment, which mediated the connection between pornography use and infidelity (Lambert, Negash, Stillman, Olmstead, & Fincham, 2012). Longitudinal data showed that the likelihood of divorce doubled for married Americans who began viewing pornography in their marriage (Perry & Schleifer, 2018).

Due to the nature of pornography portraying sexual scripts or examples of what a sexual relationship could or should look like, particularly the scripts portrayed by today’s
popular pornography (Fritz & Paul, 2017; Klaassen & Peter, 2015), there is the possibility that pornography use most potently affects sexuality in relationships (Leonhardt & Willoughby, 2017; Leonhardt et al., 2018a). Some negative sexual effects are addressed in the individual effects section such as unrealistic sexual expectations (Doornwaard et al., 2017) and sexual objectification (Klaassen & Peter, 2015; Zurbriggen, Ramsey, & Jaworski, 2011), and it is likely that these individual effects also affect sexual relationships. Additionally, pornography use has been associated with sexual aggression (Peter & Valkenburg, 2016), and ultimately lower sexual satisfaction (Leonhardt & Willoughby, 2017; Szymanski & Stewart-Richardson, 2014; Wright, Tokunaga, Kraus, & Klann, 2017; Zillman & Bryant, 1988).

Although the research on the problematic individual effects of pornography use is more prevalent, most individuals seeking treatment to stop viewing pornography do so for relational reasons such as concerned parents (Rothman, Kaczmarsky, Burke, Jensen, & Baughman, 2015; Rothman, Paruk, Espensen, Temple, & Adams, 2017;), perceived future relationship challenges (Leonhardt et al., 2018b; Rothman et al., 2015) and betrayed partners (Manning & Watson, 2008; Vogeler et al., 2018; Zitzman & Butler, 2009). Thus, potential problematic relational effects may be especially pertinent for clinicians to inform treatment with the qualitative factors that may be at the core of their client’s concerns with their pornography use (Gola, Lewczuk, & Skorko, 2016).

While the literature indicates a net negative effect of pornography on its users, there exists a discrepancy between those who report a positive or a lack of negative effects as opposed to those who experience negative outcomes. Recent research has suggested that there are mediating variables that assist in explaining why pornography
use is problematic for some and not others (Leonhardt et al., 2018a). These underlying reasons for the possible pornography effects can be particularly helpful for clinicians assisting clients seeking recovery from problematic pornography use (PPU) (Gola et al., 2016).

**Mediating variables of potential negative effects.** There is a growing body of recent literature that asserts that those who report higher levels of religiosity and/or conservative values are more likely to report adverse pornography effects (Cranney & Štulhofer, 2017; Grubbs & Hook, 2016; Rasmussen, Grubbs, Pargament, & Exline, 2018). Additionally, there is increasing literature claiming that many of the negative outcomes are related to the individual’s self-diagnosed addiction to pornography as opposed to a less problematic compulsion or habit (Grubbs et al., 2017d; Grubbs, Engelman, & Grant, 2017a; Grubbs, Exline, Pargament, Hook, & Carlisle, 2015; Leonhardt et al., 2018b; Twohig, Crosby, & Cox, 2009). These two findings portray the possibility that believing pornography to be problematic, either as being incongruent with the individual’s values or as a behavior that feels out of control, may account for many of the adverse effects of PPU. However, it could also be explained that more religious pornography users and those that describe their relationship with pornography as an addiction may not be the only ones that experience adverse effects but are simply more motivated to do something about it. Another explanation is that these groups of pornography users could merely be more likely to attribute personal issues to the use of pornography. No matter the reason, the research is clear that conservative, religious, and self-diagnosed addiction populations report experiencing more deleterious effects of
pornography use (Bradley, Grubbs, Uzdavines, Exline, & Pargament, 2016; Grubbs et al., 2015; Grubbs, Wilt, Exline, Pargament, & Kraus, 2018).

Regarding relationally-oriented mediators of pornography, one study suggested that pornography use discrepancies between partners (one partner views more porn than the other) could also be a mediating factor for negative couple outcomes (Willoughby, Carroll, Busby, & Brown, 2016), suggesting that if both partners are morally accepting of using pornography and use it together, then negative effects may be diminished. More research is needed to fully examine factors that contribute to acceptance of a partner’s pornography use. Nevertheless, research still shows adverse effects of pornography use for individuals and relationships (Manning, 2006) as outlined in the previous sections.

**Treatment Prevalence and Implications**

Regardless of the possible positive or negative effects of pornography use on individuals and their relationships, and irrespective of why those effects are reported, there remain some individuals who seek therapeutic help for clinically significant distress regarding their PPU. The previously cited research in combination with survey research of how people perceive their pornography use (Grubbs et al., 2017b; Leonhardt et al., 2018b; Willoughby & Busby, 2016), provides strong evidence that at least a significant minority of both individuals and relationships that experience their pornography use as clinically problematic. However, the fraction of people who view their pornography use as problematic that actually seek out treatment is even smaller. In one study, 14% of male pornography users reported interest in seeking treatment for their pornography use, while only 6.4% had previously sought out treatment (Kraus, Martino, & Potenza, 2016a). In
another study only 5.4% of Polish pornography using women were seeking treatment for their PPU (Lewczuk, Szmyd, Skorko, & Gola, 2017). Current statistics demonstrate that there may be barriers (i.e. stigma, treatment availability, financial means) that complicate the treatment seeking process for PPU (Kraus et al., 2016a). Despite the seemingly low levels of interest for treatment of PPU, there are still people, particularly those in highly conservative and religious communities (Grubbs et al., 2015; Kraus et al., 2016a), that desire treatment for PPU. Additionally, there are reports by marriage and family therapists (MFTs) that pornography use is regularly disclosed by clients in therapy as being problematic (Ayres & Haddock, 2009). Irrespective of the moral, political, and academic debate surrounding the issue of pornography use and how it affects its users, there is still a need to better understand effective treatment of PPU for these clients desiring treatment.

**Conceptual Framework: Common Factors of Change**

Although a substantial amount of scholarly work has been done in the area of pornography use effects, much less is known about its treatment and the change process in particular. In this study, I seek to help fill this gap by examining the most important change mechanisms for couples who have successfully worked through one partner’s PPU. To do this, a common factors theoretical framework is appropriate (Sprenkle & Blow, 2004). Common factors refer to the core ingredients of change that exist independent of specific therapy models that make therapy effective (Frank, 1971; Sprenkle & Blow, 2004; Wampold & Imel, 2015).
For the past 80 or so years, common factors models and ideas have been explored as a compliment to the evidence-based movement, which has sought to determine what models work for whom (Sprenkle & Blow, 2004; Weinberger, 1995). In the early 1990’s, Frank and Frank (1991) built upon previous common factors literature and claimed that all psychotherapies shared four elementary components: (a) an emotionally charged confiding relationship with a helping person; (b) a setting that is judged to be therapeutic, in which the client believes the professional can be trusted to provide help on his or her behalf; (c) a therapist who offers a credible rationale or plausible theoretical scheme for understanding the patient's symptoms; and (d) a therapist who offers a credible ritual or procedure for addressing the symptoms. This scholarly work was just the beginning of an outpouring of common factors literature over the next couple decades. Though there appears to be a movement towards unifying common factors literature (Sprenkle & Blow, 2004), there has yet to be an official consensus on exactly what the common factors of change are (Davis, Lebow, & Sprenkle, 2012; Fife, Whiting, Bradford, & Davis, 2014; Lambert, 1992; Sprenkle & Blow, 2004).

Due to the lack of research regarding effective treatment of PPU, a common factors framework is an effective structure for organizing the limited existing PPU treatment literature, providing a foundation for the current study research questions, and presenting directions for future research. For the purposes of this study I have identified four major categories of common factors which are (a) client variables (Sprenkle & Blow, 2004; Tallman & Bohart, 1999), (b) therapist variables (Davis et al., 2012; Simon, 2012), (c) relationship variables (Fife et al., 2014; Miller, Duncan, & Hubble, 1997), and (d) extratherapeutic factors (Lambert, 1992; Miller et al., 1997). Within each of these
categories are several common factors of therapeutic change that I outline in the subsequent sections. These chosen categories and subcategories of common factors are not an exhaustive list, but rather represent a majority of common factor themes that directly apply to the previous treatment literature of PPU as well as the current study. This framework is used to organize and present the previous literature regarding effective treatment of PPU.

**Client Variables**

Just as aerobic machines or fitness programs will not help an individual achieve better health without their participation, therapists and therapeutic techniques also cannot force a client into improved wellbeing (Tallman & Bohart, 1999). Client variables have accounted for up to 40% of change in the therapeutic process (Miller et al., 1997), quite possibly making clients and what they bring to therapy most responsible for whether or not change occurs. Common client variables of change include a client’s commitment to change (Davis et al., 2012; Sprenkle & Blow, 2004), their hope for change (Davis et al., 2012; Lambert, 1992), and their efficacy for change (Rand, 2017). There is some argument in the literature that commitment, efficacy, and hope may all be measuring the same construct (Zhou & Kam, 2016). However, for the purpose of this study and in line with the previously cited literature, a client’s commitment to change is their desire for change, a client’s hope is their belief that they can and will change, and a client’s efficacy is their belief that they currently have the resources and ability to change. Once again, there is little research that specifically focuses on client variables in PPU treatment. The majority of what I discuss in this section are side arguments that some studies proposed
regarding client variables, but they were often not the primary findings or the focus of the article, again indicating that this is a highly understudied variable in this field.

**Commitment for change.** Few studies mention the client’s commitment to change as a factor in PPU treatment, however, the few that do emphasize its importance. Reid (2007) showed that a significant proportion of clients seeking treatment for PPU had high levels of ambivalence about the changes they desired. He asserts that it is important to first assess the client’s readiness for change before administering interventions that may be ahead of the client (Reid, 2007). A study by Gilliland and colleagues (2011) showed that feeling guilt for PPU significantly increases a client’s motivation for change while feelings of shame around PPU decreases their motivation for change. The importance of the client’s commitment to change in the PPU treatment process necessitates further examination.

**Hope for change.** Multiple models of therapy include efforts in fostering hope in their clients as a primary and initial part of the therapeutic process (Davis et al., 2012). However, a client’s level of hope seems to be an unaddressed variable in PPU treatment literature. Though hope is not specifically explored in the recovery process from PPU, conceptually, shame diminishes hope and there is some mention of shame in the PPU treatment literature (Chisholm & Gall, 2015; Gilliland et al., 2011).

**Efficacy for change.** Very little research discusses efficacy for change regarding PPU. However, one study by Kraus, Rosenberg, and Tompsett (2015) evaluated a new measure for assessing individual’s self-efficacy in effectively utilizing cognitive behavioral strategies for reducing PPU. This study provides a list of self-initiated
pornography reduction strategies that individuals may employ as a sign of higher self-efficacy in their ability to diminish PPU (Kraus et al., 2015).

**Therapist Variables**

Therapist variables of therapeutic change address what the therapist is responsible for in the change process. Research on therapist variables reports that there is greater variance in treatment outcome due to therapist differences than the treatment models they used (Wampold, 2001) and it has been difficult to define the differences that account for the variance (Davis et al., 2012). The broad categories of therapist variables in common factors literature include the therapist’s chosen diagnosis and treatment models (Sprenkle & Blow, 2004), the specific skills/techniques the therapist uses in treatment (Fife et al., 2014; Simon, 2012), and the therapist’s way of being (Anderson, 2006; Blow, Sprenkle, & Davis, 2007; Fife et al., 2014).

**Models.** The majority of PPU treatment literature focuses on therapist variables, primarily proposing theoretical treatment models that focus on how PPU should be conceptualized and what the therapist should do (i.e. Cohn, 2014; Ford, Durtschi, & Franklin, 2012). Referring again to Frank and Frank (1991), two of their four elementary components of effective psychotherapy are covered within theoretical models. Models are where the therapist offers a plausible theoretical scheme for understanding the client’s problem (diagnosis), and a credible procedure for addressing the problem (treatment).

**Diagnosis models.** Diagnosing PPU in therapy exposes another debate in the field of PPU treatment, with researchers and clinicians expressing strong opinions about how some diagnosis terminology or conceptualizations may support treatment while some may impede treatment and recovery (Cohn, 2014; Grubbs et al., 2017c; Sniewski, Farvid,
Disagreements in the literature have existed for several decades about how problematic sexual behavior should be conceptualized and diagnosed (Coleman, 1987; Kafka, 2009; Kor, Fogel, Reid, & Potenza, 2013). The prominent diagnosis models, particularly for PPU, are compulsive sexual behavior (i.e. Cohn, 2014; Coleman, 1987), sex addiction (i.e. Ayres & Haddock, 2009; Bird, 2007; Carnes, 1983, 1991; Ford et al., 2012; Love, Moore, & Stanish, 2016; Young, 2008), internet infidelity (i.e. Hertlein, 2011; Hertlein & Piercy, 2008; Schneider et al., 2012), hypersexuality (i.e. Gilliland et al., 2011; Grubbs et al., 2017a), and problematic pornography use (i.e. Crosby & Twohig, 2016; Gola & Potenza, 2016; Sniewski et al., 2018; Wetterneck, Burgess, Short, Smith, & Cervantes, 2012). The differences between these models seems to be that the addiction, internet infidelity, and hypersexuality models often view pornography use as objectively harmful for individuals and relationships while the compulsive sexual behavior and problematic pornography models conceptualize pornography as only being harmful to some because of other confounding variables that define the pornography use to be problematic for them. Therefore, how the therapist diagnoses PPU seems to highly affect how they will treat it (Ayres & Haddock, 2009). Therapists should be aware of how their individual theoretical perspective and personal biases may be impeding effective treatment and should seek evidence-based models of diagnosis and treatment (Duffy, Dawson, & das Nair, 2016; Hertlein, 2011; Hertlein & Piercy, 2008; Walters & Spengler, 2016). Kraus and colleagues (2016b) suggested that it is important for clinicians to develop and utilize effective screening practices or measures that assist in the effective diagnosis of PPU symptoms.
**Treatment models.** Multiple models of treatment have been explored theoretically in their application for effectively treating PPU including structural family therapy (Ford et al., 2012), motivational interviewing (Giudice & Kutinsky, 2007), dissociative states therapy (Southern, 2008), and emotionally focused therapy (Love et al., 2016). Mindfulness-based relapse prevention and spiritually integrated therapies have been suggested as ideal for treating the shame component of PPU (Chisholm & Gall, 2015; Gilliland et al., 2011). Narrative approaches have been explored by changing the meaning the couple or individual creates around the PPU (Cohn, 2014). There are also a few articles that present ideas for specific steps or stages of recovery that do not necessarily follow traditional therapy models and require additional empirical evidence to prove their effectiveness (Schneider et al., 2012; Southern, 2008; Young, 2008; Young, Griffin-Shelley, Cooper, O’Mara, & Buchanan, 2000).

Cognitive behavioral therapies (CBT) have been the most empirically researched models proven to effectively treat PPU (Young, 2007). Included in the CBT model umbrella is acceptance and commitment therapy (ACT; Crosby & Twohig, 2016; Twohig & Crosby, 2010), along with a CBT-based experiential group therapy (Klontz, Garos, & Klontz, 2005). With these being the only empirically supported models for PPU treatment, there is a great need for further empirical research regarding effective PPU treatment (Wéry & Billieux, 2017; Sniewski et al., 2018). Additionally, there is a growing body of literature exploring medical treatment for PPU (i.e. Gola & Potenza, 2016; Khazaal & Zullino, 2006; Wainberg et al., 2006). However, an exploration of nontherapeutic treatment literature is beyond the scope of this paper. There is a multiplicity of ways that a clinician may address diagnosis and treatment, however, in
accordance with common factors, simply having a model is maybe what is most important (Frank & Frank, 1991).

**Skills and techniques.** In addition to clinical models of treatment, there are a few articles that also focus on the effectiveness of specific interventions. Some of the research claims that appropriate disclosure is both necessary and helpful for a couple’s recovery from PPU but should be navigated sensitively by the therapist (Bird, 2007; Corley & Schneider, 2002). Schneider (2000) has recommended making internet access more regulated and less anonymous as well as combating isolation through increased time with relationships and social activities. Gilliland and colleagues (2011) suggested that it is important for therapists to teach their clients to recognize the difference between shame and guilt and offer techniques to reduce feelings of shame. Affirmations have been proposed as another effective way to combat the shame often connected with PPU (Giudice & Kutinsky, 2007). Meditation / mindfulness is another skill that was empirically proven to be effective treatment (Klontz et al., 2005). While treating PPU in relationships, attachment-based enactments have been conceptually explored as an effective technique (Seedall & Butler, 2008). One of the most common findings regarding therapist skills and techniques in PPU treatment literature was that most therapists did not receive instruction in their graduate programs regarding the treatment of PPU and thus felt inadequate in their ability and skills to treat this presenting problem (i.e. Ayres & Haddock, 2009; Jones & Tuttle, 2012). It is important that there be additional empirical research done on specific interventions for PPU and that these skills be taught in therapist training programs, along with effective models.
Way of being. There are only a few articles that approach mentioning the therapist’s way of being in connection with pornography treatment. In addressing a small part of the therapist’s way of being, several articles agree that the therapist’s personal attitudes towards pornography affects their treatment approach, thus PPU treatment models should have self-of-the-therapist considerations (Ayres & Haddock, 2009; Hertlein, 2011; Hertlein & Piercy, 2008). Additionally, if treating PPU in a relationship, it is imperative that the therapist be able to sensitively and empathetically explore the partner’s experience with the PPU in the relationship (Bird, 2007). Simon (2012) proposed that there is too much attention given in therapy research on the efficacy of models and techniques while generally neglecting more examination on what effective therapists do and this seems to be the same when it comes to PPU treatment literature.

Relationship Variables

There are a variety of relationships that affect treatment of all presenting problems in therapy. This section focuses on the therapeutic alliance and relationship therapy as common factors of change for PPU treatment.

Therapeutic alliance. At the convergence between the client’s role in the change process and the therapist’s role, is how they come together creating a unique alliance that has been shown to influence up to 30% of psychotherapy outcome (Lambert, 1992). Other scholars may claim that the therapeutic alliance accounts for less, yet it is seemingly universal in the research that the therapeutic relationship is a powerful factor in the change process (Sprenkle & Blow, 2004). According to Bordin (1979), therapeutic alliance variables can be broken up into the therapeutic goals and tasks that are mutually decided upon in the treatment process, as well as the bonds that are shared between
therapist and client. Treatment of PPU literature rarely addresses the role of the therapeutic alliance. Gilliland and colleagues (2011) suggested that a supportive therapeutic relationship can assist in reducing toxic shame that may be a major aspect of PPU, while Giudice and Kutinsky (2007) suggested that aspects of motivational interviewing (i.e. affirmations and client autonomy) can be uniquely effective in fostering a healing alliance with PPU clients. Additional research is necessary on the role of the therapeutic alliance in treatment of PPU, particularly addressing the role of goals, tasks, and bonds as key elements of the therapeutic alliance.

**Relationship therapy.** Sprenkle and Blow (2004) claimed that it is a common factor of change unique to marriage and family therapy to conceptualize human difficulties in relational terms. Relationship therapy as a common factor indicates that it might not matter as much what you do with the couple in treatment, simply having the couple together in therapy creates positive change. This relational conceptualization expands the direct treatment system of the client as well as the therapeutic alliance, allowing the therapist to bond with additional members of the system and utilize them for positive change in the system (Sprenkle & Blow, 2004). Applied to PPU treatment, some literature claims that relationship therapy could be more effective in treating PPU than individual therapy (Bird, 2007; Love et al., 2016). Additionally, Zitzman and Butler (2005) proposed with some empirical backing that conjoint marital therapy is an essential component in treating PPU in relationships due to its ability to provide relationship and individual healing for both partners. Hentsch-Cowles and Brock (2013) theoretically utilized systems theory to claim that the partner of the pornography user (or co-addict) has an important role in the recovery process for themselves and their addicted partner.
Schneider et al. (2012) proposed ideas for treating the partner’s betrayal symptoms such as validation, education, social support, structure, and hope. It is clear that the partner is in a key position to influence recovery from PPU and should be further investigated empirically.

Extra-Therapeutic Factors

The change process for clients of all presenting problems does not only take place within a therapy room. There are out of therapy experiences and decisions that can greatly influence therapeutic outcomes. Lambert (1992) has suggested that these extra therapeutic factors would include life experiences and environments such as social support, community involvement, and stressful/fortuitous events. Unfortunately, extratherapeutic factors are another area of the PPU treatment literature that is underexplored. The following are some of the few examples where extratherapeutic factors have been examined in the PPU treatment research.

Social support. Because PPU has be significantly and bidirectionally related with loneliness (Butler et al., 2018; Yoder, Virden, & Amin, 2005), a common part of PPU treatment plans involves some form of social support. Group therapies have often been suggested for PPU treatment and shown to be effective (Flores, 2007; Line & Cooper, 2011; Lothstein, 2001;). Though there is some debate on its effectiveness, some clinicians and clients have found 12-step groups such as Sexaholics Anonymous (SA) to be helpful in providing extra therapeutic recovery support (Stein & Goodman, 2017; Young et al., 2000). One article discusses the benefit of using online resources to assist in social support for PPU recovery such as chat rooms, newgroups, and bulletin boards.
(Putnam & Maheu, 2000). From these findings, there is evidence that social support may be a key element in recovery from PPU and should be studied further.

**Community involvement.** No articles that address community involvement related to PPU treatment. There are a few articles that address social isolation as a common personal effect of PPU (Twohig & Crosby, 2010; Young, 2007), but never has community/social involvement been investigated as a possible support for PPU treatment.

**Stressful/fortuitous events.** Pornography use is often conceptualized as a coping mechanism for life stressors (i.e. Kraus et al., 2015; Kraus et al., 2016b; Reid, Li, Gilliland, Stein, & Fong, 2011). If this is true, events that increase stress may have a significant impact on the recovery process. One study showed that stressful life events such as emotional abuse (Shapero et al., 2014) that have a prolonged traumatic effect may lead to increased coping behavior. Another study showed that marital distress was reciprocally related with increased use of sexually explicit internet material (Muusses, Kerkof, & Finkenauer, 2015). It is important for future research to take a closer look at how stressful and/or traumatic life events effect PPU treatment and recovery timelines.

**Purpose and Relevance of the Study**

As shown, the available academic literature regarding the effective treatment of PPU is limited. Most of the studies done previously suggest specific therapeutic models and interventions for their effectiveness in treatment of PPU but lack the broader approach of discovering what clients have found to be most helpful in their recovery. This includes a major shortage in PPU treatment literature investigating key common factors of change (i.e. client and extra therapeutic variables). The purpose of this study is
to address some of the largely neglected gaps in the research concerning effective therapeutic treatment of PPU and how change actually occurs. This study is the first of its kind, as far as I could tell, to take an exploratory approach in ascertaining what has been most helpful to couples as they successfully went through the process of recovery from PPU, specifically addressing each of the aforementioned common factors of change and their influence on PPU treatment. Ultimately, I sought to discover how couples recover from PPU and what might be the key change moments in that recovery.
CHAPTER III

METHODS

Irrespective of the political, academic, and cultural debates regarding how pornography use affects its users, there are still individuals and couples who consider their pornography use to be problematic and seek treatment (Kraus et al., 2016a). However, treatment of problematic pornography use (PPU) is not sufficiently addressed in academic literature. Few articles test specific models in the treatment of PPU, but none seem to outline core elements of change in the recovery process. Even less is known about how couples recover from PPU as a clinically significant issue in their relationship. The purpose of this study is to give a more comprehensive understanding of the process by which recovery from PPU occurs within romantic relationships. More specifically, I explore how common factors of change are experienced throughout the couple recovery process from PPU and how they elicit key change moments in and outside of therapy.

Research Design

Qualitative Research

In this study we sought to discover the lived experience of couples who achieved self-perceived significant recovery from PPU. This goal naturally lends itself to qualitative methodology. More specifically, a qualitative design best fit this study for the following reasons: (a) the design helps broaden the field of PPU treatment literature by giving an in-depth picture of the recovery process from PPU, and (b) it gives further insight as to what important aspects of PPU treatment from the client’s perspective still needs to be further researched. Thus, broadly exploring the topic in question by
investigating self-reported lived experiences and sifting through their layers of meaning will assist in creating a foundation for this field of research that is greatly lacking.

**Phenomenology**

Within the field of qualitative research and the broad range of research design options (Creswell, Hanson, Clark Plano, & Morales, 2007), one approach is phenomenology. Phenomenology is the search for a better understanding of phenomena by examining the perspectives of those involved (Groenewald, 2004; van Manen, 2016). The phenomenological process typically involves collecting the lived experiences of people regarding a phenomenon (i.e. recovery from PPU) and analyzing what similarities exist between those experiences (Creswell et al., 2007; Daly, 2007; Groenewald, 2004). Unlike grounded theory where a theoretical model is created from self-reported experiences, phenomenology seeks to understand and describe the essence of what and how a phenomenon is experienced (Creswell et al., 2007; van Manen, 2016).

Phenomenology is founded in the philosophy of how objects, actions, and events appear in the subjective consciousness of each participant, in other words, their lived experience. A key component of phenomenology is intersubjectivity. Intersubjectivity is the idea that, although every reality has subjective perceptions, there are also common elements and shared meanings within those realities (Creswell, 2007). With a phenomenology design for this study I sought to discover the essence of the phenomenon of recovery from PPU by evaluating the common elements and shared meanings among the recovery stories of 11 couples.

Within phenomenological research, there are multiple approaches for carrying out a phenomenological study. For this study I have chosen a transcendental or psychological
approach outlined by Moustakas (1994) for its focus on the subjective experiences of the interviewees rather than the interpretation of the researcher (Creswell et al., 2007). Moustakas claims that it is important for the researcher to take a fresh perspective of the phenomenon under investigation. Thus, transcendental in this context means “in which everything is perceived freshly, as if for the first time” (Moustakas, 1994, p. 34). Therefore, an initial step in this approach is to acknowledge and separate out my own experience with this phenomenon, a technique called bracketing (Creswell et al., 2007; Groenewald, 2004). I delineate (or bracket) my experiences later in the methods. Finally, one of the aims of phenomenological research is to immerse the reader in the story to the extent that they feel personally addressed by the overarching story presented; that their own humanity may connect with the humanity of the participants in the story being told (van Manen, 2007). I believe that the story told by the 11 participating couples is not only understandable, but also relatable and inviting of introspection.

Data Collection

Recruitment

Recruiting took place over a 4-month period using purposive sampling methods (Patton, 2002; Palinkas et al., 2015) which effectively yielded the appropriate sample for saturation of ideas to occur. I recruited participants by providing information regarding this study to practicing licensed clinicians across the US who specialize in working with clientele seeking treatment for PPU. I gave these clinicians a general overview of my study. I also posted a flyer that advertised my study on the Certified Sex Addiction Therapist (CSAT) listserv as well as a listserv for clinicians of an international clinical
organization that specializes in treating sexual addiction and betrayal trauma. Clinicians from these varying sources who reported interest were sent a recruitment email outlining further details of my study as well as the criteria to participate. I also provided the clinicians with the flyer that they could then pass on to those clients who they believed fit the sample inclusion criteria. The flier directed all interested current and former clients to an online screening assessment through Qualtrics (see Appendix A). Interested clients that took the survey and met the inclusion criteria were asked to give their contact info through the Qualtrics survey. To avoid disclosing unnecessary demographic information, I only asked those who qualified for the study to provide additional demographic and descriptive information (see Appendix B). If the interested subjects completed the survey and met the inclusion criteria, they were contacted by email to finalize details of the interview.

**Sample Inclusion/Exclusion Criteria**

To participate, subjects were required to be in a committed relationship, where both partners participated in the recovery process at some level. Couples also needed to demonstrate that they had made adequate steps towards recovery and were in the final stages of treatment or had already completed treatment. Specifically, the pornography user in the relationship must have had a significant or comfortable amount of recovery from pornography use, as defined through ratings on the Assessing Pornography Addiction Scale (APAS; Skinner, 2011) and the Sexual Addiction Recovery Capitol Scale (SARCS). The APAS assessed the level of sobriety, while the SARCS assessed the level of recovery. Additionally, both partners needed to score in the non-distressed range on the couple satisfaction index (CSI-4) (Funk & Rogge, 2007). To ensure couple ability
to fully describe their change process, participants also needed to have completed treatment within the past year or be in the final stages of treatment.

Sample Demographics

Our sample consisted of 11 heterosexual married couples who met the criteria for achieving significant progress in recovery from PPU. Eight couples were from Utah, one was from Nevada, one from Oklahoma, and one from Arkansas. Six couples had completed therapy less than 6 months ago, while the other 5 couples were still finishing up the final stages of treatment. All 11 couples were highly active members of a Christian faith with 10 of those couples being members of the Church of Jesus Christ of Latter-day Saints. All participants were Caucasian except for one male who identified as Mexican. For all couples, the male was the recovering pornography user (RU) and the female was the recovering partner (RP). The average age of marriage was 14 years with an average of 3.4 kids. The average time in therapy for recovery between all the couples was 2 years.

Regarding the sobriety of the RUs, in the past year, eight of them have not viewed pornography, two reported to have viewed pornography 1-2 times, and one said that he viewed pornography every two or three months. Additionally, in the past year, five RUs reported that they thought or fantasized about pornography very rarely to never, four thought or fantasize about pornography every two or three months, one said once a week and one said multiple times a day.

Sample Size

In phenomenological research, the goal is to achieve saturation, denoting that new data fails to yield new information regarding the phenomenon under examination
There is no conclusive sample size in phenomenological research, and it is encouraged to use saturation as a guiding principle rather than to premeditatively decide upon a sample limit (Mason, 2010). As I collected participants and began the interviewing process, I kept careful notes of the emerging themes during the interview. The coding team (of which I will discuss further on in this section) and I commenced coding the interviews throughout the recruitment process. It was agreed that the data was reaching saturation around interview nine. For confirmation, we included two additional interviews and upon coding these interviews, it was confirmed that saturation was reached which prompted the completion of the recruitment process.

**Procedure**

Once participants met qualifying criteria, filled out a demographic survey, and gave their contact info, they were contacted to set up a time and place for the interview. They were given the choice to participate in an in-person, video conference, or telephone interview. All interviews, no matter the method, were audio recorded for later transcription and analysis. At the conclusion of the interview, each participant received a $20.00 gift card ($40 per couple) for their participation in the study.

**Semi Structured Interviews**

The guiding theoretical framework of common factors, as well as previous literature helped me to create a semi-structured interview. The questionnaire (see Appendix C) consisted of 5 primary questions for exploration with the couple participants. Each main question had several suggested follow-up topics to assist in achieving further understanding and richness. As is customary in phenomenological research (Creswell, 2007), these questions served as a guide throughout the interview but
were only intended as a launching point for further investigation through additional follow-up and probing questions. Each couple was interviewed for approximately 60-90 minutes to ensure that each question was sufficiently answered. Each interview started with a review of the informed consent form and a final chance to decline participation in the study. I then gave a brief overview the interview questions, including a reminder to, if possible, refrain from using identifying information in the interview. After this preliminary information was shared, the interview commenced.

**Data Preparation**

All interviews were audio recorded using a Zoom H2N Handy Recorder. Once the interview was recorded, the MP3 file was assigned a three-digit number and transferred to a password protected USU box.com folder that was only accessible to the research team. A hired transcription team of three USU students (graduate and undergraduate) took turns transcribing each interview in full, while simultaneously removing all identifying information. Once the interviews were transcribed, de-identified, and checked by the student researcher, the audio files were deleted. As part of member-checking procedures (outlined in the credibility section), each de-identified transcription was emailed to the associated participants for confirmation that what was recorded accurately represented their story of recovery. All participants agreed that it was accurate, with a few who responded with additional insights and clarifications.
**Data Analysis**

Three male and three female graduate student coders were recruited from the USU Marriage and Family Therapy program. Coders were trained in phenomenological methodology during multiple training sessions that included both didactic and experiential components. Additionally, important phenomenological concepts and practices were reviewed during each coding meeting to ensure sustained understanding and application. After I bracketed my own experience with this phenomenon, as outlined below, the next step in this phenomenological approach was to begin analyzing the data by highlighting and collecting the significant statements or quotes that give insight into the lived experiences of the subjects specifically regarding the phenomenon under examination. This process is also called open coding (Gallicano, 2013) and began upon the completion and transcription of the first interview. The coding team reviewed the first interview and gave feedback to the interviewer on the interviewing procedure and made suggestions for improvement. Once the significant statements and possible themes of the first interview were captured by each member of the coding team, we met and began axial coding, or piecing together what seemed to be the emerging themes and subthemes (Gallicano, 2013). After thoroughly analyzing the first four interviews in this way, we then proceeded to selective coding (Gallicano, 2013), a confirmatory approach to coding with each successive interview while still open coding for fresh ideas that represented new emerging themes and subthemes. Our coding meetings would then consist of sharing exemplary quotes of previously discovered themes as well as any possible new themes or subthemes. We would then discussing how the new ideas fit with what we had previously discovered that we felt was describing the phenomenon of couple recovery from PPU.
When there were disagreements regarding how an idea was conceptualized or where it fit into the overall picture of the studied phenomenon, each perspective was heard and the perspective that the majority of the coding team agreed with was adopted. The resulting themes and subthemes from the coding process ultimately provided the pieces to a puzzle that still needed to somehow fit together in a way that told the story and captured the full picture of the phenomenon of recovery from PPU. After hours of reviewing the transcribed stories and discussion amongst the research team, a conceptual framework was proposed that sought to account for all discovered themes as well as told the story of recovery that the participants had portrayed. As part of the member-checking procedure (outlined in the credibility section), this framework was emailed to each of the participating couples as well as the remaining members of the research team for feedback.

**Context of the Lived Experience of Recovery**

To capture the phenomenon of recovery from PPU, it is important to describe as much of the lived experience of the participants as possible. Explaining the emerging themes of recovery is only a part of the story because each account of recovery is inseparably connected with a context of the lives of the participants. Including each subjective life-world context of the participants of our sample is imperative to capturing the whole picture of recovery (Porter, 1995); particularly for the generalizability and applicability of the emerging themes. I will give a brief summary of the context of each couple, with the intention that as much of their story as possible be considered throughout the explication of the results in order to better capture the whole phenomenon under study.
Couple 1: Andy and Alexis

Alexis and Andy had each been married previously for 12 years before they were married to each other. Ten years into this current marriage, Alexis caught Andy “in the arms of another woman” which is where their recovery story started. Alexis was ready to leave Andy, especially since she found out there were other women he was having an affair with and that pornography use played a key role in his infidelity. However, she was familiar with addiction because her previous husband was an alcoholic, so she was willing to help Andy with his recovery before she left him. Andy’s experience of being discovered by his wife pushed him to seek out counseling and join some support groups. As they went through the recovery process together, Andy and Alexis both made significant changes. Alexis decided to stay with Andy as she saw him work his recovery and they are now very happy.

Couple 2: Billy and Barbara

Billy and Barbara were married for 3 years before their recovery story started. Billy considered himself addicted to pornography for the previous 12 years but had told...
Barbara that it was in the past and that he had it under control. For the first two years of their marriage he continued to view pornography weekly and kept it a secret from Barbara. They got to a point when they were both unhappy in their marriage and Barbara pushed Billy to disclose his pornography use. That time was difficult for both of them and Barbara was willing to leave Billy, but they each found therapists and support groups and jumped into the work of recovery. They have been actively working recovery for nine months, Billy has remained abstinent from pornography use, and they are committed to a lifelong recovery process together.

**Couple 3: Chris and Cathy**

Chris and Cathy have been married for over 15 years. Chris told Cathy about his pornography use when they were engaged, but then he continued to struggle and not do much about it other than telling Cathy about some of his relapses for the first six years of their marriage. Cathy had a cousin who had been divorced because of pornography, so it scared her, but she did not know what to do about it. Chris hit a low point where he realized he couldn’t stop and considered himself addicted. He then started going to therapy and group therapy. After about four months he stopped going to therapy because he thought he was cured. However, his previous habits with pornography slowly crept back into his life in the following months. Years later Cathy was getting counseling for postpartum depression and they decided to start a recovery program together with a therapist who specialized in sexual addiction. They said they have learned a lot and are still on their recovery journey. Recently they have been diving into trauma work, but they feel like they are doing better than ever and are committed to a permanent and hopeful recovery lifestyle.
Couple 4: David and Dianna

David and Dianna have been married for about 4 years and had talked a lot about David’s pornography use before they got married. Dianna was divorced and wanted to make sure she knew exactly what she was getting into with this marriage. However, David was never fully honest with Dianna, and she later discovered pornography on David’s phone two years into their marriage. Dianna experienced a strong traumatic response to the discovery that was made worse by a bad experience with a therapist who told her to lower her expectations. David got right to work on recovery with individual therapy and support groups in order to try to save the marriage and finally recover, but it took eight months to find a good therapist for both of them. They each made their individual recovery work a priority while also working through their relationship challenges and they are now on a path of recovery in which they are confident and experiencing positive change.

Couple 5: Eric and Elaine

Eric and Elaine have been married for 15 years, but there always seemed to be a distance between them. Eric had been viewing pornography since he was a boy every couple of weeks and had kept it a secret from Elaine their entire marriage. One day he lost his temper with her and his kids and during his apology he disclosed to Elaine about his pornography use. Elaine immediately went about researching what they needed in order to get through this challenge and encouraged Eric to get help. They both started personal therapy, but when Eric kept viewing pornography, they both got involved in specialized support groups where they learned a lot more about what they were dealing
with. Eric now proudly reports almost 600 days of sobriety and they are both still active in their support groups.

**Couple 6: Fred and Felicity**

Fred was exposed to pornography through family members at an early age and grew up viewing pornography to cope with his emotions. His wife Felicity had never felt like she was enough for Fred, especially in their sexual relationship. Fred started to seek some information on his own about recovery and came to an understanding of how this struggle with pornography was affecting his marriage and could affect his kids. This led him to disclose to Felicity about his pornography use and seek recovery. She at first responded supportively because it didn’t feel like a betrayal to her, in part because she had grown up in a home where there was a lot of pornography around. However, as she continued to learn more about the secrets Fred had kept from her and how pornography was influencing their sexual relationship, it had more of an effect on her. They decided on an in-house separation to initially help her feel safe and to motivate Fred’s recovery. Individual recovery was important to both of them and with specialized support from multiple sources they made progress on their own recovery journeys, which ultimately made significant improvement in their relationship.

**Couple 7: George and Gretchen**

George began viewing pornography in his childhood with some friends. He eventually reached out to family and ecclesiastical leaders throughout his teenage and young adult years for help. However, he felt like they never really gave him solid direction for how to recover. When he got married at 26, he chose to keep it a secret from
his wife for years until she discovered it. Gretchen came from a rough childhood where both her parents had remarried many times and marriage was finally the stability she wanted, but for the first five years of their marriage George seemed distant and uninterested in her. Her discovery of his pornography use was devastating to her because it brought up a lot of insecurities she developed as a child and responded by kicking him out. George lived in a tent for a little while, which gave him time to reflect on what he wanted and what he was willing to do to find recovery and save his marriage. Gretchen policed his recovery for a long time as she struggled to feel safe again. They both got involved in the work of recovery with therapists and 12 step support groups and have been steadily progressing for the past 7 years. They now feel they have achieved significant recovery and are happy in their marriage and their new recovery lifestyle.

**Couple 8: Harry and Hannah**

Harry was exposed to pornography by his brothers when he was six and was sexually abused by an older brother around that time. He had made several unsuccessful attempts to stop viewing pornography through young adulthood. Feeling discouraged, he chose to hide it from his wife, Hannah. About 7 months into their marriage, Hannah found some of the pornography he was viewing on their computer and the resulting emotions from that discovery were devastating to both of them. They got some initial help and Harry stayed abstinent for a while, but 5 years later he started viewing pornography again every few months for the next 6 years without telling Hannah because of how much it hurt them the first time. Finally, he disclosed, Hannah was again devastated, but they both plunged further into recovery than before and got more support. They had some hindering experiences with therapists and therapy groups, but eventually
found the support that worked for them. They now feel confident in their recovery path moving forward.

**Couple 9: Isaac and Isabella**

Isaac had struggled with pornography since he was 7. He was terrified that his fiancé, Isabella, would leave him if he told her so he kept it secret. Isabella felt like something was wrong but didn’t understand what it was until she caught him viewing pornography 2 years into their marriage. Isaac promised he wouldn’t view it anymore, but secretly kept viewing anyway. A few years later Isaac participated in an emotional affair, but when he was discovered, he simply said that he would stop talking to the other woman and told Isabella that she should get over it. They started going to couples counseling to work on their relationship, during which, Isaac disclosed that he had another sexting affair. They had an in-house separation and started working more heavily on their own recoveries by seeking out more specialized help. After 6 years of their lives being centered on recovery, they now report to have a closer relationship than ever and are now active in helping other couples with their recovery journey.

**Couple 10: Jerry and Josie**

Jerry first viewed pornography when he was 13 and quickly became interested because it filled a void that was left by a family move. When he met his now wife Josie, he let her know before they got married that he struggled with pornography use and she was supportive. For the first several years of their marriage he continued to want to stay abstinent from pornography and would even tell Josie about his relapses, but he didn’t seek other support. Josie eventually told him to get more help or she would leave him,
and they started couples therapy and individual group therapy. Josie was a major support for Jerry and developed strict boundaries to hold him accountable to his recovery. Jerry worked hard to live within their boundaries and make sacrifices for recovery. He was encouraged when he started to finally see some sobriety and feel closer to Josie. Group therapy didn’t last for them because of some hindering experiences, but they worked hard to apply the things they learned in specialized couples therapy. Their communication increased and now Josie feels like Jerry is a better man than ever before.

**Couple 11: Kory and Kelly**

Kory almost always viewed women in swimsuits or lingerie as his pornography throughout most of his 15+ years of marriage with Kelly. He tried a 12-step group that helped him to stop masturbating, but he felt like he was still seeking out lust regularly. Their marriage was deteriorating and after a relapse in viewing pornography Kelly told Kory to move out. Kory couldn’t stand being away from his kids, so it was then that they both joined specialized group programs and found a lot of success on their individual recovery paths. Kory is now 3 years sober from any sort of pornography and is living a personalized daily program of recovery. Kelly has found a lot of healing and support from her online group. They admit that they are still working on their relationship recovery but are now living together again and they feel like they have made significant progress.
Role of the Researcher

As with many qualitative studies, I (the researcher) was the primary data collector to capture more thoroughly the experience of the sample. I was the sole point of contact throughout the study for each of the participants and therefore responsible for maintaining participant confidentiality and anonymity. I set up and facilitated each interview and thus was also accountable for collecting their experience. The direct interaction with the participants increased the insights gained from the interview data, as well as provided the opportunity for adjustment throughout the research process—an important part of what makes qualitative research so valuable (Creswell, 2007). Common with phenomenology research, it was my role to make an interpretation of the meaning of the expressed lived experiences (Creswell et al., 2007) both within the data collection and data analysis processes. This suggests that it is imperative that I was aware of my preconceived notions and biases regarding this phenomenon and have procedures in place to put them in check. I have outlined those biases and procedures in the next section.

Potential Researcher Bias

Within all research, particularly with qualitative research, researcher bias unavoidably plays a role. As previously stated in the research design section, the transcendental phenomenological approach (Moustakas, 1994) that I chose for this study particularly emphasizes that the researcher brackets out their own experience with the phenomenon (Creswell et al., 2007; Groenewald, 2004) in order to view the subject’s experiences with fresh eyes. Thus, I recognize that it is essential that I am not only aware
of what my biases may be, but also that I also explicitly state what these biases are and how they may affect the study.

**Bracketed Researcher Experience**

First, I am a member of a faith tradition that views pornography as maladaptive and destructive to divine connection and to relationship health. My personal views on the nature of pornography may not be as extreme as my faith tradition, but I do acknowledge that I still view pornography use as principally problematic to individual and relationship wellbeing. Participants in my sample were from a few differing faith traditions and did not always share the same views as me about how pornography has affected them. As a result, it was essential that I was open to other possibilities and experiences.

Second, I was trained as an intern at Addo Recovery, a therapy clinic that specializes in sexual addiction and betrayal trauma treatment. The trainings I have received as a clinician there have given me a lens through which I conceptualize problematic pornography use in clients as well as how to treat it. Essentially, I view pornography use as a maladaptive coping mechanism stemming from minor and major attachment/connection traumas often occurring in childhood and romantic relationships. I believe that the recovery path from PPU involves gaining understanding of the history and story underlying why the individual is using pornography and then to replace the behavior with more connecting coping behaviors that provide affirmation and support. These views likely had an effect on the questions I asked as well as how I made meaning of the experiences that were shared. The participants in my sample received treatment from a variety of different organizations and therapists throughout the US who likely conceptualized this issue and treatment differently.
In order to limit this bias, I took careful notes during each interview and strived to write what was said rather than how I interpreted their meaning. I additionally utilized the coding team which represented a variety of experiences and beliefs that counterbalanced my own views and offered fresh perspectives of the collected data. It was also essential for me to be aware of the power I had as the principle researcher among my research team, and then relinquish that power and treat their insights with the same value as my own. I was open with them throughout the coding training and the coding process about my biases and asked them to assist me in keeping my biases in check.

**Trustworthiness**

Within qualitative research methodology, trustworthiness defines how the data collection and analysis processes are scientifically sound (Williams & Marrow, 2009). Trustworthiness consists of three main components: integrity of the data, the balance between participant meaning and researcher interpretation, and clear communication and application of findings (Williams & Marrow, 2009). Put more succinctly, trustworthiness is dependability, confirmability, credibility, and transferability, each of which are discussed below (Miles & Huberman, 1994).

**Dependability**

Dependability is all about consistency and stability within the research design. This means that the methodological procedures are described in detail and could be easily replicated (Williams & Morrow, 2009). Patton (2002) referred to this detailed articulation of procedures as “a systematic process systematically followed” (p. 546). To ensure dependability with my study, I have given particular attention to detail as I have
outlined the research design of this study as well as given adequate justification for the chosen procedures. Notes taken during each interview as well as the coded interviews by each coding team member tracked the methodological adaptations included in the results section of this manuscript.

**Confirmability**

Confirmability is the balance between participant meaning and researcher interpretation (Williams & Marrow, 2009). This balance relies heavily on subjectivity and reflexivity. Subjectivity in this context is the acknowledgement that there is researcher bias due to the differing subjective experience between the researcher and the participant. Reflexivity in this context is an “awareness of self, wherein the researcher remains self-reflective and able to identify, as clearly as possible, what comes from the researcher and what comes from the participant” (Williams & Marrow, 2009, p. 579). The more the researcher is able to incorporate subjectivity and reflexivity into the research design, the greater confirmability there is within the study. I have given careful consideration to these principles within this study and have thoroughly outlined my potential biases. Checking with the coding team throughout the coding process regarding my biases protected against predisposition of our findings. Furthermore, when I was finalizing and organizing the coded themes of recovery, the final themes were checked with members of the coding team, my advisor, and each of the participants to ensure that I was not subconsciously forming the themes to my preconceived paradigm of recovery from PPU. These sources significantly assisted me in guaranteeing that my own potential biases were not influencing the results of the study.
Credibility

Credibility is desirable for the collected data to accurately represent the reality of the population being studied (Creswell, 2007). By following the data collection procedures described above, I sought out a sample that represented a variety of demographic experiences of couples who have been through the recovery process from PPU so that the collected data more accurately represents the population being studied. Additionally, member checking was utilized in order to more effectively increase credibility (as well as confirmability and dependability). Member checking is the process by which the researcher solicits participant insight on research findings and is considered the gold standard for establishing trustworthiness in qualitative studies (Kornbluh, 2015). At the conclusion of the coding process, I sent the resulting themes to the participants for their feedback and confirmation that the themes accurately represented their experience.

Transferability

Transferability refers to the ability for the research findings to be applied to others who share a similar experience. Important aspects of transferability are that the research findings and interpretations are presented with clarity and supported by participant quotes (Williams & Marrow, 2009). Additionally, the context (demographics) of the participants should be taken into account and the part it might play in the participant’s experiences with the phenomenon and ultimately the generalizability of their experience to other contexts. The findings of this study are likely not generalizable to all couples struggling with PPU in their relationship; however, these findings provide significant insight into the couple recovery process from PPU that can inform treatment for some and directions for further empirical exploration.
CHAPTER IV
RESULTS

The Lived Experience of Recovery: Shared Meaning and Emergent Themes

From the interviewing and coding processes emerged five overarching themes of recovery along with associated subthemes. I will first provide a broad perspective of the major themes that emerged and describe how they fit together. I will then describe the separate trajectories of recovery for each partner and how that fits in with the relationship recovery of the couple. Then I will summarize the associated subthemes while providing exemplary quotes for each partner’s recovery to better capture the essence of each theme and subtheme and its role in the recovery process. I will conclude this results section with a return to the big picture of how the overarching themes of recovery fit together with a final summary.

Overarching Themes and the General Story of Recovery

Though each recovery story was unique, they each followed a similar progression regarding the five overarching themes. Each recovery story started and progressed with catalysts for recovery (theme 1) that led to building or expanding a foundation of support (theme 2) for recovery. From this foundation of support, the work of recovery (theme 3) progressed, and healing perspectives (theme 4) were internalized. The work of recovery and the healing perspectives seemed to develop simultaneously as some healing perspectives were gained only after some work was in motion. Reciprocally, some work was not initiated until a proper perspective was adopted. Furthermore, the work of
recovery and healing perspectives of recovery appeared to bidirectionally influence the quantity and quality of the support received. These three themes (themes 2-4) seemed to make up the core of the recovery process, aided by catalysts (theme 1) or impeded by hindrances (theme 5) throughout each couple’s journey of recovery. See figure 1.

**Separate Trajectories of Recovery**

Before discussing in detail each theme of recovery, it is important to highlight a process element of recovery that couples identified. Originally, I set out to discover themes of recovery for couples. However, the coding team and I quickly noticed a principle pattern that the recovery trajectories for the recovering user and the recovering partner were separate. They shared the same themes of recovery, but each couple made it clear that they had to focus on their own recovery and that it was even sometimes harmful to their recovery if they focused initially on recovering together. For example, Alexis said:

I worked on my recovery. He worked on his recovery. And then we worked on it together. I didn’t police him. I expected it, but I feel like some women spend so much time worrying about what their husbands are doing that they forget they’ve got work to do. I think that we each have our own work to do and it’s different. It’s important that you dive in headfirst and do your work.

Additionally, almost all the couples seemed to be in consensus that their individual recoveries were somewhat separated from the overall relationship recovery and that relationship recovery required individual recovery efforts first. On this point, Gretchen said:

I think you have to heal yourself. You have to heal that hurt emotion first before you can work on the relationship. That’s really helpful to get to that place and it’s possible. It’s possible. And you can be happy, and divorce
doesn’t have to be the answer. But like George said, it does take two. It can’t just be one-sided.

For these reasons, I will discuss the recovery trajectories of the recovering user (RU) and the recovering partner (RP) together, while also striving to highlight nuances between their recovery paths, including a few differing sub-themes. The relationship recovery trajectory was practically unaddressed by the couples in comparison with how much they discussed their individual recoveries. This stark difference in focus as well as a few supporting comments suggested that the majority of the relationship recovery occurred as each partner recovered. There were only a few mentions of specifics to the relationship recovery process, which will be addressed in a separate section at the end of the description of the five major themes of recovery. See Tables 1-3.

I will now discuss each of the five overarching themes of recovery with associated subthemes. Each subtheme will be accompanied by example quotes from the RUs and/or the RPs to further exemplify the unique differences of their recovery paths and to more accurately describe the phenomenon of couple recovery from PPU. There was a wealth of great quotes from each couple that addressed almost every theme and sub theme. The example quotes utilized in the write-up below were specifically chosen because they were representative of what many other couples had shared for each subject.

**Themes and Subthemes of Couple Recovery From PPU**

**Catalysts for Recovery (Theme 1)**

One of the first things we noticed was that in each of the subject’s stories of recovery there seemed to be a turning point where they felt like real and honest recovery began. In example, for years Jerry put forth minimal efforts towards recovery and
describes his turning point experience: “finally, we had, I guess you’d call the moment. We had the moment where she threw all my clothes on the bed and threw a wedding ring on top and said, ‘You get professional help or I’m out’.” From then on, recovery really started to progress for him and his partner. Additionally, for many of the couples, there were also several turning points along their journey that acted as catalysts for their recovery. However, we also noticed that it was not these events alone, but the emotional responses, relational consequences, and resulting internalized motivations that transformed them into turning points and catalyst events along their recovery journey.

**Turning points/rock-bottom experiences.** Often the catalysts started as a difficult or painful experience (i.e. discovery of porn use, disclosure to spouse, relapses) that seemed to lead the couples to a crossroads. These successful couples appeared to catalyze these events to awaken them to a new sense of willingness and determination for recovery. For example, George got kicked out after a relapse but made the choice to allow that experience to change his life:

> There was a point basically where she kicked me out for a while. And it gave me an opportunity to recognize how my life would be different without her, without our kids... During that separation it gave me time to think, time to reflect on who I was and who I could be, and that path of which direction did I want to go.

**Emotional responses.** In response to the majority of the turning points/catalyst events both partners often expressed strong emotional reactions to these events. This may be at the core of why these events were so significant to their recoveries. In fact, the emotional responses of the RPs were often described as betrayal trauma and seemed to be what the RP’s recovery was centered around. Gretchen related her experience in this way:

> You know when your husband is doing these things that are hurting you over and over again, it feels like you’re getting into a car and he’s saying to
you, “I know how to drive”. But then he crashes the car every time. And so, you’re just... you just feel so, just like you’re just going to go get in a car wreck. You just get hurt over and over and over again and you don’t have any control over it.

The traumatic response, as described by Dianna, was similar to several other RP’s experience:

I turned into a completely different person. That’s something that I always wish that I could tell people. Or get people to understand, that I turned into somebody I never ever, ever, ever thought that I could be. I was surprised by how traumatic it was for me, considering he wasn’t engaging in prostitution or anything, you know? I was shocked at how I started getting violent with him. I started throwing things and hitting things and having rages and suicidal ideation. I’d have panic attacks daily and there was self-harm. Things that aren’t totally unfamiliar to me, but it was so concentrated for that solid eight months. That was horrible. Indescribable.

The emotional response by the men often included feelings of guilt and shame for their behaviors but these feelings became catalyzing and significant to their recovery as they witnessed the trauma experienced by their partners. Jerry said what many of the recovering users had expressed: “one of the hardest things for me as the addict was that I knew I was hurting her, and I so badly did not want to hurt her. I truly loved her. I loved our children.”

Relational consequences. Emotional responses often led to relational consequences that frequently enhanced the potential of the event to push the couple further into recovery. Relational consequences often took the form of ultimatums, separations, or relational disconnection. In addition to the ultimatum experienced by Jerry and George’s experience of getting kicked out as described above, Fred and Felicity shared their experience of having Fred move into a different room in their house.

Fred: “The boundaries that she mentioned I think were helpful because it was not feasible for us to completely separate, like be in different locations, but we did have a spare room, so I basically moved in there.” Felicity: “Yes,
I want to add to that. That was huge for us. We needed to have that space. That abstinence from sex. That therapeutic separation if you will. Yeah, that’s a huge part of it.” Fred: “Yeah, almost as a marking of our old relationship and building towards a new one. With that physical boundary that she had set up, of ‘You need to work on your recovery,’ I think needed to be integral through that. Because she had her own things to work on. So that time of separation for me was beneficial to evaluate, basically, “Why am I in here? Why is this a problem? What have I been doing to contribute to the issues that she’s dealing with, that I’m dealing with? An opportunity to read. I mean I could have been in there and been doing the same things I was that were destroying our relationship, but because I was in a different setting and it was a barrier that we had set up between us, it made me look at my choices and why and what do I need to do different.”

Each of the RUs could have chosen to take offense to these relational consequences and continued in their destructive behaviors. Perhaps what made these couples successful was the willingness of the RUs to respond introspectively and transformatively to the relational consequences given by their partners. As an example of relational disconnection, Chris, in consequence to his relapses, expressed that “we got to a point where we realized, we were just…there was always drama and we weren’t clicking emotionally.” The discomfort from relational disconnections like these also seemed to further catalyze the recovery process for these successful couples.

**Recovery motivations.** Many of the catalyst events, including the subsequent emotional responses and relational consequences, resulted in internalized motivations that continued to inspire further recovery efforts throughout the recovery process. Jerry describes his parenting legacy as a motivator for him:

The other thing that was really big for me is we had our third child, our youngest daughter. We had her really quickly after we had our middle child and you can call it providence, you can call it divine intervention, but something about her was really motivating to me when she was born because I realized, ‘I’m the father of three children now and they can’t grow up in a home where this is happening,’ and I wanted to be there for them. So, when she was born, just looking at this cute little girl and realizing I didn’t want her to have a dad that was a pornography addict.
Fred had similar concerns and said “I don’t want it to be a problem for our kids. So, something has to change… the damage that can be done not just to me but to others, almost like secondhand smoke.” Andy expressed a sentiment about his spouse that seemed to be felt by all the RUs as a motivation for their recovery:

I was scared to death to lose her. It’s that simple. It really is. I tell people that I mentor: ‘Reach out, you’ve got to find your why.’ You find your why, you’ve just got the ticket, the Willy Wonka, golden ticket. But that was my why.

Despite these external motivations seeming to make a big difference for the RUs recovery, both the RUs and the RPs expressed that internal motivation was essential for recovery to be successful. Billy shared: “It kinda started changing ‘cause I knew I needed to find the motivation within myself and why I wanted to beat this addiction and to stay clean and not relapse.” Hannah may have said best what many of the RPs also expressed:

I don’t want him to be a part of my recovery. *laughs* In a way. Like I feel like a little bit protective of that, because I know that it is easier for me to recover and I do better when he is loving and supportive and open and honest, right? …But I'm recovering regardless of if he does. If he were not in recovery right now, I would still be in recovery, I would still be working, I would still be trying… I have power over my own life and it doesn’t have anything to do with him and that my happiness and my peace has nothing to do with him.

Foundation of Support for Recovery (Theme 2)

Following the catalyst events, these flourishing couples used that motivation and momentum to then seek out support for their recovery from several different sources, often more than one. They were essentially creating a foundation of support that strengthened and grounded all further recovery efforts. Each support for recovery that was mentioned fell into one of four categories: specialized psychotherapy, social support,
partner support, and spiritual support. It is important to know that most of the statements made about support were typically about how the support was effectively given, focusing on the supporter, rather than how the support was effectively received by the RU or the RP.

**Specialized psychotherapy.** Getting support from a specialized psychotherapist seemed to play a major role in almost every story of recovery. Like several couples expressed, Dianna shared: “If I could say, the most important thing to our recovery has been a therapist who is trained in this: sexual addiction, betrayal trauma, recovery. That has been it.” Similarly, Isaac responded with this statement when asked what was most helpful for his recovery: “Getting specialized help from a certified sex addiction therapist, ‘cause we’ve been to three different therapists before we found someone who was certified. That was the best decision as far as recovery that we made.” Unfortunately, many of the couples shared that they had to go through some hindering experiences with other therapists before they were able to find effective specialized help from a therapist or life coach that was trained to handle their concerns. Those hindrances will be discussed as part of theme 5: Recovery Hindrances and Cautions.

The comments made about psychotherapy referred often to what the therapists did in therapy that was helpful. Chris shared what was helpful for him:

I think the best things they did starting out was giving me the education to understand what was going on and then holding me accountable in giving me assignments and structure and giving me a safe place to work on things and come back and share them, is huge.

Giving assignments and holding the couples accountable to those assignments was expressed by many of the couples. George talked about how important this was to him:
I’ve been to many different therapists; I would say the one that helped me the most was the one that gave me assignments at the end of our sessions and asked me when I came back how I did on those assignments. So, I actually had work that I had to do. I was accountable to him, accountable to myself, accountable to my wife with the things that I was supposed to work on.

Another thing that seemed important was the education the couples got from their therapist on what they were dealing with. Jerry shared:

So, I think the first part that therapy really helped me was to see the why. Why I was addicted, why it was such an attractive addiction for me, and why I responded so heavily to it… [therapist] mapped out my addiction cycle for me. We spent a long time, we spent months on my cycle, but once we did that, she taught me the things to look out for. When I’m triggered, my heart really starts to palpitate, like it really starts to race. And I start to get fidgety, and I’ll get up and I’ll walk around. Those were some of my signs that I was in a triggered state. We mapped that out and she helped me recognize that. Then we worked on specific things to combat that.

Dianna expressed what she learned from her therapist that seemed critical to most of the RPs’ recovery:

You hear it all the time, ‘it’s not my fault” or “I didn’t have any control over it.” I did understand that but understanding that I had to go through just as intense of a recovery process as [RU]. And having a therapist understand or explain that to me has been monumental in my own recovery. And accepting that, yes, my life has changed forever, and that it’ll take a lot to work through. But him knowing and walking me through it has been game changing. We’ve been in therapy with this guy for over a year and a half now.

For many of the RUs and especially for the RPs, it was also imperative that they saw a therapist that could help make connections with and resolve some adverse childhood experiences. On this point Gretchen said:

One therapist helped me to resolve childhood issues. And that can play, that can add to betrayal trauma if you’ve had other things that have happened in your life so recognizing what those were and helping me resolve those was great. And then another therapist who really understood
addiction and specialized in it helped me understand what to expect and what, you know, I needed to be patient with addict behavior.

In addition to talking about what the therapists did, the couples would also often comment about the type of person their therapist was and how that helped their recovery.

Andy shared:

I think a therapist probably cares about every client, but not the way that [therapist] cared for us. That’s probably not right, but when a therapist will cry with you, that made me know that [therapist] was invested in my recovery. It wasn’t just another hour, another 150 dollars and then get out the door. It wasn’t like that. Sometimes he cared more than I cared. At the first, I would be frustrated and say, ‘you know what, just bag this!’ and he’d say, ‘really? You're going to throw that at me?’ He was invested in my recovery.

David also talked about how the traits of his therapist helped: “It’s nice also to have a sort of friendship with him. Just feeling like I can identify, communicate well. It’s not just all business when I walk in there. It just helps the relationship grow.” Representing the RPs side of recovery, Isabella recounted:

She also, I don’t know if this matters, but it kinda mattered to me. She has her own story of betrayal. She’s divorced and her husband kind of did the same, I mean lots of other things, but she understood. She’s healthy, she’s not a man-hater. She loves Isaac. She could still see both sides which I think is cool.

Social support. Social support was also critical for the recovery of every RU and RP interviewed. This support took many forms (i.e. group therapy members, family, friends, 12 step group members, etc.), but essentially, each RU and RP had built a team of support around them of people they could turn to, particularly in a time of need. Support or therapy groups were the most common types of social support discussed, so I will focus my comments here on that type of social support and how it was experienced.
A commonly expressed reason for why social support was so helpful was because this meant they were no longer isolating themselves and didn’t feel alone. Chris said that “getting out of isolation was huge. Learning tools to deal with my emotion, vocabulary to describe my emotions, like courage and license to not just deny and swallow and deal with them and having a place to go with them.” George shared that his support group meetings were a place where he could “talk openly about my problem with others who understand exactly what I’m dealing with as they’re going through it as well.” Isabella expressed similar feelings:

For me, group therapy was huge because I’m so isolated and I needed to get past that idea of ‘I’m so alone in this, no one can understand, my story’s not acceptable, like my pain isn’t valid, it doesn’t have value’. It was important for me to learn empathy for others and empathy for myself in my own story as well as Isaac’s.

Effective support for the RUs also meant more accountability as David expressed: “being able to go to group meetings and talk with other addicts, having a little bit more accountability. After a while, I obtained my own sponsor. Which proved to be one of the best things for my recovery.” Jerry shared that “having an accountability partner, specifically was really, really key for me.” However, for the RPs effective support seemed to be more about understanding and empathy. Josie shared:

I loved having other women that were the same as me, it made me feel like I wasn’t alone, that I wasn’t doing something odd. One thing that addictions do is it makes you feel very lonely and it makes you feel like an outcast. So, to have groups of women that are struggling to similar problems made me go, ‘I’m not alone.’ Not only was that good for my self-esteem, but then I look at other women now and I have more empathy towards them in any situation they’re in. So, group therapy provided that understanding and that empathy.

**Partner support.** Though each couple was clear that their trajectories of recovery were at first separate, there were still things that the RUs and RPs did that supported
recovery for each other. For RUs, what seemed to be most helpful was that their partners provided more accountability by holding boundaries, honestly expressing what they needed, and sometimes reminding them of their recovery commitments. George may have summed it up best with his comment:

She was good or she has been good, especially now, of gentle reminders. Not being an enforcer but just you know, gently reminding me or asking me what I need, letting me know the things that she needs from me or the things that she expects from me in our recovery…and to make sure that I’m aware of that because it’s easy to become self-absorbed in addiction and not think of others, but just think of yourself. So, it’s good for me to have her remind me of things that she needs from me. And she does it in a very loving, very supportive way.

For the RPs, effective partner support looked more like allowing them to express their emotions, working their own recovery and staying sober, being honest, and supporting their efforts to get more support. Elain said that “seeing him finally be proactive started making me feel safe.” Gretchen shared:

I think it’s really, really helpful for me when he’s honest, when I don’t have to have caught him. *laughs* When he comes to me and says, ‘I messed up’. That helps me so much. Or even when he says, ‘I had triggers today’. Even if nothing necessarily happened that he was having, you know… just that open communication is so big for me.

Hannah, like many of the RPs, greatly appreciated her husband’s support. She expressed:

He was supportive of me going to groups and stuff like that. And we were starting a business at the same time and living in my parent’s basement *laughs* when he started recovery with 3 kids, and so I was, there were lots of times that I should have or could have been at the business, that, he was supportive. He was supportive at the time.

**Spiritual support.** Spiritual support was often expressed as an important aspect of recovery for the RUs and the RPs. Though the spiritual support often came from a relationship with a higher power, several couples also discussed how an ecclesiastical leader played an influential role in their recovery. After many discouraging experiences
with parents and other authority figures George expressed: “we at that point began meeting with another church leader who was great. He, I felt like, was the first one who actually understood and wanted to try and figure things out for us” The relationship with the higher power was described to be helpful for the RUs when their higher power was another source of accountability, someone they could surrender to and trust in for help, and assisted in their forgiveness of themselves. Billy said that “there’s also the spiritual side as well to motivation. That accountability to God being that motivation as well.”

David discussed the benefit of being able to surrender to a familiar higher power:

That’s kind of the same time I [gained] my understanding of surrender. I was able to make sense of it more and at the same time personify someone who I'm surrendering to a little bit more, the higher power. Because it was just a vague understanding but when I was able to have a little more of a spiritual base, I was able to surrender to someone a little more effectively. God being that person.

For the RPs, support from a higher power looked more like a source of comfort and peace that would help provide meaning for the pain they were going through as well as take care of things that were out of their control, even the forgiveness of their spouse. Josie expressed that “my recovery was a lot of relying on the Lord.” Alexis described her experience with a higher power as “an overwhelming comfort and peace and knowing that everything would be okay. And then it looked like, that's why you’re here: to have trials…and maybe you’re here to help someone else.” Gretchen shared “what was very influential of my recovery was my belief in God and in His ability to heal my suffering. And I felt that very real, and I felt pain lifted from me in that process that never returned.”
The Work of Recovery (Theme 3)

Once the couples had established or further developed their foundation of support for recovery, the work of recovery commenced. The subthemes of the work of recovery include recovery psychoeducation, the structure, the routine, and trauma work. Each story was most unique when it came to the work of recovery and the specific actions they did for recovery. The complete list of specific examples of how these subthemes were portrayed in each of the recovery stories can be found in Tables 1 and 2.

Recovery psychoeducation – awareness and understanding. Often the primary progress that transpired for these couples after they gained effective support was that they got educated about what they were dealing with. Some RUs and RPs seemed to feast on recovery information wherever they could find it (i.e. therapists, life coach, support groups, books, podcasts, online programs, etc.) Fred said his recovery really commenced when he chose to “engage in it; seek out or take advantage of additional resources, not just try and white-knuckle through it on my own… online groups, materials, books, therapy, talking with other guys, things like that, were all helpful.” Isabella shared that the “education part…was where I started. I just needed to understand what I was feeling was a thing, and what he was dealing with was something. And it wasn’t just this bad habit… his brain was actually functioning this way.”

Even though the RUs and the RPs were recovering in different ways, they both often expressed that it was helpful to get educated on both their own and their partner’s side of the recovery. Understanding constructs such as the origins of addiction and betrayal trauma, the neuroscience of addiction, emotional intelligence, boundaries, attachment, and shame were all mentioned as important for recovery. In a few
representative quotes, Eric shared what he learned that was effective: “Understanding how my brain worked and how the chemicals in my brain trigger certain thoughts and how my own feelings can trigger some thoughts too.” Also, Harry shared what the basics of recovery were for him:

I think in the beginning just some of the simple things like learning about the addiction cycle and having bottom lines and knowing what a relapse was vs. a slip up, just in the beginning just the nuts and bolts of sobriety and recovery and healing. Those were really essential keys to going from just having some sobriety onto having some recovery.

Hannah expressed: “I think the education was very important. Because learning the right words and learning the definitions, learning about boundaries, learning about self-care, learning about those kinds of things was huge.”

**The structure.** The next piece in the work of recovery included creating a deliberate structure of safety that allowed for further recovery work to take place. For the RU’s this looked like having boundaries and bottom lines for their behaviors. There were many examples given of what bottom lines worked for each RU, but maybe the best representative quote explaining bottom lines was said by Chris: “for me personally, I learned that it was easier to create safety to avoid temptation rather than to just put myself in a place where I had to resist it.” For the RP’s, having boundaries to keep them safe from their partner’s hurtful behaviors were essential to their recovery. Like the RUs, there were many examples given of what personalized boundaries looked like for each RP. To assist in explaining what boundaries often represented I will refer to what Dianna said regarding her boundaries:

Allowing me to protect myself if I felt like it was unsafe. It was very validating, and it felt... I was in control finally of something, in saying, ‘I don’t have to connect if I don’t feel like it’s safe.’ So, learning that skill is huge.
The routine. In addition to the structure, there was also a routine that was expressed to be important for recovery. RUs alternatively labeled their routines as dailies, their recovery toolbox, or merely self-care. Similar to structure, each RU seemed to create their personalized routine of recovery. As an example of how routines worked, Billy shared he had to “kind of come up with the recovery plan and things I can do every day to work on my recovery.” Regarding the development of routine, George said that a “big thing is just getting a routine in place and just sticking to that routine and forming good habits. It took me quite a while to figure out my routine and figure out what was working and what wasn’t working.”

For the RPs, the routine was most often referred to as self-care. However, one RP skillfully expressed what many of these RPs meant by the self-care description. Felicity said “I would even call it self-tenderness. Cuz we keep using this phrase, self-care and it just has this very fluffy sound to it and it feels like band aids for this huge, gaping wound.” Alexis’ description of self-care may give the best explanation of what many of the RPs had to do for their recovery:

I was really good at self-care. A lot of women are not good at self-care. It feels selfish to be a mom and a wife and to worry about self-care. But I end up having to tell people ‘no’ a lot. I ended up telling my own children ‘no’ a lot. And my sister and my mother, I’d tell them ‘no, I’m not doing this’ or ‘no, this is not good for me.’ I took better care of myself during the last three and a half years than I’ve ever taken of myself, doing things I wouldn’t normally do for myself. And again, I learned that from counseling, but I did it. A lot of women that I meet or talk to, they don’t dare take care of themselves because it costs money, or it takes them away from their kids, or they feel selfish about it. But I was good at self-care. When I felt frustrated, like I just couldn’t deal with it anymore, I would take a break. Whether it was a break for the day, or a break for the weekend, you know, just get away or have some space from Andy. I was able to do that. I kind of did what felt good to me.
Trauma work. As part of the work of recovery, each RU and RP put in the effort to make recovery about experiencing deep healing and transformation. They didn’t stop at abstinence from PPU or forgiving their partners. They really dove into recovery work for holistic personal revolution and each of them seem to still be on that path. Lasting recovery for many of these couples centered around healing deep emotional wounds or traumas from their life. Often this meant long term psychotherapy to address many different issues, utilizing techniques such as eye movement and desensitization reprocessing (EMDR) or neurofeedback. In example, Hannah shared “Oh I did EMDR for the last like, 6 months. And that was really helpful. Also, a lot of that ended up I was mostly working on a lot of child stuff anyway…just my own trauma.” For some, long term 12 step program work was healing and transformative or completing a structured online recovery program that helped them explore past trauma was also healing. Essentially, it was noticed that recovery for these successful couples turned into much more than what they may have originally set out to find. This idea will be further discussed in the next section of healing perspectives of recovery.

Healing Perspective of Recovery and Meaning Making (Theme 4)

This theme arose out of numerous comments made by the couples that proclaim that getting support and doing work is not enough. A major part of the transformation of recovery that these couples went through seemed to be a transformation in the way that they thought about the problem. A paradigm shift in the way they managed their lives, included the way they thought about each other and themselves.

In this section I will address the perspectives that seemed to make a significant difference in the recovery and healing of both the RUs and the RPs. The first four
thematic perspectives seemed to be operative in assisting and motivating the work of recovery. These included acceptance and surrender, individual recovery before relationship recovery, living a recovery centered life, and confidence in your recovery. Some recovery efforts were not made until these perspectives were employed. The final three perspectives of recovery were more about the meaning the couples made of their challenges and recovery experience. These subthemes were externalization of addiction, determining that pornography is not the problem, and a crucible perspective. These defining perspectives of their experiences seemed to motivate recovery but would often not be adopted until preliminary recovery progress and been made.

**Acceptance and surrender.** A turning point for many couples was when they abandoned an internal resistance to change and accepted something that needed to change for recovery. For example: many of the RUs testified of their need to accept that they could not do recovery alone and that they needed accountability. Speaking of his recovery, George shared:

> It’s something you can’t do alone, like I said earlier. Early on I tried, I’ve always wanted to get over this, move past my addiction, and I would have filters on my computers and other things, but I would try to police them myself…and that would work for a few days, but being an addict... it doesn’t solve the problem or doesn’t fix things.

Isaac’s dedication to daily accountability appeared to be fundamental to the recovery he experiences when he said: “If I hadn’t been accountable every single night, well, if I hadn’t been accountable to my sponsor since October of ’14, the last four and a half years, I would not have the level of mindfulness that I have now.”

For the RPs, it seemed essential to accept that they had a recovery of her own to undertake. In illustration, Dianna shared.
I actually hated it in the beginning. I thought that I wasn’t supposed to be doing so much work because he’s the one that caused this problem. As much as I resented it in the beginning, it empowered me in my own recovery. Knowing that I actually had the capability of dramatically changing my day or my week or my situation. It’s not just waiting for him to be better. That I actually truly can be better even if he’s not.

Some aspects to recovery were more difficult to accept and therefore required what was often described as a surrender. The concept of surrender is a common term used in 12-step models meaning to let go of things that were out of your control and give them to your higher power to manage (Dyslin, 2008). Many of these couples were involved with 12-step support, which may have been why this was such a strong subtheme within the recovery stories, yet even the couples not involved with 12-step groups expressed a surrender perspective. David’s experience with surrendering seemed to model what many expressed about surrendering:

I would say one of the single most important things in my recovery was understating the concept of surrender, because that is something I think is so misunderstood. Even in myself, I still, every day am trying to figure out more of what that is, surrender. In the last few months I think I’ve understood it more than I have, than in the entirety of recovery. But it’s all encompassing. They call it the first step of 12 steps. But it actually goes all around every other step. All around your life. It’s not for me just saying ‘I don’t have control. I’m just going to give it up to the higher power.’ It’s about me saying to myself in any situation, be it emotional or otherwise, that ‘I don’t need to power through it.’ I don’t need to just feel like I have control because that’s what’s gotten me into trouble in the past anyway.

Additionally, representing the RPs, Gretchen shared:

One of the big steps that really hit home for me was to surrender. Just you know, my reaction, my gut reaction when something happens and I’m triggered, my betrayal trauma’s triggered, I go into like control mode, because my life has always been so out of control. So, it felt so out of control, that I try to control but learning to surrender and let that go and that’s big too.
One thing that was not easy yet seemed critical to surrender for both partners was the outcome of their relationship. Hannah’s experience with this seemed particularly important to her recovery:

“The day I decided to surrender the outcome of my marriage, not my marriage, not me, not him, not everything else, the outcome of our recovery journey, when I was able to surrender that and say, ok God, no matter what happens at the end of this, I’m gonna, you know, I’m gonna trust you. That was for me, the absolute turning point in my recovery.”

Representing the RUs, Harry shared:

“It came to the point where we were willing to let go of the relationship if that’s what had to happen. And to still be at peace with ourselves and with God and with where we were at in our lives and that’s a hard thing to come to that point where it’s just so hard where you’re like, you know what, I’m ready to let go of this if I have to but then to realize what you need to do so that you can be at peace with yourself, it’s a key turning point in a way.

Similarly, many of the RPs recognized that they not only needed to surrender the outcome of their relationship, but also that they needed to surrender attempts to control their partner’s recovery. On this point, Alexis shared: “So once I finally let go of trying to figure out what he’s doing, where he’s at, who he’s with, all day long, every day, that was a turning point. It gave me peace and comfort.”

**Individual recovery before relationship recovery.** This next helpful perspective was the reason why we determined that the recovery trajectories for the RUs and the SPs and the relationship were all separate, yet, still linked. Every couple discussed the importance of focusing on your own recovery before the relationship could heal. Because this seemed to be most impactful for the RPs (likely due to its role in accepting the necessity of their own recovery and the surrender of their partner’s recovery), the best exemplary quotes come from them. Josie expressed:
Trust the recovery process. And when I say that I mean trust your own recovery. I trusted that if he came and he did his work that he would get through. And so, I needed to just let that be his to do and I needed to trust that if I showed up and did what was asked of me, I would get through my work. It never was the same rate. Some weeks I would be very much further ahead than he was, and other weeks he would be much further ahead than I was. When I quit focusing on where I felt that we were at in our recovery and just trust that he was doing his and I was doing mine, it seemed like at that point we were finally able to come together and do it together.

In another example of the differing partner recovery progressions, Alexis said:

I feel like Andy’s recovery may have been faster than mine… I liken it to him dumping all the junk he had been carrying around for many, many years and he was able to kind of unload and be honest for once in his life. And that was able to be freeing to him in a way, but once I heard about all the stuff that was very hard. Like a lot of digging out of, you know, like he dumped all of his crap right on top of me, then I had to dig out. He was definitely further along in recovery than I was for a long time. He was in a better place than I was for a long time.

**Recovery centered life.** To introduce this next subtheme, I will refer to David’s words as he discussed his recovery lifestyle:

I think one of the very first things that anyone needs to do, regardless of their beliefs, is decide to make your lifestyle fit your recovery, instead of your recovery fit your lifestyle. I believe that the vast majority of people who don’t make it and fall apart or don’t make many changes (this is just for sobriety’s sake) are entitled to their lifestyle. They don’t want to make the changes that are hard. I don’t think I could have gone anywhere if I didn’t first decide to make those hard decisions.

This subtheme described another significant surrender the couples had to undertake, but it seemed to be such an integral part to each story, that we kept it as a separate subtheme.

For these successful couples, recovery became the foundation of their daily living that almost all other life responsibilities seemed to fit around. For example, Andy said: “we would schedule things around group. It became our number one thing that we revolved around.” Specialize therapy and extensive support often wasn’t cheap, but even finances
seemed to take a backseat to the importance of recovery as Isaac and Isabella skillfully exemplified:

Isaac: “Three weeks into this, we just dropped $1100 on three months’ worth of therapy and I was laid off from my job, and I was like, what? But, in 3 weeks, we knew that this would make such a big difference. In just 3 weeks! So, we were like, we gotta figure out how to do this.” Isabella: “We pay a lot every month cause our kids are in therapy too, probably close to a $1000, in mental health in therapy because it’s so important to us, because we’ve seen such a benefit. That’s, I would say most people’s most important reason for not getting it. Not getting help, it’s so much money, insurance doesn’t cover it, it doesn’t. But this is an education that is far more powerful than our college education. So, I would say don’t let that get in the way, like figure it out. Sell something, ask for help, do whatever you need to do and get help. And keep going! Like you don’t graduate.”

We chose to label this subtheme as recovery centered life instead of recovery centered lifestyle because many couples shared how this new lifestyle of recovery was meant to be lifelong. Chris shared this realization that was helpful for his recovery:

Another big thing for me was accepting that this may be a life-long thing. Lust may be something that’s always just whispering in the back of my ear for as long as I live. And not waiting for the magic bullet that’s just around the corner and I’ll finally be free. And I think realizing that now, that’s more of a growth mindset verses a fixed mindset.

Alexis expressed similar sentiments:

The thing that I would say, is that Andy and I will always be working on recovery. Always be doing things like attending 12 steps, or attending group meetings, or attending counseling because there’s always something we can be learning and benefiting from…. It’s not something we’re going to forget about because we’re in a good place. We’re going to always continue.

Confidence in your recovery. One of the final turning points that seemed to develop for many of the RUs was when they realized that they were making progress and that recovery was possible. Many had been battling PPU for years and even decades, which was often discouraging when they had been struggling for that long without much success. So, when they finally started to see some success after they achieved the support
they needed and putting effort into recovery, there appeared to be a shift in confidence that was meaningful. Isaac articulated his confidence experience: “in that moment, 16 months into recovery, I realized that all of my thoughts and my actions and behaviors were so different than what they used to be… I had empirical evidence that I was a different person.” Jerry also had a huge moment of success that empowered his recovery:

I flew into Vegas and I was all alone. I had complete access to Las Vegas. Which is like, you know, it’s called sin city for a reason. I made it through the trip. I didn’t have a single slip up. It was awesome. That was such a cool moment to be able to go on that trip and I remember one night I had like a seven-hour break for whatever reason. I could have easily driven to Vegas or wherever in Nevada and totally indulged myself. But I drove up to St. George and I had dinner at a restaurant and I ate at a restaurant that overlooked the St. George [religious building] and it was just peaceful and I just felt like I was different at that moment and then yeah, coming back and seeing her and talking with [therapist] and the [ecclesiastical leader], it was like, ‘I actually did it.’ It was really, really cool. That was definitely a turning point.

Kory summed it up like this: “once you start having success, that really motivates you. Once you learn that you can control what you do, how you think, it's very propelling.”

Though the RPs didn’t usually have years or decades of discouraging efforts towards recovery, there still appeared to be moments that helped them to have a more confident perspective in their recovery. Dianna’s experience was representative of many of the RPs when she realized: “You know what? I can deal with this. I can deal with this honesty if I have to. I can deal with this addiction.’ It totally inspired confidence in myself. I can do this based on the things that I have learned.”

**Externalization of the problem.** This subtheme was the first of three that described the helpful defining perspectives these couples took towards the challenges they were facing during the recovery process. In each couple, their challenges with PPU were defined as an addiction. However, what seemed helpful for many couples in their
recovery was when they no longer subscribed to the idea that the RU was the problem, separating the “addiction” from the RU. Eric had this to say regarding the addiction label:

I’d like to say that I am in this recovery, but I don’t want to say that I’m addicted because it feels like it’s defining me. I happen to be addicted but I’m not an addict. I’m not sure if I’m explaining it correctly, but it doesn’t define me.

Jerry and Josie, from the encouragement of their therapist, even gave the “addict” side of Jerry a different name to help with externalization. Jerry shares:

So, having the name Jack, that was really, really key. That really was the big first step. Once we separated Jerry from Jack or Jack from Jerry, that was really a huge moment for me to allow me to see that Jerry was capable of really doing good things. He was capable of being a good student, of being a good husband, of being a good father, of being successful. Whereas Jack was the opposite of that. Before then, I had never been able to separate the two. I felt I was worthless and couldn’t succeed and I was failing. So that was a huge, huge moment in my recovery process, was the adding the name.

This externalization of the problem from their partners seemed especially helpful for the RPs. Elaine expressed her revelation about her partner:

“I want people to know that my husband is not a bad person. He’s not an evil man. He’s a good man. A man of God. He just has this disease that he has to fight, just like anyone would have to fight something that troubled them.”

Additionally, it was particularly helpful for the RPs when they were able to externalize the problem from themselves. Cathy stated:

For a while, like a lot of me thought, ‘I’m just not enough. No matter what I do, it’s just not enough.’ And then I thought, ‘Well wait, no matter what I do, he still acts out. This is not my fault’ and that was really freeing.”

Barbara also shared her experience with realizing that she wasn’t the problem:

I would go to my [support group] meetings and I would see you know, these gorgeous women with like these awesome bodies. And I would think ‘freaking their husbands have this problem, and they look like that?’ *laughs* It can’t be me. It can’t just be me.
**Pornography is not the problem.** Another helpful conceptualization that couples made of their challenges was that pornography was not the main issue that needed to be addressed. When RUs would discuss their recovery, they would rarely be discussing pornography as the problem that they were recovering from. They would often make statements about bigger issues such as this from Chris:

For a long time, I just felt like I had a storm inside of me and there was no room for love, or trust or even clarity because it was just swirling emotions of fear and expectations and responsibilities. And having a time every day to first of all, just work on me, but also clear all the junk out and create space in my heart for stillness and love and clarity to come in has really been huge.

Or like Billy, many RUs discovered that recovery had a lot to do with underlying emotional issues: “we were figuring out the reasons behind my addiction. A lot of it was around emotional things and that’s a vulnerability, not being able to be vulnerable.” It appeared meaningful to the couples that recovery was about resolving challenges that were so much bigger than PPU and more influential to their overall wellbeing. Which leads us to our final subtheme for meaning making.

**Crucible perspective.** As I neared the end of each interview with these couples and asked for their final thoughts, it was incredible to me when many of them expressed gratitude in some way for what they have been through. As if the pain and the struggle they had just recounted was all worth it to them. Alexis was ready to divorce her husband when she caught him cheating on her and learned about his pornography use. She now feels what many of the RPs feel:

Andy and I’s marriage is way better than it’s ever been. Going through this and the change that I see in him, and the change that we have together, we enjoy our lives so much better. I wouldn’t change what we’ve been through, ever.
In another example, Josie expressed similar sentiments:

Now that Jerry’s in recovery, he’s very self-less. He understands the need of communication. He understands the need for cooperation, for openness, honesty... He gets what loves means, what it means to make love, what it means to show love and he shows that to the kids, and he shows that to me. There’s a lot of respect there and I think I finally understand what [therapist] was saying when he said he wants his daughters to marry someone that is in recovery. Because I think I now have that and it’s much more beautiful than who I fell in love with, nine, ten years ago.

Additionally, this crucible perspective not only seemed to be about the relationship being better or your partner being better, but many of the RUs and RPs expressed that they felt like they were personally better. Isaac shared his thoughts on this point:

We both found that recovery for us has turned us into the people we always wanted to be, but it was like, we had to think about, to say, I am going to choose to commune with God daily, whatever that looks like, this is what it looks like for me. I’m going to be intentional about moving my body and I’m going to learn how that the skill set of emotional intelligence and just start to understand what the heck I’m feeling. So yeah. It’s something I dreaded and was afraid of and now it’s like I don’t ever want to go back.

**Recovery Hindrances and Cautions (Theme 5)**

The final major theme of recovery from PPU that arose from the interviews was hindrances to recovery. As the interviewer, I originally only sought explanations of what made recovery for these couples successful. Yet, within the first few interviews I noticed that the couples were also divulging efforts they made or experiences they had that hindered their recovery, specifically hindering experiences with therapists. We determined as a coding team, that it would be wise to seek more information about hindering experiences in the remaining interviews. As a result, there were numerous examples given of what hindered each couple’s recovery, however, there was very little overlap between the couples hindering experiences. This could mean that what was
hindering for one couple may not have been hindering for another. For example, one SP expressed that detaching from her partner at first was very helpful for her healing, while another SP shared that detaching from her partner hindered their relationship recovery and that she wished she wouldn’t have. Therefore, we determined that when it comes to hindrances for recovery, most examples given should be considered merely as cautions. These examples have the possibility of hindering recovery but may not be a concern for all couples or individuals seeking recovery.

Nevertheless, the exception to this rule for hindrance cautions were that there were several common statements made about experiences with therapists that hindered recovery among most of the stories of recovery. I will discuss this hindering subtheme, and then give a few examples of the other support cautions, work of recovery cautions, and perspectives of recovery cautions. The complete list of mentioned hindrances and cautions can be found in Tables 1-3.

**Therapist hindrances.** While each couple discussed their attempts to seek support from therapists during their recovery, almost every couple discussed having some unhelpful or even harmful experiences with therapists. Two common subthemes of therapist hindrances emerged that will be addressed here. There were several other hindering experiences with therapists that did not overlap with other stories.

Two hindering subthemes came from experiences with therapists that the couples considered unfamiliar or untrained with sexual addiction and betrayal trauma. The first and most concerning subtheme of hindering recovery experiences was that several couples experienced a few of these therapists as unaffirming and sometimes even
blaming of the RP. Felicity was told by a therapist that she was being manipulative. She shared:

Once my husband started coming in, this therapist…just started talking to me like I’m co-dependent and overly controlling and overreactive and all this stuff, and I was just getting all these shame messages, where up until this point, I didn’t have shame. It did a lot to damage to us, to our relationship. Because, now suddenly, anything I do or say is seen as controlling and manipulative. When that’s not at all what I was trying to do, but that’s what the therapist is saying.

In support, her husband Fred said: “It hurt Felicity and it hurt our relationship…Anything that came across as blaming or pointing the finger at my wife or even my family members that exposed me, that did not feel helpful.” Hannah had a similar experience:

We went to the counseling further and did a few sessions with a guy who was, now like I said this was 15 years ago. So back then pretty much the message I got from the therapist was ‘he’s gonna relapse and you need to be patient and loving.’ *laughs* Just super invalidating.

The second common hindering theme had to do with the therapist’s approach to treatment. It seemed that with these presenting problems, many of these couples were seeking more of a directive approach to therapy and were disappointed when they walked out of therapy without some sort of direction for recovery. Many couples expressed similar encounters with therapists to what George experienced:

Like Gretchen mentioned, we had very many therapists that were really good listeners, you’d go in, sit and talk for an hour, you’d pay them for an hour of their time and they would listen to you and empathize with you, but at the end of the session I don’t feel like they gave me any direction. A lot of good listening and whatnot but not any tasks ahead.

Elaine shared similar feelings about one of her therapists: “I felt like when I went to her it was more of just me talking for 50 minutes and she just took notes. I really wanted more than that. I wanted advice or a challenge for the week.”
Cautions to recovery. There were many examples given by the couples of other hindrances to recovery. Again, these experiences were isolated and part of the recovery story of two or three couples at the most. Therefore, we recognize them as merely cautionary to recovery. For other supports of recovery, a few of these examples included a support group not providing much accountability for the RU, strong hostile feelings within the relationship, and broken confidentiality in a therapy group. For work of recovery cautions, a few examples include a trickle-down disclosure or divulging pieces of the betrayal over a long period of time as well as trying to work recovery in isolation without any accountability. Finally, examples of perspective of recovery cautions include comparing recovery stories with others in recovery, labeling the RU as a porn addict, and believing that a higher power will just take away your struggles without much personal effort or trying to “pray away the addiction” as Dianna put it.

Relationship Recovery

The recovery of the relationship from PPU was what I originally set out to discover. My original research question was “how do couples recover from PPU?” You can imagine my bewilderment (and even initial frustration) when the couples hardly ever talked specifically about the recovery of their relationship during the interviews. Yet, at the end of their stories, their relationship had almost always recovered. The few comments that were made about the relationship recovery made it seem as if the relationship recovered simultaneously as each partner recovered individually. Isabella gave a great example of this as she shared her experience.

But I think it was probably like, it was over a year, I’m not sure how many months into recovery that I was standing there like, my gosh! I can say that
I trust my husband! That I feel safe. And it really came down to me seeing him every day, show up for himself, like he said despite me being there or not, and really changing. And so, it wasn’t just him saying, like all the right things, it was him doing all the things. So, you know, that, maybe he didn’t know I was keeping an eye on him, but I saw him change and that was really the only thing that could build the safety of trust for me.

Comments like these developed an idea for us that maybe it was a false assumption that the individual recoveries and the relationship recovery were separate. We even considered that the individual recovery was the relationship recovery. This was partially in alignment with the healing perspective subtheme that individual recovery should take place before relationship recovery efforts. However, there were several key comments that suggested that there were still some actions and some perspectives of recovery that were specifically for the relationship. I will discuss those here.

The Work of Couple Recovery

Though the overarching themes of recovery are still the same between the individual recoveries and the relationship recovery, there were significant differences in how each of the subthemes presented. For example, psychoeducation was still important for the relationship, however, specifically relationship education such as healthy communication practices were expressed to be extra helpful for the recovery of the relationship. The part of relationship recovery that was seemingly most mentioned was the importance of rebuilding trust. Barbara shared:

Earning my trust back was huge. And I think during that first two months was really difficult. I couldn’t even spend a weekend with him it was too much for me. We basically kind of just lived our own lives and he showed me through his actions that he was you know getting better doing all the things that he needed to do so I could trust him again.
Like Barbara’s, most of the comments about rebuilding trust involved witnessing the partner taking care of their own recovery work, again emphasizing the importance of preliminary individual work to initiate couple recovery.

It appeared that once some trust had been re-established through individual work, then it was helpful to set time aside for relationship work to increase emotional and intellectual intimacy. For example, Eric and Elain went on a walk every night: “He and I started walking together every night. I think that’s where a lot of our healing took place because we could just talk about anything. Even if it was snowing outside, we went.” Many couples talked about having specific times set aside for check-ins on a regular basis. Billy talked about how check-ins were helpful for him: “checking in every night with each other is really important. Just to know you have that accountability to your partner.” Also, Cathy shared why check-ins were important for her and many of the RPs: “Transparency is huge in being able to heal and to rebuild trust. If the addict isn't transparent then healing is much harder, and rebuilding of trust just doesn't happen. So that is where the check-ins are important.”

After much progress had been made in their individual recoveries, many couples chose to create something new of their relationship. Several couples described setting up an experience that marked the recreation of a new relationship. Isabella shared what that experience was for her and Isaac: “we renewed our vows and I think that was big… because we wrote vows, which we never did when we first got married, and it was such a different experience.” For some, the recreation of their relationship was more of a process like they were rebuilding a new relationship. Barbara described this experience for her
and Billy: “we kind of started from the beginning and learned who we were to each other with this new information to both of us.”

**Healing Perspectives of Couple Recovery**

Several of the healing perspectives of recovery that assisted in the individual recovery, also greatly aided the relationship recovery. Of course, the perspective that the individual recovery should take place before the relationship recovery not only allowed the individuals to focus on their individual recovery, but also helped them to not prematurely jump into relationship repair and end up doing further harm. The relationship could be put on hold while each partner did their own work. Externalizing the problem seemed especially helpful for couple work. Separating the problem from their partner allowed each couple to join together against the problem instead of blaming and taking up arms against each other. Gretchen conveyed how her therapist helped her externalize the problem so she could support her husband easier in his recovery:

> She helped me see addiction in a way that was at least for me, more like a disease. Say he had diabetes instead of that he was purposefully hurting me. Wherein the past, my view of it was he’s just hurting me… and now I see it in a different way. And I have more compassion for what his struggles are.

Additionally, most of the crucible perspectives that were shared (as described and exemplified in the perspectives of recovery section) involved a view of a greater relationship rather more than just a greater self. Ultimately suggesting that the end result of each couple’s recovery process was more defined by the relationship recovery rather than the individual progress they each made separately.

A couple different perspectives that were mentioned that seemed to be particularly applicable to the relationship. Comments that were made about empathizing
with your partner and the pain/struggle they were going through seemed to make a significant effect on the recovery of the relationship. Jerry discussed how it was important for him to know what triggered Josie’s betrayal trauma and made specific efforts to avoid those triggers:

I had to understand then that, that was something that triggered her and so I tried to develop a habit, if I did stop for gas to say, ‘Hey, I stopped for gas,’ or ‘I stopped to get something to eat,’ something simple so she would know and wouldn’t be wondering what was going on. I would also try and send a picture of where I was at the time. You know, with cell phones, that’s so easy to do, so I tried to kind of do that to ease her mind.

Fred shared how an empathy mindset made a big difference for his ability to support Felicity:

I would add to that another turning point, as far as our relationship… was a statement in a book about ‘every interaction is an opportunity for understanding.’ And I think that was a mindset change for me. To embrace the conversations, even if they were difficult, even if they were painful, or I didn’t like what I was hearing, it was opportunity to understand and to move us forward.

And finally, many couples expressed that it was important for them to maintain hope for their relationship and what could be. This seemed particularly helpful when the relationship was put on hold for individual recovery as they would hold on to the hope that as things got better individually, their relationship could recover too. Partway into their recovery process, Alexis changed her mind about leaving Andy and Andy expressed: “that was a huge turning point: knowing that if I’m working as hard as I can work, she’s going to still be there.” When Dianna was asked about advice, she would give others who are struggling, she shared:

I had one person tell me, ‘my relationship is better now after my husband's affair.’ I thought it was the biggest load I’ve ever heard. I didn’t believe it whatsoever. But I can say that. I think our relationship is better than it was before. I think that hope and that realization that this is not unique to get
through this, I think would be important for me to know. Knowing that there’s hope. That it’s really real, it’s not unobtainable.

**Tying It All Together**

As I have explained, the majority of the couple’s recovery from PPU seemed to take place as each individual did their own recovery work. Each RU and RP seemed to play a critical role in the recovery of their partner, supporting them in their own recovery, but the majority of real and honest recovery took place individually. Catalyst events (theme 1) jump started the recovery of the RU and at the same time often seemed to be the initiating event of the recovery of the RP. In some cases, the catalyst event was also a traumatic event that the RP seemed to be recovering from. Following catalyst events, the couples sought out additional support for their recovery (theme 2). Sometimes this support was found together, but most often they primarily found individual support that created a firm foundation for their recovery. Arising out of that support came an understanding of the work of recovery (theme 3) and perspectives that were helpful to recovery (theme 4). Again, as each partner achieved progress in their own work, this seemed to motivate and assist in the healing of the other partner, simultaneously healing the relationship. No recovery was perfect and often sustained several hindering experiences (theme 5), yet these successful couples kept working and often catalyzed the hindering experiences to push them to seek recovery all them more. With each story of recovery in this study, this pattern was followed. The outcome was not merely abstinence from PPU or even a “recovery” back to a previous state in the relationship. These successful couples, in many ways, described experiencing a transformation, both individually and relationally. Their recovery efforts transformed them into something
superior to what they were before the recovery process had begun. The themes of recovery outlined above in combination with the resulting transformation, constitutes the phenomenon of couple recovery from PPU.
CHAPTER V
DISCUSSION

The purpose of this study was to discover more about the couple recovery process from PPU. Following the summary of the resulting themes of the study described in the previous paragraph, I will build upon that initial purpose and discuss several important implications of my findings for therapists and researchers that I will discuss here. I believe that these considerations will shed additional light on the phenomenon of couple recovery from PPU and provide some varying angles of interpretation and application. I will begin by discussing some clinical implications of the study and their connection with the employed common factors of therapeutic change framework (Sprenkle & Blow, 2004).

Common Factors and Clinical Implications

I previously utilized a common factors of therapeutic change framework to organize the previous literature in this field. There were a significant number of research gaps regarding recovery from PPU. Though common factors were not directly involved in the coding process in order to be true to the phenomenological design of the study, many of the resulting themes correspond with the previously discussed common factors. In the following paragraphs, I will discuss a few principle implications of PPU treatment for each of the major categories of common factors. While these implications are primarily for clinicians and researchers in this field, they could also be valuable for couples experiencing PPU.
Client Variables

The client variables chosen for the literature review were a client’s commitment to change (Davis et al., 2012; Sprenkle & Blow, 2004), their hope for change (Davis et al., 2012; Lambert, 1992), and their efficacy for change (Rand, 2017). The previously available literature describing these variables in the treatment of PPU was highly limited. However, the themes from the current study provide additional implications for client variables in PPU treatment and recovery.

**Separate trajectories of recovery.** An important implication of this study is that couple recovery from PPU is not all about assisting the recovering user (RU). It is imperative that clinicians, professionals, and couples struggling with PPU understand that one partner’s pornography use will affect the other partner in potentially traumatic ways. Previous literature has also attested to this finding (i.e. Hentsch-Cowles & Brock, 2013; Schneider et al., 2012; Vogeler et al., 2018). This study extends those findings by highlighting that many couples must seek their own recovery from PPU and its effects first as well as expect that each partner will likely not recover at the same rate or in the same way. The couple’s recognition of and attention to both partner’s separate recovery paths powerfully affected motivation, hope, and efficacy for change in the couples of this study. Clinicians and professionals who support couples facing PPU should carefully monitor both recovery trajectories and avoid assuming each partner is in a similar state of recovery. If only one partner is seeking therapeutic treatment, it will be beneficial to that client and the couple for the clinician to seek greater understanding on how PPU is affecting the other partner (either the RU or the RP) and whether that partner is receiving sufficient support.
Process of client variables for recovery. The results of this study also highlight the importance of client motivation for change for couples to be successful, particularly at the commencement of the recovery process. Many couples seemed to go years into ineffective recovery processes until they experienced catalyst events (i.e. discoveries, disclosures, etc.) and subsequent relational consequences (i.e. ultimatums, separation, etc.) which amplified the motivation for recovery in each partner. This aligns with systemic models of treatment such as brief strategic therapy (Santisteban, Suarez-Morales, Robbins, & Szapocznik, 2006) and structural family therapy (Minuchin & Fishman, 1981) that highlight the importance of “perturbing the system” (Gardner, Burr, & Wiedower, 2006) for change to occur. Once these clients experienced a semi-traumatic relational event or a major life transition, they were more motivated than ever to seek support and change. Correspondingly, some literature for treating addiction makes claims about a “rock bottom” experience that is necessary for real and honest recovery to occur (Shinebourne & Smith, 2010; Waldorf, 1983), particularly with addiction recovery. Clinicians could find ways to encourage healthy disclosure (Corley & Schneider, 2002) and healthy boundaries (Bird, 2007) to inspire greater recovery motivation. Additionally, motivational interviewing techniques have been shown to be effective at highlighting motivational consequences and increasing client motivation (Giudice & Kutinsky, 2007).

Hope for recovery and recovery efficacy were also important to achieve for these successful couples but seemed more like fruits of an effective recovery process rather than instrumental in the beginning or the goal. However, effective psychoeducation regarding sexual addiction (Young, 2008) and betrayal trauma (Vogeler et al., 2018) as well as the associated recovery processes seemed to instill greater hope and efficacy in
the couples of this study. Learning that there was an explanation for the effects of PPU that both partners were experiencing seemed to help them to not feel so out of control and that there was something they could do about it to effectively recover.

**Therapist Variables**

The therapist variables discussed in the literature review include the therapist’s chosen diagnosis and treatment models (Sprenkle & Blow, 2004), the specific skills/techniques the therapist uses in treatment (Fife et al., 2014; Simon, 2012), and the therapist’s way of being (Blow et al., 2007; Fife et al., 2014, Anderson, 2006). Though this grouping of common factor variables was the most prevalent in previous PPU treatment literature (at least in terms of models and techniques), there remains a need for additional study to effectively and thoroughly describe the therapist’s role in the PPU recovery process. This study expounds upon these variables and highlights key implications for clinicians and future empirical research.

**Training in sexual addiction treatment.** Every couple of this study identified their struggles with PPU as a sexual addiction. Some made comments about learning that terminology from a source of support, often a therapist, and then adopting it for themselves. No comments were made about the importance of labeling their problem as an addiction for recovery to occur, but many made comments about the importance of seeking out a therapist who was trained in treating sexual addiction (Young, 2008). In a dire time of need, these clients were looking for someone they could trust to know how to help them and seeing a therapist who was specifically trained in treating their primary concern gave them hope. Conversely, there were several mentions of the importance that the label of addiction be externalized from the RUs and avoid defining them as an addict.
Admittingly, my own understanding of clinical addiction and my own clinical experience causes me to be hesitant to label PPU as a sexual addiction, however, similar change mechanisms that are effective for treating substance addictions (i.e. personal and relational boundaries, abstinence, trauma work) seem to also be effective for treating PPU (Adams & Robinson, 2001; Ayres & Haddock, 2009). Regardless of the label, training in effective treatment for addiction (particularly sexual addiction if available) will assist in the therapist’s conceptualization and treatment of the presenting problem of PPU, as supported by all 11 recovery stories.

**Training in betrayal trauma treatment.** Every RP labeled their struggles as betrayal trauma (Birrell, Bernstein, & Freyd, 2017; Vogeler et al., 2018), which was expressed to be beneficial to their recovery. The label of betrayal trauma can seem extreme in response to pornography use; however, it resonated with the RPs because it gave them language that accurately represented the extreme emotions they were experiencing. Assessing for how PPU has affected the partner of the pornography user is critical due to the possibility that they will experience an acute emotional response, like unto the responses that were exhibited in this study. In addition to sexual addiction training, also receiving training in betrayal trauma conceptualization and treatment will be valuable for clinicians in this field (Hentsch-Cowles & Brock, 2013; Schneider et al., 2012).

**Directive therapeutic approach.** Of the many hindrances to recovery (theme 5) shared in the interviews, possibly the most common among them was the experience of receiving nondirective therapeutic support. Drawing from these comments and other themes regarding the specialized psychotherapy, we can conclude that a passive approach
to therapy is not ideal for this population. This may have been problematic due to the level of relational pain or either partner feeling out of control. Regardless of the reason, these couples wanted their therapist to not only help them understanding their challenges, they also strongly desired specific direction on how to recover. They wanted to feel assured that their therapist was experienced in this area and confident in a successful treatment path for them to follow. They needed a therapeutic vision that they could align with that would give them hope that things could finally get better. There is a large body of literature on the benefits and disadvantages to a directive approach to therapy (Cooper, Norcross, Raymon-Barker, & Hogan, 2019; Haley & Richeport-Haley, 2012). Nevertheless, it seems that for this presenting problem in therapy, a directive approach is more beneficial for the client’s recovery. Building upon the implication of the previous paragraph, specialized training will likely assist with a more confident directive approach to treatment.

**Collaborative therapeutic approach.** There were also comments regarding the importance of customizing treatment to the client’s unique needs was also found in the resulting themes. This suggests a healthy balance between a directive approach and a collaborative approach to treatment may be most effective, depending on the independent attributes and concerns of the couple client. Directive and collaborative approaches to therapeutic treatment are not mutually exclusive. There is previous literature regarding this delicate balance (Cooper et al., 2019; Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003). Ultimately, careful assessment, collaboration, and attunement to each client’s unique needs is about the creation of the therapeutic alliance (Bordin, 1979). Though this
is a relationally focused variable of change, I mention it here because of its direct connection with the implication for a directive therapeutic approach.

The offense and defense of PPU treatment. Regarding models of treatment, it appeared that each couple was following a different model in how they approached recovery, none of which seemed to be closely tied to a specific evidenced based treatment. Some discussed interventions their therapist used or interventions they utilized at home, however there was little to no overlap between the couples in which interventions they utilized. As was presented in the results section, there was a common process element to the overarching theme of the work of recovery. Work of recovery interventions from various models fit into the organization of structure for recovery (e.g., boundaries and bottom lines) and recovery routine (e.g., mindfulness, check-ins, yoga, etc.). The structure acted as a fortifying defense against relapse/further harm and the routine acted as the offensive or proactive measures utilized to heal from and replace PPU and the resulting partner trauma. The implications of these findings are explicit that couple-based treatment for PPU should be active on both fronts; protecting against further harm as well as eliciting healing for both partners.

Relationship Variables

The therapeutic alliance (Lambert, 1992; Sprenkle & Blow, 2004) and relationship therapy (Sprenkle & Blow, 2004) were considered the most pertinent relational common factors for the subject of this study. However, much like the other variables discussed previously, there was little former research addressing these variables for PPU treatment. In addition to what was said earlier about a collaborative therapeutic
approach, the results of the current study directly address these variables with another pertinent implication.

**Timing of relationship therapy.** Relationship therapy is considered a common factor of change for marriage and family therapy (Sprenkle & Blow, 2004). Accordingly, it makes sense that relationship therapy would be effective for treating PPU in a couple (Zitzman & Butler, 2005). Though relationship counseling of some sort was a part of every recovery story in this study’s sample, there are some cautions. From this study we know that there are separate trajectories of recovery for each partner and the relationship, as well as the finding that preliminary improvement in individual recovery is necessitated before relationship recovery can progress. Therefore, professionals who begin treatment of PPU with both partners should not prematurely strive to facilitate relationship repair without addressing individual recovery trajectories. Recent scholarly literature supports this implication. Butler, Spencer, and Seedall (2019) suggested that helping partners to have a more balanced view of themselves in relation to their partner is an important prerequisite for the work of recovery (Butler et al., 2019; Butler & Spencer, 2018).

**Extra Therapeutic Factors**

The extra therapeutic factors outlined in the literature review were life experiences, social support, community involvement, and stressful/fortuitous events (Lambert, 1992), and each were previously understudied in PPU treatment literature. In this study, it was clear in each of the recovery stories that the majority of recovery did not take place in the therapy office, giving extra therapeutic factors a large role in the recovery process.
Accountability is essential. While building a strong foundation of support was essential for the initial steps of effective recovery, possibly the most important way that effective support was given was by providing the RU with thorough accountability for behaviors and goals. All five major themes of recovery addressed the importance of accountability for recovery in one way or another. Shame was shared to be a central part of the issues underlying PPU and a barrier to real and honest recovery. Fundamental to shame is secrecy and deception (Chisholm & Gall, 2015). Accountability is a direct and effective counter to shame characteristics that are connected with all addiction recovery (Adams & Robinson, 2001). Many therapists understand the connection between addictive behavior and shame and appropriately assess for it. Yet they may not realize that extensive extra-therapeutic support that provides accountability is an effective way to combat shame. Clinicians should provide accountability in session to their clients struggling with PPU, but once a week accountability may not be sufficient. Clinicians would do well to also encourage clients struggling with PPU to set up extra-therapeutic thorough accountability systems to promote swifter recovery.

Broadening systemic treatment. A final and important implication from this study came from observing that all couples who participated in this study received support from a variety of sources outside of therapy. Systemic thinking is essential to all marriage and family therapy models (Becvar & Becvar, 2017). However, clinicians may implicitly consider “systemic treatment” in practice as simply including one’s partner or immediate family members. The recovery stories of this study emphasize that effective treatment for PPU and associated betrayal trauma requires a system of support that extends far beyond this limited definition of systemic therapy. Therapists who participate
in the treatment of PPU, particularly with couples, need to broaden their scope of systemic treatment to encourage their clients to mobilize a network of support from as many difference sources as possible. The lifestyle necessary for effective recovery identified in this study was highly involved and transformative. Encouraging anything less may hinder the progress of recovery. Supporting that kind of change takes much more than just a weekly one-hour session of psychotherapy. Conclusively, therapists in this field need to be aware of helpful extra-therapeutic resources available to these clients. and collaborate to help them achieve more holistic and systemic treatment (Wampler & Patterson, in press).

**Limitations and Implications for Future Research**

As with all empirical studies, there are limitations to this study that affect the applicability and generalizability of its findings. As one example, the sample is small and relatively homogenous. Despite a small sample size being appropriate for a phenomenological study (Mason, 2010) and the sample arguably being representative of the type of couples that experience and seek treatment for PPU (Kraus et al., 2016a), the results should still be applied with caution. Every couple reported to be highly religious, which may have biased our findings for more religious themes. Future research should examine recovery experiences with a non-religious sample and compare results with this study. Additionally, the sample was collected through therapists that specialize in the treatment of PPU. With this sampling method, it is little wonder that each of the couples discussed the imperative nature of working with a specialized therapist as part of their recovery story as well as their common conceptualization of their concerns with PPU.
Repetition of this study utilizing additional sample collection methods would be beneficial for the validation of study results. Furthermore, it would be beneficial if the findings from this qualitative study were then explored quantitatively to further determine their applicability to the recovery stories of diverse populations.

Future research in this field would do well to analyze a comparison group. Though there may be ethical concerns that would need to be addressed, involving a comparison group of couples who have not been successful in their attempts for recovery could allow us to compare and contrast recovery themes between couples who were still struggling versus those who had achieved significant recovery. Furthermore, we did not assess for co-morbidity of mental illnesses or disabilities within our sample. Comparing PPU treatment between groups of individuals and couples dealing with other common mental health challenges would also provide further insight into effective treatment for PPU. Perhaps these concerns could be partially accomplished as part of quantitative studies, allowing the unsuccessful couples and comorbid pornography users greater anonymity.

**Conclusion**

The scholarly, moral, and political debate surrounding the implications of pornography use is divisive and complex. For couples who report experiencing deleterious effect from PPU and seek treatment, there is little research that provides the answers for healing and recovery regarding common mechanisms of change. The current study endeavored to address this concern. The phenomenon of couple recovery from PPU is complex, and each recovery story and the couple contexts they embark from are
unique. However, the reported phenomenological analysis of the successful recovery stories of 11 couples from PPU provides strong thematic implications and a firm foundation for future research in this area. Five major themes of recovery emerged, along with associated subthemes, that significantly illuminate key processes in the phenomenon of couple recovery from PPU. In summary, effective recovery processes were initialized and further motivated by *catalysts for recovery (theme 1)*. Following catalyst events, couples sought out a *foundation of support for their recovery (theme 2)* where they learned what was effective *work of recovery (theme 3)* as well as *healing perspective of recovery (theme 4)* to adopt. Finally, many couples experienced *hindrances to recovery (theme 5)* along their recovery path, yet persevered and achieved individual and relationship transformation as a result of their recovery efforts. Additionally, there are essential separate trajectories of recovery for each partner that ultimately synthesizes into a more complete picture of couple recovery. Psychotherapists and other professionals who assist others in the recovery from PPU should consider the results of this study and subsequent implications in their future treatment of this issue. Future research in this field would do well to build upon the resulting themes of this study with further empirical exploration and substantiation. Conclusively, this study is foundational and monumental for the ever-rising concern of PPU. I believe it has the potential to provide significant hope and healing to the many individuals, couples, and families and their supporters who are directly affected by the harmful effects of pornography.
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APPENDICES
Appendix A

Qualifying Questionnaire (User)
(Highlighted in Red = Disqualifies)

| Give the Informed Consent to Research | a) I agree to the terms of the study  
b) I do not agree to the terms of the study |
|--------------------------------------|------------------------------------------------------------------|
| 1. Are you in a committed relationship? | a) Yes  
b) No |
| 2. Have you gone to therapy with problematic or addictive pornography use being a main reason for seeking help? | a) Yes  
b) No |
| 3. When was your last therapy session? (Individual or group) | a) I’m still actively going to therapy  
b) Last week  
c) Last month  
d) Less than 6 months ago  
e) Less than a year ago  
f) Over a year ago |
| 4. What level has your partner been involved in the treatment and recovery process? | a) Not involved  
b) Minimally Involved  
c) Somewhat involved  
d) Involved  
e) Highly involved |

Sexual Addiction Recovery Capital Scale (SARCS)
Please tick if you agree with any of the following statements: *(Disqualified if under 30 are checked)*

| 5. Having a sense of purpose in life is important to my recovery journey. | |
| 6. I am able to concentrate when I need to. | |
| 7. I am actively involved in leisure and sport activities. | |
| 8. I am coping with the stresses in my life. | |
| 9. I am currently completely clean from engaging in unwanted sexual behaviors. | |
| 10. I am free from worries about money. | |
| 11. I am actively engaged in efforts to improve myself (training, education, and/or self-awareness). | |
| 12. I am happy dealing with a range of professional people. | |
13. I am happy with my personal life.
15. I am proud of my home.
16. I am proud of the community I live in and feel a part of it.
17. I am satisfied with my involvement with my family.
18. I cope well with everyday tasks.
19. I do not let other people down.
20. I am free from threat or harm when I am at home.
21. I am happy with my appearance.
22. I engage in activities and events that support my recovery.
23. I eat regularly and have a balanced diet.
24. I engage in activities and events that support my recovery.
25. I feel physically well enough to work.
26. I feel safe and protected where I live.
27. I feel that I am in control of my sexual behaviors.
28. I feel that I am free to shape my own destiny.
29. I get lots of support from friends.
30. I get the emotional help and support I need from my family.
31. I have a special person that I can share my joys and sorrows with.
32. I have access to opportunities for career development (job opportunities, volunteering or apprenticeships.)
33. I have enough energy to complete the tasks I set myself.
34. I have had no ‘near things’ about relapsing.
35. I have had no recent periods of sexually acting out.
36. I have no problems getting around.
37. I have the personal resources I need to make decisions about my future.
38. I have the privacy I need.
39. I look after my health and wellbeing.
40. I make sure I do nothing that hurts or damages other people. 
41. I meet all my obligations promptly. 
42. I regard my life as challenging and fulfilling without the need for acting out sexually. 
43. I sleep well most nights. 
44. I take full responsibility for my actions. 

45. It is important for me to be involved in activities that contribute to my community. 
46. In general I am satisfied with my life. 
47. It is important to me to do what I can to help other people. 
48. It is important to me that I make a contribution to society. 
49. My living space has helped to drive my recovery journey. 
50. My personal identity does not revolve around my sexual behaviors. 
51. There are more important things to me in life than sex. 
52. What happens to me in the future mostly depends on me. 
53. I have a network of people I can rely on to support my recovery. 
54. When I think of the future I feel optimistic. 

| 55. Assessing Pornography Addiction (1) | a) 1-2 Times 
| In the last year, what is the frequency with which you have viewed pornography? | b) Every Two or Three Months 
| | c) Once a Month 
| | d) Every Two Weeks 
| | e) Once a Week 
| | f) 3-5 Times a Week 
| | g) Almost Every Day, If not Daily 

| 56. Assessing Pornography Addiction (2) | a) view it briefly, but don't look again for weeks or months 
<p>| Once you start looking at pornography do you: | b) view it 3 or 4 times within a short period of time and then stop for weeks or months |</p>
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| 57. Assessing Pornography Addiction (3 - Descriptive)                  | a) multiple times a day  
b) once a day  
c) three to five times a week  
d) once a week  
e) every other week  
f) once a month  
g) every two or three months  
h) very rarely to never |
| How often do you think about or fantasize about viewing pornography?    | c) view it and then repeatedly look at it for a few days before trying to stop  
d) view it daily for a few weeks before trying to stop  
e) view it multiple times a day for weeks at a time and then stop for a few days before you go at it again  
f) view it as often as I can, every day all day if I could |
| 58. Assessing Pornography Addiction (4)                                 | a) multiple times a day  
b) once a day  
c) three to five times a week  
d) once a week  
e) every other week  
f) once a month  
g) every two or three months  
h) very rarely to never |
| How often do you act upon your fantasies and view pornography or act out? | a) multiple times a day  
b) once a day  
c) three to five times a week  
d) once a week  
e) every other week  
f) once a month  
g) every two or three months  
h) very rarely to never |
| 59. Assessing Pornography Addiction (5)                                 | a) 8 months to a year  
b) 6-8 months  
c) 4-6 months  
d) 2-4 months  
e) 1-2 months  
f) two weeks to a month  
g) one week  
h) one or two days |
| What is the longest period of time that you have gone without pornography in the past year? | a) Strongly disagree  
b) Disagree  
c) Neither agree nor disagree  
d) Agree  
i) Strongly Agree |
| 60. To what level do you agree with this statement: “I have achieved significant progress in my recovery process from problematic or addictive pornography use and it is no longer a major problem in my life.” | a) Strongly disagree  
b) Disagree  
c) Neither agree nor disagree  
d) Agree  
i) Strongly Agree |
| 61. To what level do you agree with this statement: “My partner believes that I have made significant progress in my recovery process from problematic or | a) Strongly disagree  
b) Disagree  
c) Neither agree nor disagree  
d) Agree  
e) Strongly Agree |
addictive pornography use and it is no longer a major problem in our life.”

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| 62. CSI-4 (1) | Please indicate the degree of happiness, all things considered, of your relationship. | a) Extremely Unhappy  
b) Fairly Unhappy  
c) A Little Unhappy  
d) Happy  
e) Very Happy  
f) Extremely Happy  
g) Perfect |

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| 63. CSI-4 (2) | I have a warm and comfortable relationship with my partner | a) Not at All True  
b) A Little True  
c) Somewhat True  
d) Mostly True  
e) Almost Completely True  
f) Completely True |

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| 64. CSI-4 (3) | How rewarding is your relationship with your partner? | a) Not at All  
b) A Little  
c) Somewhat  
d) Mostly  
e) Almost Completely  
f) Completely |

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| 65. CSI-4 (4) | In general, how satisfied are you with your relationship? | a) Not at All  
b) A Little  
c) Somewhat  
d) Mostly  
e) Almost Completely  
f) Completely |

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| 66. Are you and your partner willing to participate as a couple in a 1-hour audio recorded interview regarding the process of your recovery from problematic pornography use? (Check all that apply) | a) No  
b) Yes – in person  
c) Yes – Over video conferencing  
d) Yes – Over the phone  
e) Other (Fillable) |

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<td>67. What is your partner’s first and last name?</td>
<td>a) (Fillable)</td>
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| 68. What would be the best way to contact you? | a) By phone (Fillable)  
b) By email (Fillable) |

Qualifying Questionnaire (Partner)  
(Highlighted in Red = Disqualifies)

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| Give the Informed Consent to Research | a) I agree to the terms of the study  
b) I do not agree to the terms of the study |

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| 1. Are you in a committed relationship? | a) Yes  
b) No |
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| 2. | In the last 2 years have you sought treatment for your own problems with pornography, not related to your partner’s pornography use? | a) Yes  
   b) No                                      |
| 3. | What level have you been involved in the treatment and recovery process with your partner for their problems with pornography? | a) Not involved  
   b) Minimally Involved  
   c) Somewhat involved  
   d) Involved  
   e) Highly involved |
| 4. | To what level do you agree with this statement: “My partner and I have made significant progress in recovery from problematic pornography use and it is no longer a major problem in our life.” | a) Strongly disagree  
   b) Disagree  
   c) Neither agree nor disagree  
   d) Agree  
   f) Strongly Agree |
| 5. | CSI-4 (Must score above distressed to qualify) (1) Please indicate the degree of happiness, all things considered, of your relationship. | a) Extremely Unhappy  
   b) Fairly Unhappy  
   c) A Little Unhappy  
   d) Happy  
   e) Very Happy  
   f) Extremely Happy  
   g) Perfect |
| 6. | CSI-4 (2) I have a warm and comfortable relationship with my partner | a) Not at All True  
   b) A Little True  
   c) Somewhat True  
   d) Mostly True  
   e) Almost Completely True  
   f) Completely True |
| 7. | CSI-4 (3) How rewarding is your relationship with your partner? | a) Not at All  
   b) A Little  
   c) Somewhat  
   d) Mostly  
   e) Almost Completely  
   f) Completely |
| 8. | CSI-4 (4) In general, how satisfied are you with your relationship? | a) Not at All  
   b) A Little  
   c) Somewhat  
   d) Mostly  
   e) Almost Completely  
   f) Completely |
| 9. | Are you and your partner willing to participate as a couple in a 1-hour audio recorded interview regarding the process of your recovery from problematic pornography use? (Check all that apply) | a) No  
   b) Yes – in person  
   c) Yes – Over video conferencing  
   d) Yes – Over the phone  
   e) Other (Fillable) |
| 10. | What is your partner’s first and last name? | a) Fillable |
| 11. What would be the best way to contact you? | a) By phone (Fillable)  
| | b) By email (Fillable) |
### Appendix B

**Demographic Questions**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What city and state do you live in?</td>
<td>a) Fillable</td>
</tr>
</tbody>
</table>
| 2. | What is your marital status? | a) Married  
   |   | b) Single (but in a committed relationship)  
   |   | c) Divorced (but in a committed relationship)  
   |   | d) Widow/Widower (but in a committed relationship) |
| 3. | How many children do you have? (Sliding Scale) | a) No children  
   |   | b) 1  
   |   | c) 2  
   |   | d) 3  
   |   | e) 4  
   |   | f) 5  
   |   | g) 6+ (fillable) |
| 4. | How long have you been in a committed relationship with your current partner (if you are married, how long have you been married?) | a) Less than 6 months  
   |   | b) Between 6 months and a year  
   |   | c) Between 1 year and 5 years  
   |   | d) Between 5 years and 10 years  
   |   | e) Between 10 and 15 years  
   |   | f) Between 15 and 20 years  
   |   | g) 20+ years |
| 5. | What is your gender? | a) Male  
   |   | b) Female  
   |   | c) Other |
| 6. | What is your sexual orientation? | a) Heterosexual (straight)  
   |   | b) Lesbian  
   |   | c) Gay  
   |   | d) Bisexual  
   |   | e) Other |
| 7. | What is your race/ethnicity? | a) Caucasian (white)  
   |   | b) African American  
   |   | c) Native American  
   |   | d) South American  
   |   | e) Asian  
   |   | f) Other (fillable) |
| 8. | What is your religion? | a) Christian  
   |   | b) Catholic  
   |   | c) LDS (Mormon)  
<p>|   | d) Muslim |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
</table>
| **9.** How often do you participate in religious services? | a) Multiple times a week  
  b) Every week  
  c) Every other week  
  d) About once a month  
  e) Once to a few times a year  
  f) Never |
| **10.** How many therapists have you seen throughout your recovery from pornography? | a) Sliding scale from 1 to 10+ |
| **11.** Did you ever participate in group therapy? | a) Yes  
  b) No |
| **12.** What times would you and your partner be available for a 1-hour interview in the upcoming week? | a) Insert a fillable calendar for them to fill out |
| e) Jewish  
  f) Atheist  
  g) Agnostic  
  h) Other (fillable) |
### Appendix C

#### Semi-Structured Interview Questions

<table>
<thead>
<tr>
<th>Q's for the Couple</th>
<th>Clarifying/Digging Q's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disclaimers:</strong></td>
<td>Things to possibly follow-up on:</td>
</tr>
<tr>
<td>• Informed consent</td>
<td>• How pornography affected life</td>
</tr>
<tr>
<td>• Brief overview of interview</td>
<td>• Perceptions of pornography use</td>
</tr>
<tr>
<td>• Give opportunity for questions</td>
<td>• The path to seeking help</td>
</tr>
<tr>
<td>• Start recording</td>
<td>• Partner disclosure / discovery</td>
</tr>
<tr>
<td></td>
<td>• Experience of partner</td>
</tr>
<tr>
<td></td>
<td>• Role of partner</td>
</tr>
<tr>
<td></td>
<td>• Role of other relationships (help &amp; harm)</td>
</tr>
<tr>
<td></td>
<td>• Motivation</td>
</tr>
<tr>
<td></td>
<td>• Hope</td>
</tr>
<tr>
<td></td>
<td>• Self-efficacy</td>
</tr>
<tr>
<td></td>
<td>• Treatment efforts</td>
</tr>
<tr>
<td></td>
<td>• Challenges faced as a couple</td>
</tr>
<tr>
<td></td>
<td>• Role of therapy</td>
</tr>
<tr>
<td></td>
<td>• Role of therapists – helpful and not</td>
</tr>
<tr>
<td></td>
<td>• Most recent therapy</td>
</tr>
<tr>
<td>1. Talk to me about your journey for overcoming pornography. (Seek client variables and recovery timeline)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. When you look back on this recovery journey you have been through, what were the key turning points / change moments?</td>
<td>Things to follow-up on:</td>
</tr>
<tr>
<td></td>
<td>• Individual characteristics</td>
</tr>
<tr>
<td></td>
<td>• What role did partner play?</td>
</tr>
<tr>
<td></td>
<td>• What other resources were useful?</td>
</tr>
<tr>
<td></td>
<td>• Most important lessons</td>
</tr>
<tr>
<td></td>
<td>• Timing / Life events</td>
</tr>
<tr>
<td></td>
<td>• Unique moments for each partners</td>
</tr>
<tr>
<td>3. What does recovery look like for you now?</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Things to follow-up on:</td>
</tr>
<tr>
<td></td>
<td>• What do you do to maintain your recovery?</td>
</tr>
<tr>
<td></td>
<td>• Advice to others in a similar situation?</td>
</tr>
<tr>
<td></td>
<td>• Advice to therapists?</td>
</tr>
</tbody>
</table>
## Recovering User Recovery from Problematic Pornography Use

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Subthemes</th>
<th>Specific Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong> Catalysts for Recovery</td>
<td>Turning Points</td>
<td>Discover, Disclosure, Relapse, Suicide attempt, Birth of a child, Realization of harm, Move</td>
</tr>
<tr>
<td>Emoitional Response</td>
<td></td>
<td><strong>User:</strong> shame, empathy, fear of loss <strong>Partner:</strong> betrayal, anger/rage/hate, disgust, blaming self, low self-esteem, insecure body image, suicidal ideation, panic attacks, no control</td>
</tr>
<tr>
<td>Relational Consequences</td>
<td>Relational Disconnection</td>
<td><strong>partner’s pain reaction, dissatisfaction with relationship</strong> <strong>Other:</strong> ultimatums, space/separation, divorce threat</td>
</tr>
<tr>
<td>Recovery Motivations</td>
<td>Parenting motivation/legacy</td>
<td><strong>fear of losing kids, fear of addiction affecting kids</strong> <strong>Religious motivation:</strong> moral incongruence, marriage covenants/vows <strong>Other:</strong> fear of relationship loss, personal growth</td>
</tr>
<tr>
<td>Specialized Psychotherapy</td>
<td>Alliance with Specialized Therapist</td>
<td><strong>caring, empathetic, unconditional positive regard, friendly, validating, knowledgeable/competent teacher (addiction recovery, betrayal trauma, trauma work), safe, engenders hope, externalizes the problem/addiction, collaborative, bold/challenging, gives assignments/homework, provides accountability, available, goodness of fit/chemistry</strong> <strong>Specialized group therapy:</strong> vulnerability, accountability, connection, psychoeducation, acceptance, people with similar challenges</td>
</tr>
</tbody>
</table>

*Table D-1: Recovering User Recovery from Problematic Pornography Use*
| Social Support | **Who:** 12-step groups, group therapy members, sponsors/support persons, life coach, parents, brothers, friends  
**How:** accountability, education, acceptance/non-judgment/safety, empathy/understanding, connection, challenge, vision, hope, safe place to share shame, comradery/”I’m not alone” |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner Support</td>
<td>Accountability, Boundaries, Willingness to stay and work recovery, Reminders of recovery commitments, Emotional support, Acknowledge progress, Let go of controlling my recovery</td>
</tr>
</tbody>
</table>
| Spiritual Support | **Higher power:** meaning making, accountability, surrender/trust, transgression forgiveness/mercy, spiritual connection,  
**Ecclesiastical leader:** transgression forgiveness/mercy, recommend resources, caring |
| Recovery Psychoeducation – Awareness and Understanding | **How:** specialized therapist, specialized group therapy, life coach, books, podcasts, online programs, support persons  
**What:** origins/roots of addiction, neuroscience of addiction, addiction cycle, triggers, boundaries/bottom lines, emotional intelligence, vulnerability, attachment, shame & guilt, trauma, coping/numbing, externalization, |
<p>| The Structure – Boundaries/Bottom Lines | Surrender will, No internet on phone, No phone in the bathroom, Get off social media, Internet filters, Moving computer to a more public place, Consistency, Avoid isolation, Never alone with another woman, Never alone while on the internet, Financial transparency, 24-hours honesty |
| The Routine – Dailies/Toolbox/Self-Care | Daily recovery workbook, Exercise, Mindfulness/awareness, Emotional drills, Read uplifting literature, Meditation, Journaling, Yoga, Music, Goal setting, Enjoyable activities, Cold shower, Breathing exercises, Distraction, Check-ins/honesty/accountability (with support person or partner), Better sleep, Better diet, Recovery/support meetings, Service, Sponsoring, Religious activity |</p>
<table>
<thead>
<tr>
<th>Theme 4: Healing Perspectives of Recovery and Meaning Making</th>
<th>Trauma Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Continued professional therapy, EMDR, Full disclosure, Neurofeedback, 12 step work, Other outlined recovery program,</td>
</tr>
</tbody>
</table>

| Acceptance/Surrender | Need support/can’t recover in isolation, Need to be accountable, Honesty is better in the long run, My life will be different than others, Recovery requires sacrifice, Surrender control of emotions and outcomes, Not needing to power through things, Self-forgiveness, Recovery takes time, Supporting partner needs recovery too, Partner’s recovery is out of your control, Supporting persons are imperfect too. |

| Individual Recovery Before Relationship Recovery | Need internal motivation more than external motivation, Recovery can’t be motivated by fear, Don’t focus on partner’s recovery or relationship recovery |

| Recovery Centered Life | Commitment to recovery: financial commitment, sacrifices for recovery, change for rest of life, recovery is highest priority, 100% committed is easier than 95% committed, Recovery is a process over time, not an event: one day at a time, patience in the journey, growth mindset, there will be setbacks, standing appointment with therapist, layers of challenges to navigate, you don’t “graduate,” persistence/not giving up, new life-long recovery lifestyle |

| Confidence in Your Own Recovery | Hope that recovery is possible, Feeling a difference, Lifestyle change, Benchmarks/milestones, seeing success |

| Externalization of the Problem | User is more than the addiction, Partner is more than their betrayal, give a name for addiction |

| Pornography is Not the Problem | Pornography is a coping behavior for underlying issues that fuel the addiction, emotional challenges need to be addressed, Trauma recovery is important Recovery vision (The whys): Sobriety, self-awareness, healthy emotional processing, connected lifestyle, trauma recovery, relationship healing |
### Theme 5: Recovery Hinderances and Cautions

<table>
<thead>
<tr>
<th>Crucible Perspective</th>
<th>“Our life is better now because of the struggles we went through,” Spiritual meaning – given this challenge for a reason</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapist Hinderances</strong></td>
<td>Not understanding/acknowledging betrayal trauma in the partner, Only talk therapy, Non-caring therapist, Cant’ healthily facilitate a disclosure, Telling the client that they are too damaged to help, Blaming others for user’s actions (gaslighting), Too much self-disclosure, Using addict label, Teaching co-dependency, Not giving assignments/homework, Too passive of an approach to treatment, Didn’t teach boundaries for recovering partner</td>
</tr>
<tr>
<td><strong>Other Support Cautions</strong></td>
<td>Partner hatred/resentment, Trying to recovery without support, No accountability, Support group changes too quickly, Support group has no sobriety, Support group doesn’t provide accountability or structure, Sponsor/support person not sober or not holding user accountable, Partner policing recovery, User or partner no self-motivated for recovery, Going to group for wrong reasons, Group members not keeping confidentiality, Labels weaponized against either partner, Recovering user is not proactive with their recovery</td>
</tr>
<tr>
<td><strong>Work of Recovery Cautions</strong></td>
<td>Emotional incompetence, Trickle-down/unhealthy disclosure, Isolation, Pain (physical and emotional), Dishonesty/keeping it secret from partner, Detachment</td>
</tr>
<tr>
<td><strong>Perspectives of Recovery Cautions</strong></td>
<td>Doing recovery for someone else, Victim mentality, Negative/pessimistic view of recovery, Low self-esteem, Belief that marriage would fix the problem, Addict label, Can pray away the addiction, Can google away or read away the addiction, Partner trying to act out recovering user’s sexual fantasies to stop the porn use, Partner is co-dependent/enmeshed/enabling or responsible in any way for recovering user’s porn use, Comparing recovery stories with others to measure how “bad” your situation is</td>
</tr>
</tbody>
</table>
Table D-2

Recovering Partner Recovery from Problematic Pornography Use

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Subthemes</th>
<th>Specific Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong> Catalysis for Recovery</td>
<td>Turning Points</td>
<td>Discover, Disclosure, Relapse, Suicide attempt, Birth of a child, Realization of harm, Move</td>
</tr>
</tbody>
</table>
|                          | Emotional Response | User: Shame, Empathy, Fear of loss  
Partner: Betrayal, Anger, Disgust, Blaming self, Low self-esteem, Insecure body image |
|                          | Relational Consequences | **Relational Disconnection:** partner’s pain reaction, dissatisfaction with relationship  
Other: Ultimatums, Space/separation, Divorce threat |
|                          | Recovery Motivations | **Parenting motivation/legacy:** Fear of losing kids, fear of addiction affecting kids  
Religious motivation: moral incongruence, marriage covenants/vows  
Other: Fear of relationship loss, Personal growth |
| **Theme 2:** Foundation of Support for Recovery | Specialized Psychotherapy | **Alliance with Specialized Therapist:** caring, empathetic, unconditional positive regard, friendly, validating, knowledgeable/competent teacher (addiction recovery, betrayal trauma, trauma work), safe, engenders hope, externalizes the problem/addiction, collaborative, bold/challenging, gives assignments/homework, available, goodness of fit/chemistry, can relate  
**Specialized group therapy:** vulnerability, connection, psychoeducation, acceptance, people with similar challenges |
|                          | Social Support | **Who:** 12 step groups, group therapy members, life coach, family, friends  
**How:** Empathy/understanding, validation, education, hope, acceptance/non-judgement/safety, availability, connection, comradery/ “I’m not alone” |
<table>
<thead>
<tr>
<th><strong>Theme 3:</strong> The Work of Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partner Support</strong></td>
</tr>
<tr>
<td>Proactively does their own recovery work, learns about betrayal trauma, stays sober, supports spouse’s recovery efforts, honesty/open communication, holds space for betrayal trauma/emotional support</td>
</tr>
<tr>
<td><strong>Spiritual Support</strong></td>
</tr>
<tr>
<td>Higher power: comfort and peace, meaning making, help with forgiveness of partner, source of worth, surrender/trust</td>
</tr>
<tr>
<td>Ecclesiastical leader: hold partner accountable, recommend resources, caring</td>
</tr>
<tr>
<td><strong>Recovery Psychoeducation – Awareness and Understanding</strong></td>
</tr>
<tr>
<td>How: specialized therapist, specialized group therapy, life coach, books, podcasts, online programs</td>
</tr>
<tr>
<td>What: origins/roots of addiction, neuroscience of addiction, emotional intelligence, boundaries, shame, trauma, self-care</td>
</tr>
<tr>
<td><strong>The Structure – Boundaries</strong></td>
</tr>
<tr>
<td>What: check in regularly with others, no internet access for user, user off social media, change phone number, no lying, consequences for a relapse, ultimatums, detachment from partner, 24-hour honest, willingness to leave partner, user sleep in the car/on the couch, recovering user talks to a support person before disclosure of relapse, creating a safe place, having the passwords to the computers</td>
</tr>
<tr>
<td>Why: to feel safe in the relationship, to keep the family safe, room for emotional healing</td>
</tr>
<tr>
<td><strong>The Routine – Self-Care</strong></td>
</tr>
<tr>
<td>Emotional expression/acceptance tools, yoga, mindfulness/meditation, journaling, time away for self, spiritual/religious practices, music, medication, plan so there are less decisions in the moment, day-care for kids (relieve responsibilities/stress), fast food instead of cooking, walks, coloring books/connect the dots, telling people no, spend money on yourself, eat chocolate, special pillow for crying, soothing self-talks, breathing exercises, self-compassion/tenderness (permission to experience emotion)</td>
</tr>
<tr>
<td><strong>Trauma Work</strong></td>
</tr>
<tr>
<td>Continued professional therapy, EMDR, neurofeedback, 12 step work</td>
</tr>
<tr>
<td>Theme 4: Healing Perspectives of Recovery and Meaning Making</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Need support/can’t recovery in isolation, Partner’s recovery is out of your control, My life will be different than others, Surrender control of emotions, This is an emotional process, Surrender relationship outcomes, Self-forgiveness, Recovery takes time, Supporting partner needs their own extensive recovery too, Supporting persons are imperfect too.</td>
</tr>
</tbody>
</table>

| Individual Recovery Before Relationship Recovery | Need internal motivation more than external motivation, Recovery can’t be motivated by fear of losing partner, Separate timing of recovery, Personal problems will carry into next relationship if not addressed now, Seek recovery regardless if partner is or not |

| Recovery Centered Life | Commitment to recovery: financial commitment, sacrifices for recovery, change for rest of life, continued connection and support for other recovering partners, connected life, Recovery is a process over time, not an event: one day at a time, patience in the journey, updating boundaries as life progresses, persistence/not giving up, new life-long lifestyle |

| Confidence in Your Own Recovery | Hope that recovery is possible, Noticing personal healing |

| Externalization of the Problem | User is more than the addiction, Partner is more than their betrayal, naming the addiction, not about my body image, addiction is like a disease |

| Pornography is Not the Problem | Pornography is a coping behavior for underlying issues that fuel the addiction, emotional challenges need to be addressed, Trauma recovery is important Recovery vision (The whys): healing from betrayal trauma, self-awareness, healthy emotional processing, differentiation, build self-esteem, connected lifestyle |

<p>| Crucible Perspective | “Our life is better now because of the struggles we went through”, Spiritual meaning – given this challenge for a reason |</p>
<table>
<thead>
<tr>
<th>Theme 5: Recovery Hinderances and Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapist Hinderances</strong></td>
</tr>
<tr>
<td>Not understanding/acknowledging betrayal trauma in the partner, Only talk therapy, Non-caring therapist, Cant’ healthily facilitate a disclosure, Telling the client that they are too damaged to help, Blaming others for user’s actions (gaslighting), Too much self-disclosure, Using addict label, Teaching co-dependency, Not giving assignments/homework, Too passive of an approach to treatment, Didn’t teach boundaries for recovering partner</td>
</tr>
<tr>
<td><strong>Other Support Cautions</strong></td>
</tr>
<tr>
<td>Partner hatred/resentment, Trying to recovery without support, No accountability, Support group changes too quickly, Support group has no sobriety, Support group doesn’t provide accountability or structure, Sponsor/support person not sober or not holding user accountable, Partner policing recovery, User or partner no self-motivated for recovery, Going to group for wrong reasons, Group members not keeping confidentiality, Labels weaponized against either partner, Recovering user is not proactive with their recovery</td>
</tr>
<tr>
<td><strong>Work of Recovery Cautions</strong></td>
</tr>
<tr>
<td>Emotional incompetence, Trickle-down/unhealthy disclosure, Isolation, Pain (physical and emotional), Dishonesty/keeping it secret from partner, Detachment</td>
</tr>
<tr>
<td><strong>Perspectives of Recovery Cautions</strong></td>
</tr>
<tr>
<td>Doing recovery for someone else, Victim mentality, Negative/pessimistic view of recovery, Low self-esteem, Belief that marriage would fix the problem, Addict label, Can pray away the addiction, Can google away or read away the addiction, Partner trying to act out recovering user’s sexual fantasies to stop the porn use, Partner is co-dependent/enmeshed/enabling or responsible in any way for recovering user’s porn use, Comparing recovery stories with others to measure how “bad” your situation is</td>
</tr>
</tbody>
</table>
### Relationship Recovery from Problematic Pornography Use

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<thead>
<tr>
<th>Major Themes</th>
<th>Subthemes</th>
<th>Specific Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong> Catalysts for Recovery</td>
<td>Turning Points</td>
<td>Discover, Disclosure, Relapse, Suicide attempt, Birth of a child, Realization of harm, Move</td>
</tr>
<tr>
<td>Emotional Response</td>
<td>User: Shame, Empathy, Fear of loss</td>
<td>Partner: Betrayal, Anger, Disgust, Blaming self, Low self-esteem, Insecure body image</td>
</tr>
<tr>
<td>Relational Consequences</td>
<td><strong>Relational Disconnection:</strong> partner’s pain reaction, dissatisfaction with relationship</td>
<td><strong>Other:</strong> Ultimatums, Space/separation, Divorce threat</td>
</tr>
<tr>
<td>Recovery Motivations</td>
<td><strong>Parenting motivation/legacy:</strong> Fear of losing kids, fear of addiction affecting kids</td>
<td><strong>Religious motivation:</strong> moral incongruence, marriage covenants/vows</td>
</tr>
</tbody>
</table>

| **Theme 2:** Foundation of Support for Recovery | Specialized Psychotherapy | Specialized family/couples therapist |
| Social Support | Educational therapy groups for couples |
| Partner Support | Each did their own work of recovery, Both willing to participate in relationship recovery |
| Spiritual Support | Spiritual meaning making of relationship work, Spiritual/religious motivation to stay together, |

<p>| <strong>Theme 3:</strong> The Work of Recovery | Relationship Education | Healthy communication, Time-outs, Holding space |
| Trust Regained | 100% honesty (24-hour honesty from recovering user), Vulnerability and respecting vulnerability, Relationship boundaries and consequences, Communication according to partner’s needs, Both partners doing their own recovery, Full disclosure from recovering user, Check-ins |
|-----------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Increasing Intimacy                                       | Intellectual intimacy, Emotional intimacy, Vulnerability, Check-ins |
| Recommitment/Recreation of the Relationship               | Renewing vows, Dating to start over, Connection, Dates/time together |
| Individual Recovery Before Relationship Recovery          | Individual work results in relationship healing |
| Empathy                                                   | Understanding each partner’s pain/perspective, Emotional expression is an opportunity for understanding, Avoiding defensive reactions |
| Externalizing the Problem                                 | Recovering user is more than their addiction, Recovering partner is more than their betrayal, Emotional work for better relationship connection |
| Crucible Perspective                                     | The relationship can be better because of the struggle, The relationship recovery enhances the depth of personal recovery, Spiritual meaning – given this challenge for a reason |
| Hope for the Relationship                                | We can get through this, Recovery work is worth it for this relationship, |
| Theme 5: Recovery Hinderances and Cautions               | Therapist Hinderances | Not understanding/acknowledging betrayal trauma in the partner, Only talk therapy, Non-caring therapist, Can’t healthily facilitate a disclosure, Telling the client that they are too damaged to help, Blaming others for user’s actions (gaslighting), Too much self-disclosure, Using addict label, Teaching co-dependency, Not giving assignments/homework, Too passive of an approach to treatment, Didn’t teach boundaries for recovering partner |</p>
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<tr>
<th>Other Support Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner hatred/resentment, Trying to recovery without support, No accountability,</td>
</tr>
<tr>
<td>Support group changes too quickly, Support group has no sobriety, Support group</td>
</tr>
<tr>
<td>doesn’t provide accountability or structure, Sponsor/support person not sober or</td>
</tr>
<tr>
<td>not holding user accountable, Partner policing recovery, User or partner no self-</td>
</tr>
<tr>
<td>motivated for recovery, Going to group for wrong reasons, Group members not keeping</td>
</tr>
<tr>
<td>confidentiality, Labels weaponized against either partner, Recovering user is not</td>
</tr>
<tr>
<td>proactive with their recovery</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Work of Recovery Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional incompetence, Trickle-down/unhealthy disclosure, Isolation, Pain (</td>
</tr>
<tr>
<td>physical and emotional), Dishonesty/keeping it secret from partner, Detachment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perspectives of Recovery Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing recovery for someone else, Victim mentality, Negative/pessimistic view of</td>
</tr>
<tr>
<td>recovery, Low self-esteem, Belief that marriage would fix the problem, Addict label,</td>
</tr>
<tr>
<td>Can pray away the addiction, Can google away or read away the addiction, Partner</td>
</tr>
<tr>
<td>trying to act out recovering user’s sexual fantasies to stop the porn use, Partner</td>
</tr>
<tr>
<td>is co-dependent/enmeshed/enabling or responsible in any way for recovering user’s</td>
</tr>
<tr>
<td>porn use, Comparing recovery stories with others to measure how “bad” your situation</td>
</tr>
<tr>
<td>is</td>
</tr>
</tbody>
</table>
Figure E-1. Major themes of couple recovery from problematic pornography use.