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COUPLES SHARING RECOVERY FROM A HUSBAND'S ADDICTION
TO PORNOGRAPHY: A QUALITATIVE STUDY

by

Spencer T. Zitzman

A thesis submitted to the faculty of

Brigham Young University

in partial fulfillment of the requirements for the degree of

Masters of Science

Department of Marriage and Family Therapy

Brigham Young University

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BRIGHAM YOUNG UNIVERSITY

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ABSTRACT

COUPLES SHARING RECOVERY FROM A HUSBAND'S SEXUAL ADDICTION TO PORNOGRAPHY: A QUALITATIVE STUDY

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Department of Marriage and Family Therapy

Masters of Science

This study evaluated the therapy process for married couples recovering from addictive use of pornography. The author's proposal was that in conjoint couple therapy, clinicians are able to help organize the relationship to sponsor recovery while helping both members of the relationship heal individually. The prevalence and effects of pornography are discussed through a review of the current literature. Six couples were interviewed following the termination of their treatment in marital therapy to gain a holistic view of the process of recovery and gain groundwork for future development of a concise model of treatment. Results demonstrated that an increase in understanding of each other's position in the sexual addiction and recovery process (i.e., emotional, cognitive and behavioral) increases a) marital trust and faith in the future, b) softening towards each other, c) the ability to discern key points of intervention in helping the other spouse during recovery, and d) client-perceived marital enhancement. These preliminary

findings suggest that couples perceive that conjoint marital therapy is a useful component in treating addiction to pornography.

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Chapter I

Introduction

During the past decade, sexual compulsivity rates have continued to increase (Wolfe, 2000). Certainly, part of this apparent increase is due to a heightened awareness and reporting of the problem. An increase in means and mediums, such as the Internet, however, has also made sexual materials more available than ever before. One sexually compulsive man, married, father of two, explained what the coming of the internet did for his addiction: it was like “nickel night Scotch for an alcoholic or Las Vegas for a gambling addict” (Turner, 2000, p 33).

The National Council on Sexual Addiction and Compulsivity (Young, 2000) reported that as many as 15 percent of Internet users have accessed online sex chat-rooms or sites with pornographic material. Research has found that up to 9 percent of Internet users spent over 11 hours a week searching for and looking at sexual content (Cooper, 2000). Between 1997 and 1999, there was an increase of 35.3 million users of the Internet (Goodson, McCormick, & Evans, 2001). According to another study, there were 92 million users of the internet (in the U.S. and Canada alone) during 1999 (Goodson, McCormick, & Evans, 2001).

In a report by Lycos.com (Schatz, 2002), the word “sex” was the search term entered most on their site during their weekly study. Furthermore, the word “porn” was listed as the 9th most frequent search term. The terms “adult,” “free porn” and “XXX” were also listed in the top 50. Clearly from a strictly demographic point of view, the pervasiveness and ready access of sexual materials is evident.

In addition to the Internet, various other mediums are used to distribute pornographic content: magazines, phone services, videos, etc. Overall, it is estimated that \$56 billion is spent on pornographic mediums each year worldwide (Forbes, 2000).

One of the destructive effects of sexual addiction occurs within the marriage relationship of the pornography user. Sexual addictions, inflamed by the Internet, “can choke the life out of marriages and partnerships” (Young, 2000). Schneider and Schneider (1996) did a survey of 88 couples that were attending counseling for sexual addictions. The participants were “asked to rank the three most important current problems in their relationship.” They rated “rebuilding trust in my partner,” “lack of intimacy,” and “setting limits or boundaries” as the top three (p. 116). Several other concurrent problems during recovery were analyzed. Some reported a need for years of therapy and personal work to recover from the effects of the addiction.

Various models of treatment are suggested in current literature. Common suggestions include the use of individual therapy, 12-step and psychodynamic groups. Minimal literature reports the use of conjoint therapy, whether in group or marital formats. Swisher (1995) found that individual and group therapies were the most commonly suggested methods of treatment. The results from their survey of 248 professional counselors reported the following: “233 (94%) would use individual therapy; 231 (93%) would use professional group counseling; 162 (65%) couple/marital counseling; 157 (63%) family counseling; 176 (71%) involvement in twelve-step groups” (p. 35).

There is a continuing need for further research on conjoint marital treatment of sexual addiction. The current study focused on the client's perception of treatment of sexual addiction within the context of conjoint marital therapy.

Chapter II

Literature Review

Prevalence of Pornography

Prevalence rates of pornography have risen dramatically in the last few years, mainly due to the introduction of pornography on the internet. A recent study found that approximately 9 percent of the several million users of the Internet spend over 11 hours a week looking for and viewing pornographic material on the Internet (Cooper, 2000). The combined amount of yearly expenses for pornographic material is \$56 billion (Forbes, 2000). The magnitude of this behavior causes an amplified need for research and investigation into the potential effects.

The Effects of Pornography

Carnes (1983) was one of the first to bring the problems of sexual addiction to community awareness. According to Cooper (2000), this is in response to the estimated 7 to 10 percent of the U.S. population that is struggling with some type of sexual addiction. Due to this continual growth of sexual addictions, “tremendous interest has been generated among professionals and in the lay press” (Wolfe, 2000, p. 235). There are those clinicians and others that suggest that compulsive pornography use is potentially destructive (Schneider & Schneider, 1996; Carnes, 1983). An increasing amount of literature is examining the dynamic of sexual compulsivity with pornography, including the possible diagnosis based on its effects on recreational, occupational and social aspects of life.

Defining Pornography, Sexual Addiction and Diagnosis

Pornography. In a legal domain, where we are concerned with the establishment of societal regulations, statutes and criminalization with prosecution of certain, proscribed behaviors, there is the necessity of developing specific, operationally recognizable definitions. Therapy, however, is concerned more with the subjective experience of clients and less with universal definitions. One area where this is especially important is attachment. Attachment is a subjective experience, in that what gives someone a sense of security is subjective to that person (Cassidy & Shaver, 1999). Attachment and security are influenced by personal experiences, attachment experiences, early childhood experiences, relationship history, etc. (Cassidy, 1999). Experiences of attachment vary from individual to individual and couple to couple. Therapists do not impose their views about who should or should not feel secure or about what creates a sense of attachment.

The description of pornography included in this study is subjective and anchored in attachment experience. The basic identifiers for pornography used in this study are 1) sexually oriented materials (pictorial or textual), 2) that do not involve another person in a direct interaction (e.g., pictures, videos, internet chat rooms, etc.), and 3) presents to the spouse a threat to their feelings of safety and security in the relationship and is experienced as a betrayal or danger signal for betrayal.

Sexual addiction and diagnosis. In the clinical community, there is a growing tendency to view sexually compulsive behavior as an addictive dynamic (Goodman, 1993). The first major work providing a clinical discussion of sexual addictions was *Out of the Shadows* by Patrick Carnes, published in 1983 (Swisher, 1995). Since then, professionals have begun to discuss out-of-control sexual behavior as a sexual addiction

(Adams, 1991; Carnes, 1991, 1992; Earle & Crowe, 1989; Kasl, 1989; Schneider, 1988, 1991; Sprenkle, 1987).

While there is still much debate over the use of the term “sexual addiction” and the ability to clearly define a sexual addiction, it is evident that some individuals cannot control their sexual behavior and that such situations interfere with personal health and well-being, as well as marital, family, and occupational relationships (Schneider & Schneider, 1996; Carnes, 1983; Edwards, 1986). Other terms and diagnoses that are used include compulsive behavior, problems with sexual impulsivity, or a variance of OCD or PTSD (Swisher, 1995; Wolfe, 2000). Some concern about the term “sex addiction” relates to apprehension that the use of this term is simply “an opportunity for a new witch hunt for those who deviate from heterosexual monogamy” (Wolfe, 2000, p. 237) and that it is too value-laden, attempting to establish expectations or guidelines for proper, sexual expression (Sprenkle, 1987). Carnes (1986) responds to such claims with the following: “The fact remains that a significant number of people have identified themselves as sexual addicts: people whose sexual behavior has become ‘unstoppable’ despite serious consequences” (p. 4). Carnes’ statement was confirmed by the terminology of the participants of this study.

Currently, there is neither a disorder nor diagnostic criteria found within the DSM-IV-TR for sexual addiction or compulsivity (American Psychiatric Association, 2000). The absence of a diagnosis has lead many clinicians to “not address the real problem of sexual addiction” (Swisher, 1995, p. 32). This lack of diagnostic criteria may be partly due to the disagreement among professionals about what criteria should define a sexual addiction (Swisher, 1995; Barth & Kinder, 1987; Coleman, 1992; Levine &

Troiden, 1988) and may also be due to our unwillingness to pathologize any sexual promiscuity (Sprenkle, 1987). However, given the increased awareness and concern among professionals, some have created basic criteria as a guideline (Tays, Earle, Wells, Murray, & Garrett, 1999; Goodman, 1990). Some of the common criteria include the following: negative consequences due to the sexual behavior combined with continued engagement with sexual behaviors regardless of awareness of these negative consequences; consistent desire and failed attempts to discontinue the behavior; accelerating appetite for sexual experiences; interference with social, occupational, or recreational activities as a result of the sexual behaviors (such as loss of employment, conflict and/or marital separation/divorce, etc.); and restlessness or irritability when unable to engage in sexual behaviors.

These criteria are similar to those found in the DSM-IV-TR (American Psychiatric Association, 2000) for pathological gambling, substance abuse and substance dependence. Goodman (1993) proposes that “the pattern ... meets the diagnostic criteria ... common to all addictive disorders” (p. 227). It is simply the behavior, not the symptoms or “the underlying pathological process,” (p. 227) that differs when considering sexual addictions specifically. Although it is not the purpose of this study to further examine or support this debate, Goodman’s (1993) research article in the *Journal of Sex and Marital Therapy* can be referred to for further information.

In discussing the relationship between compulsive sexual behaviors and addictive dynamics, the purpose is to note that “sexually addictive behavior is often predatory and always destructive” (Tays et al., 1999, p. 285). This assumption will be further developed in the following sections.

The Relationship Effects from a Sexual Addiction

The development of a definition suggests recognition of the effects of sexually addictive behaviors as justifying a pathology perspective. Of most concern to this study are the effects that such behaviors can have on relationships. The hypothesis is that, while the ability to link the origin of sexual addictions to individual and/or systemic events is beyond the scope of this study, the repercussions and implications for treatment are systemically based.

Trust. Table 1 lists the concurrent marital problems listed by recovering couples from Schneider and Schneider's (1996) empirical study. Couples were asked to list the "three most important current problems in their relationship" (p. 116). This study was a survey of 142 "married sex addicts and coaddicts" (p. 111). Participants were married couples who were currently participating in a 12-step group for sexual addicts and coaddicts. These participants listed problematic sexual behaviors such as pornography, masturbation, multiple affairs, soliciting prostitutes, and voyeurism (with "nearly all addicts [listing] compulsive masturbation and pornography among their compulsive behaviors") (p. 114)). Couples were invited to complete a 14-page anonymous survey. The survey included questions "about the respondent's addiction history, family of origin, marriage history, and course of recovery" (p. 113). Surveys were completed individually and returned by mail. A total of 88 couples were included in the final results (although not explained in the original article, a discrepancy between the total number of participants and those included in the table is noted).

The primary concern for couples recovering from a sexual addiction was a need to regain trust. Only 14% of the coaddicts (i.e., spouses/partners of addicts) reported being

able to trust their spouse completely. Additionally, 39% reported trusting their spouse mostly.

Couples that reported being able to build the highest levels of trust are those that perceived a sincere commitment to recovery from the partner with the sexual addiction (Schneider & Schneider, 1996). When this partner was the only member of the relationship to attend therapy, however, it was more likely that the relationship would maintain high levels of problems; most commonly, the non-attending partner was found to have a propensity to persist “with a blaming attitude” (p. 112; see also Laaser, 1996), believing that the addict was the only person who needed to address the effects of the sexual addiction in therapy.

Table 1

Three Most Important Concurrent Marital Problems Reported by Sex Addicts and their Spouses

	Men (n = 65)	Women (n = 74)
Rebuilding trust in my partner	48% (1)	38% (3)
Lack of intimacy	40% (2)	42% (1)
Setting limits and boundaries	38% (3)	39% (2)
Resolving conflicts	31%	19%
Developing our spirituality	31%	20%
Our sexual relationship	32%	28%
Forgiving my partner/being forgiving	29%	22%
Financial problems	17%	20%

(Table from Schneider & Schneider, 1996)

Emotional and cognitive effects. Individuals struggling with a sexual addiction frequently demonstrate high levels of secondary emotions (e.g., anger, contempt, hostility, etc.) speculated to be a “defense against shame” and other, more vulnerable emotions (Adams & Robinson, 2001, p. 27) and potentially harmful in close relationships (Greenberg & Johnson, 1988). This may partially explain why sex addicts commonly experience difficulties with affective and anxiety disorders (Goodman, 1993), as well as

relationship problems. Therapists, therefore, need to help explore these emotions and provide interventions that change any constraining beliefs that may support such destructive emotions.

In addition, the spouse commonly experiences certain effects of emotional attacks, such as self-blaming, shame, hurt, resentment, insecurity, and emotional withdrawal (Laaser, 1996; Milrad, 1999; Schneider & Schneider, 1991). Both partners suffer the effects of struggling with forgiving oneself as well as their partner as a result of any negative interactions surrounding the addiction (Schneider & Schneider, 1996).

Secrecy. Another problem that needs to be addressed is the growing wall of secrecy between partners. Sexual addiction relies upon secrecy and flourishes in such a setting. Generally, it is theorized that the secrecy is motivated by both partners feeling a sense of shame around the topic of the sexual addiction (Schneider, 1989). Commonly the addict's shame is based on a feeling of hopelessness and loss of control. The shame a partner feels can be a result of the meaning s/he places on the sexually addictive behavior. Constraining beliefs such as a self-blaming belief that the addiction is a result of not loving the partner enough, not being attractive enough, or not being supportive enough are common among these spouses.

Another clinically observed motive for secrecy is to ensure privacy of the behavior (Young et al., 2000). The individual may engage in abnormal sleeping patterns in order to be involved in the sexual behaviors. Even during normal hours, the addictive behavior may create pursuit of increased privacy. When confronted about the privacy, the reaction is frequently one of irritation or defensiveness, potentially increasing the distancing and marital tension between spouses.

Communication and patterns of interaction. Other harmful relationship effects resulting from sexual addiction are distortions in communication and patterns of interaction. Even when there is a desire to support and work together, partners commonly have a difficult time communicating and demonstrating their support, empathy, and concerns. As previously mentioned, both partners might struggle with expressing primary emotions. Instead, emotional expressions in conversations commonly include anger as a result of blaming, criticism, and condemning.

It is common for destructive patterns of interaction to develop, such as pursue-withdraw patterns. The spouse is especially prone to develop a suppression-explosion pattern of interaction as a functional response. She may learn that talking about the addiction persistently has the outcome of conflict and turmoil, both personally and in the relationship. Therefore, the decision becomes to restrain any thoughts or feelings as a means of avoiding such outcomes. After a period of time where the thoughts and feelings exceed the ability or motivation to restrain or “dam” them any further, there is an explosion of expression, caustic to the relationship. This outcome further supports the belief that suppression is the best solution, enjoining a destructive, amplifying feedback cycle.

Therapists have recognized this development of constraining couple communication skills in consequence of a nascent sexual addiction (Tray et al. 1999; Schneider & Schneider, 1996). For example, the partners may lack the implementation of facilitative speaking and listening skills (e.g., showing sincerity and concern through communication), regulation of emotional expressions, recognition of timely expression of emotions, and other communication and problem solving skills. Couples in Schneider

and Schneider's (1996) research on the effects of sexual addictions on couples reported a significant need to learn to "fight fairly" (p. 112) during recovery.

In an attempt to facilitate family functioning within the context of the addictive behavior, couples develop maladaptive interactional patterns which evolved as a result of the sexual addiction (Earle, Earle, & Osborn, 1995). The clinical observation is that "from a systems perspective, pathological family interaction can maintain deviant [individual] behavior" (p. 9) such as sexual addiction.

Egotism. Sexual addiction also harms relationships by fostering and encouraging an egotistical and self-centered, or narcissistic, attitude in the offender (Tays et al., 1999; Wolfe, 2000; Young et al., 2000). The very nature of sexual addiction is hedonistic (focusing on fulfillment of personal desires and pleasures) and not altruistic.

Furthermore, self-serving rationalizations are necessary in order to sustain sexual addiction, thus promoting a narcissistic pattern. By working with the couple in therapy, systemic structure and cognitions that encourage this narcissism must be confronted and altered.

Additional consequences of such egotism include shifts in boundaries and roles. As a result of the addict's absence in the marital or family system, the partner, and possibly the children, may have had to learn to assume roles that have been abandoned by the adult (Young et al., 2000). As the addict recovers and re-engages in the family system, there is a potential for discomfort and even resistance to the realignment of boundaries and roles that include the recovered spouse (commonly this being a product of minimal confidence in family members that the re-joining of the family is more than temporary).

Sexuality. As seen in Table 1, 32% of men and 28% of women reported a negative effect on the couple's sexual relationship from sexual addictions (Schneider & Schneider, 1996). This negative influence is partly a result of the spouse's experience of betrayal and mistrust. The previously mentioned topic of shame may also be a factor influencing the diminished connection and trust that lead to problems within the sexual relationship.

Once the relationship effects of a sexual addiction (i.e., trust; emotional and cognitive effects; secrecy; communication and patterns of interaction; egotism; and sexuality) are understood, it is clear how sexual addiction can repress the development of a healthy, marital relationship. Moreover, with the current availability of pornographic materials on the Internet and in other mediums, relapse, and therefore the impending harm, is highly inevitable if left unmanaged. Treatment models that avoid working with the family system and its members during recovery, therefore, have been theorized to be damaging to both the individual and family's recovery work and long term prognosis (Tays et al., 1999).

Current Treatment Theories

Despite the magnitude of sexually addictive behaviors and the increasingly recognized effects of these behaviors in close relationships, there is little research and literature devoted to recovery work for couples (Laaser, 1996; Milrad, 1999). This dearth of research literature is significant and is a critical omission to the degree that sexually addictive behavior may pose an attachment threat or trauma in marriage relationships. A review of the theory and research applicable to building a model for treatment of sexual addiction will be summarized here.

A Summary of Available Theoretical Guidelines

While theory and research do not provide much in the way of concise and coherent models of treatment, a few have addressed some facets important to treatment. Others, while not creating specifics of a model, have recognized guiding principles to be used in the construction of such a model. Some of these may not be specific to sexual addictions to pornography but are relevant and can be adapted to such a model.

In a study of 248 professional counselors, Swisher (1995) found that individual and group therapies were the most commonly suggested methods of treatment for sexual addictions. Their results suggest the following: “233 (94%) would use individual therapy; 231 (93%) would use professional group counseling; 162 (65%) couple/marital counseling; 157 (63%) family counseling; 176 (71%) involvement in twelve-step groups” (p. 35). These results, however, only discussed what methods the counselors “would use” but did not report the frequency that each method *was actively used*. Furthermore, while the study reported that some of the counselors reported they did not frequently treat clients with a sexual addiction, it did not report any specific data with regards to this matter (e.g., what percentage of the clinicians’ case load includes sexual addictions; how comfortable the clinician felt treating sexual addictions). Finally, they noted that the suggestion of family therapy (and more specifically family systems therapy) was significantly influenced by a theoretical orientation of family therapy.

One of the areas recognized by current theoretical models is the need to repair negative and harmful interaction patterns. Through the use of reframing and restructuring of negative interaction styles (Johnson & Lebow, 2000), therapists can help

foster an environment more conducive to recovery of the individual, as well as relationship healing.

Through working to restructure couple interactions, renewal or initial formation of a healthy attachment can be facilitated. By doing so, the therapist can help foster a “softening” event where the offender feels free and motivated to reach out for comfort and reinforcement from his partner and thereby produce a relationship-strengthening experience (Van der Kolk, Perry, & Herman, 1991; Johnson, Hunsley, Greenberg, & Schindler, 1999). Such a context invites increased openness and honesty, which fosters improved trust and hope. Furthermore, it prepares the couple to work together through the recovery process.

Furthermore, enabling facilitating interaction patterns will augment the likelihood that either partner struggling with shame will feel confident in sharing that shame in a compassionate and sympathetic context. Sharing such feelings in this context can be the most effective way of reducing shame (Adams & Robinson, 2001). The secrecy protecting the continuation of the problem is thus absolved.

Additionally, both partners can work through altering the constraining meanings they place around the addictive behaviors with the objective of developing facilitative beliefs that help strengthen the relationship (Wright, Watson, & Bell, 1996). One common example of this process relates to the believed “cause” of the sexual addiction; namely, a wife’s belief that her appearance or ability to love (or lack thereof) is the reason her husband views pornography. Such a belief not only increases the wife’s guilt and diminishes her self-esteem, but it also allows the husband an opportunity to join this belief, blame his wife, and create marital distress and disunity.

When working with sexual addicts, research has also supported the need to process negative emotions to relieve the addict's need to escape such emotions through addictive behaviors (Adams & Robinson, 2001). For example, some theories discuss the need to address shame or childhood trauma. When discussing implications for therapy, they recognize the importance of accomplishing the goals of establishing a relationship of trust and empathy, as well as to learn to create bonds and healthy attachments (Swisher, 1995). These goals are meant to be accomplished through the context of a therapist-client relationship or through other group members, while marital or family therapy is not mentioned.

Related to the concept of restructuring and healing the interaction between the partners is the idea of creating a support system. Several 12-step programs have used the idea of having a sponsor during recovery, someone who lends support outside of therapy. The important role of this person is to be "an empathic ear ... [someone to] struggle together through the long process of recovery" (Salmon, 1995, p. 194). By working with marital partners together, a spouse can learn to be this outside support (Johnson, 2002; Beckermen & Sarracco, 2002). The use of a spouse for this support utilizes the existing understanding and attachment present in the relationship and may increase the possibility of long-term recovery through the support of a stable, committed spouse. Additionally, as the spouse begins to understand the problem in context of recovery (e.g., in context of remorse and sincere desire to recover), she is able to increase her emotional and cognitive understanding of the problem.

Along with group therapy or 12-step support groups, some suggestions have been made for a psychoeducational group format. Stratton & Newbold (1995) propose a ten

week psychoeducational group. As part of their screening process, they require that their participants have been in therapy or a 12-step group prior to participation in their group. Their model did not include spouse participation.

As noted previously, Schneider and Schneider (1996) found in their research that those couples that worked together in counseling and perceived a true commitment to recovery from the partner with the sexual addiction were those that reported being able to build the highest levels of trust.

Coyle and Alzarex (1996) suggest the use of narrative therapy. They include the use of specific techniques, such as sharing “the story of how the addictive or compulsive behaviors have influenced their life” (p. 75-76), externalizing the problem, or finding exceptions. During their discussion of treatment, they include the suggestion to include the family.

One publication was found to talk directly and exclusively about treating sexual addictions within marital therapy (Sprenkle, 1987). The treatment discussed, however, was that of marital sex therapy. The model used “draws heavily on strategic, structural, and family-of-origin approaches” (p. 12). The publication outlines six general steps to be followed in therapy: joining with the clients; defining and specifying the problem; mapping the couple (a genogram-type intervention focusing on Minuchin’s theories with boundaries); reframing the problem; restructuring the system; and termination.

Deficiencies in Current Theory

As noted, what many models and interventions are deficient of is a lack of sensitivity to relationship dynamics. There is a sense that meeting with the couple

together is, at best, merely supportive (such as a sponsor), but not meant to deal with the effects on the relationship or the spouse/family.

An evaluation of the marital effects from sexual addiction, however, identifies the potential harm to secure attachment in the marital relationship and, therefore, the importance of conjoint marital therapy. Secure attachment describes the model of healthy adult intimacy referred to as pair bonding (Hazan & Zeifman, 1999). Dimensions of secure attachment include trust, availability and receptivity (Cassidy, 1999). As has been noted, clinically observed effects of addictive pornography viewing jeopardize some or all of these components of secure attachment, demonstrating the need to view pornography use as an attachment issue which is best treated in conjoint marital therapy (Kobak, 1999).

Earl et al. (1995) theorize that “the absence of intensive family therapy ... only increases the likelihood of relapse” (p. 9). In support of this, Tays et al. (1999) claim that ignoring the relationship dynamics of addictions and treating the individual alone may send the message both to the offending spouse as well as the rest of the family that the others are not significant to the recovery, which may create a context for relapse by failing to successfully engage critical family support.

The few models that have begun to include couple or family counseling have generally not been empirically studied. There are models for treatment of other addictions and compulsions (e.g., gambling, eating disorders, and alcohol). While portions of these models may be applied to sexual addiction cases (as has been noted), the unique impact of sexual addiction on secure, healthy attachment suggests that therapists cannot simply generalize another addiction model to this situation.

Anticipated Themes

By helping the couple work together in therapy, it is expected that both partners will benefit individually and collectively. Both from a review of the literature and from collective experience, a few hypotheses have been formed as to the themes couples might discuss. However, our goal is to be open to any concepts or themes so as to not prematurely exclude potential healing narrative and interaction. Several anticipated relationship healing themes include secrecy, couple unity, support/participation, and hope (for recovery and the relationship).

Absolving the Secrecy and Increasing Couple Unification

It was expected that when an individual is able to share the secrets of the addiction, it would enable a process that would strengthen the relationship. Once the partner struggling with the shame of his addiction can share that shame with the confidence that he is doing so in a compassionate and sympathetic context, there is a greater potential for reducing that shame (Adams & Robinson, 2001). The secrecy enabling the continuation of the problem is absolved. Moreover, both partners can work through altering the constraining meanings they place around the addictive behaviors (i.e., origination, purpose, reasons for continued use, implications about each partner, etc.) with the objective of developing facilitative beliefs that help strengthen the relationship (Wright et al. 1996).

In addition, talking about such sensitive and forbidding issues for a couple presents an opportunity for openness and vulnerability, a change event characteristic of successful couples (Johnson, Hunsley, Greenberg, & Schindler, 1999). Walsh (as cited in Johnson & Lebow, 2000) also reports that the capacity to seek assistance and being

involved in a caring and committed relationship characterized by reciprocal support are correlated with a higher level of resilience. This is further supported by Schneider and Schneider's (1998) results from their empirical study.

As the secrets surrounding the addiction are made explicit, it was expected that the other partner would also have been able to gain a better sense of the level of sincerity for recovery in her partner. This knowledge would allow the partner to make an informed decision about staying in the relationship or seeking separation.

Improved Support and Participation

If the spouse chooses to remain in the relationship, she would also be able to determine the best method of intervention (i.e., whether the key point of intervention is a motivational aspect or a skills/psychodynamics aspect). In either case, the spouse could contribute and participate in meaningful ways. For example, the spouse could help her partner better understand the destructive effects of the addictive behavior in the marriage relationship, upon the spouse as an individual, and within the family system. Or, she could help in the development of skills or the practicing of skills for recovery. This available participation would then fulfill a purpose similar to that of the principle of sponsors.

By working with the marital dyad together, the addict's spouse could learn to be this outside support. As the spouse begins to understand the problem in context of recovery (e.g., in context of remorse and sincere desire to recover), she would be able to increase her emotional and cognitive understanding of the problem. After reaching the development of such an understanding, the therapist could then provide coaching of emotionally-focused enactments to help spouses demonstrate their support and

understanding. Spouses could be guided in expressing their love, desire for change, and hope for the relationship and recovery. Emphasis should be given on resonating to the redeeming virtues, or strengths, that the other person possesses.

The sincere support and love that could subsequently be shown in an empathic and caring marital relationship would then be an additional means to increase the potential for “long term relapse prevention” (Tays, Earle, Wells, Murray, & Garrett, 1999). While the addict increases his potential for recovery through an understanding of himself and of the problem, his spouse could also promote the recovery process through supportive and empathic understanding and encouragement. Hence, not only the addict but also his partner, and thus the relationship which he is in, would begin to stabilize and organize in a manner that sponsors recovery.

Hope for Recovery and the Relationship

This type of understanding and partner participation could also increase hope for recovery and the relationship. As mentioned earlier, empirical study supports that those couples that had the best success rate in rebuilding trust were the ones that had a true sense of commitment to recover (Schneider & Schneider, 1998). When couples work together and have a belief that they are both understood and that they understand their partner, there is greater evidence for commitment to recovery and to their relationship. The resulting hope could then motivate the couple to continue to make changes and apply the interventions provided through therapy.

Summary of the Rationale for this Study

Given the absence of concise and concrete models of treatment for couples to deal with the individual, relationship and systemic effects of sexual addiction, this study

focused on building a foundation for future studies through increased understanding of client-perceived benefits of conjoint marital therapy for sexual addiction. The use of qualitative methods provided basic and tangible principles necessary to form a proper treatment model (the rationale and explanation of which will be given in the methods section).

Summary

As has been noted, the breadth of pornography and the ensuing sexual addictions is vast and on the rise. Furthermore, there are many destructive effects from sexual addiction on the addict, his partner, and their relationship/system. Clinicians and researchers are beginning to become aware of this phenomenon and treat accordingly. However, the topic is still a new area within the field of empirical research. Much of the literature is still limited to the creation of lists of the effects of addictive sexual behaviors.

Empirical research is still very limited in the reviewing and establishing of a clear and coherent model of treatment. There are a small number of models for 12-step programs and group treatment; yet even within this subgroup, few empirical research studies have been completed to support the treatment models. The controversy of the diagnosis and criteria of sexual addiction seems to inhibit the development of such empirical models. Within the area of couple and family therapy, there is even a greater need for work to be done to add to the scarce literature, which is currently based mostly in the area of clinical observation and editorial commentaries.

Therefore, the purpose of this study was to research the use of conjoint marital therapy for sexual addictions in order to explore what is and is not helpful to the individual and relationship healing process. This information was collected from the

self-reported perceived benefits of therapy from clients who have participated in and finished the therapy process. The interviews gave insight into the systemic process of recovery, as well as individual healing for both partners. This information is available for the continuation of further studies, including quantitative studies, focused at the development of a concrete model of treatment.

Chapter III

Methods

Design

The study employed a qualitative design (Newfield, Sells, Smith, Newfield & Newfield, 1996). Methodology consisted of a structured interview, using open-ended questions, of couples in therapy for sexual addiction. The interviews were analyzed by a qualitative, group hermeneutic or interpretive approach, which is outlined in greater detail in the analysis section. The qualitative, group hermeneutic approach is supported as an appropriate and valuable method for analysis of qualitative data (Benner, 1994; Bird, 2001; Chesla, 1995; Gale, Chenail, Watson, Wright, & Bell, 1996; Odman, 1998; Packer & Addison, 1991; Wright et al., 1996).

Leininger (1985) defined ethnographic research as “a systemic means for observing, analyzing, detailing, and describing the lifeways or specific patterns of a culture ... within the environment in which the culture normally lives” (p. 25). This descriptive analysis is a useful tool in helping practitioners “understand a client’s conceptual model” (Newfield et al., 1996, p. 25). Increasing understanding of the client’s perspective in marital and family therapy continues to be a need of the field, which can be seen in the growing trend of ethnographic research (Newfield et al., 1996).

The qualitative method facilitates development of a processual, holistic profile of couple healing from a sexual addiction (Bird, 2001). In this study it was used to generate a holistic view of couple-perceived processes contributing to recovery within couple. A qualitative method is especially well suited to studying a topic which lacks widespread study, allowing deep and extensive inquiry (Rosenblatt & Fisher, 1993). It is useful to

“uncover ... what lies behind any phenomenon about which little is yet known and can give the intricate details of phenomena that are difficult to convey with quantitative methods” (Strauss & Corbin, 1990, p. 19). Qualitative methods are also particularly useful in providing “clinically relevant and applicable data” (Bird, 2001, p. 27) that is an especially useful prelude to focused, quantitative research.

“Holistic and processual qualitative investigations provide clinically relevant and applicable data, are theoretically fruitful, and are potentially useful for guiding future quantitative investigations” (Bird, 2000, p. 27). This method also allows investigation of sexual addictions without disregarding any potential themes or concepts not yet considered. A final benefit to qualitative methods is that the interview process itself has been reported as therapeutic by study participants (Cobb, 2001). Qualitative methods, therefore, are an appropriate design for studying couples’ healing from sexual addictions. Qualitative methods were consequently chosen based on the explained advantages and the limited research regarding the use of marital therapy to help in the healing of sexual addictions.

Participants

Couples were recruited through a marriage family therapist from Brigham Young University who specializes in treating couples recovering from sexual addictions and through student/intern therapists at the Brigham Young University Comprehensive Clinic. Therapists identified couples that were 1) treated for a spouse’s sexual addiction and 2) that the therapists perceived were able to benefit from therapy.

Eleven couples were recruited for participation. Therapists explained the purpose of the study, the nature of their participation, and the voluntary nature of their

participation. Eight couples agreed to participate; of these, two dropped out because of extenuating circumstances.

The age range for the participants was 26-45 years, with 83.3% responding in the 26-35 range and 16.7% in the 36-45 range. Participants were Caucasian (92%) and Asian American (8%). Participants were well educated (“some college,” 50%; “bachelor’s degree,” 42%; “graduate degree,” 8%). Reported income ranges were 10-29,000, 58%; 30-49,000, 25%; and above 70,000, 17%. The mean number of years married was 6.5, with a range from 2 to 17 years and 100% in their first marriage. Five of the six couples had children. All of the couples reported “Christian” as their religious affiliation. All of the couples reported that the husband was the one with the sexual addiction. Six of the participants reported that the sexual addiction was revealed by the husband and 5 reported that it was discovered by the wife (1 missing response from a wife), with one discrepancy between one husband and his wife.

	Age	Years Married	# Sessions
Adam & Amy	26 to 35	3 yr.	12
Craig & Carrie	36 to 45	16 yr. 10 mo.	4
David & Diane	26 to 35	2 yr. 7 mo.	27
Kevin & Kathy	26 to 35	2 yr. 2 mo.	9
Mike & Mary	26 to 35	7 yr. 6 mo.	10
Steve & Sarah	26 to 35	7 yr.	7

Therapists

The six couples were treated by four different therapists. Three therapists were Masters students from Brigham Young University’s Marriage and Family Therapy program and one was a licensed Marriage and Family Therapist from Brigham Young University. All four therapists were married males. Three of the therapists had children (range from 1 to 6). Therapists employed various treatment methods. Two of the

therapists reported using cognitive-behavioral marital therapy, one reported emotionally focused therapy with some components of cognitive-behavioral marital therapy included, and one reported an eclectic approach (including structural, cognitive-behavioral marital therapy, and psychodynamic components).

Procedures

The couples were contacted by their therapist and invited to participate in a study aimed at helping therapists understand how to assist couples recovering from sexual addiction (see Appendix A). When the couple agreed to being contacted by the primary researcher, they were sent a letter (see Appendix A) further detailing the study. The letter also explained the nature of their participation. Confidentiality was assured.

Interviews took approximately one hour. Five of the interviews were conducted by the primary researcher, with no participation by their previous therapist. The final interview was conducted by a different member of the research team (following proper training regarding the process of conducting a structured interview and use of the question-probe format).

Prior to the interview, the couples were provided an explanation and offered their informed consent to participate in the study (see Appendix A). Any questions that the couple had were then answered. The couple was also asked to fill out a brief demographic questionnaire prior to the interview (see Appendix B).

Spouses were interviewed together, resulting in one interview from each couple. Conjoint interviews were intended to increase internal validity, reducing the risk of therapist leading during the interview. Conjoint interviewing facilitates each spouse's comments eliciting their partner's comments, thus reducing the need for therapist

questioning and probing, which could be leading and create a demand effect. The quantity of interview data is also increased.

All interviews were tape recorded and transcribed. All identifying information was removed. In order help the analysis team keep track of the couples, pseudonyms were assigned for each transcription, using the same first letter for spouses: Adam and Amy; Craig and Carrie; David and Diane; Kevin and Kathy; Mike and Mary; and Steve and Sarah.

Measures

The structured interview questions (see Appendix C) were chosen based on the ability to elicit comments regarding the couple's perceived benefits of conjoint marital therapy for sexual addiction. The structured interview was formulated prior to the interviews by the primary researcher. Questions were open-ended and focused on the process of emotional healing, rebuilding trust, overcoming the addictive behavior, and any other aspects of the therapeutic process that the couples perceived as important. The interview was also reviewed by the couple's referring therapist to determine appropriateness and efficacy, and help increase internal validity. The same interview guide was used for all couples.

Interviews followed a question-probe pattern. For example, the initial question would be, "Were there other ways that the therapist helped or hindered you in taking the steps required for healing your marriage?" If the participants did not have a specific answer, further probing would be, "In other words, what additional things, if any, did the therapist do or say that helped change occur?"

Data Analysis

Questions were framed to be open-ended and non-leading. Further work was done to provide internal reliability, specifically, reducing demand effects, by reassuring the participants that their answers would not be used in any way against their therapist. They were asked to provide sincere and direct answers, so as to give the most helpful and accurate information. These instructions were also given in an effort to reduce social desirability while seeking to obtain the couples' self-reported perceived benefits from therapy.

Following transcription of the interviews, the tapes were destroyed. The tapes, transcripts, and any other materials were marked by identification number only. All materials were kept in a locked file cabinet that can only be accessed by the principal researchers. A list of participants and their identification numbers were kept in a separate locked file cabinet, which could only be accessed by the principal researchers.

The interviews were coded following a qualitative hermeneutic/interpretive approach (Newfield et al., 1996). A team of three analysts examined the interviews. Two of the analysts were male and two were married. Two were graduate Marriage and Family Therapist students and one was an undergraduate Family Science major.

The use of a team of analysts in the hermeneutic process is “for the purpose of triangulation, helping assure stable, reliable results consistent with the data through” a consensus-building analytic process (Butler et al., 1998, p. 457). By using a team, development of themes required negotiation and achieving consensus of at least two analysts, promoting internal validity and reliability of the results. Significant opposition of any analyst to a specific theme would have lead to a reevaluation or discarding of that

theme. Therefore, inclusion of a theme required at least the advocacy of two analysts with the consent of the third. Some were unanimous.

The four phases of the analysis are described below. The process of these phases was adapted from Gale, Chenail, Watson, Wright, and Bell (1996) and Wright, Watson, and Bell (1996).

Phase 1. The analysts were given a copy of the transcribed interview. Each read the interviews once to gain a general perspective. They next read the interviews a second time, noting and highlighting key themes. They were instructed to identify themes consistent between multiple couples and relating to the therapeutic process for treating pornography addictions in conjoint marital therapy. Each analyst coded the interviews and footnoted references from the interviews to support observed themes. Finally, they wrote a summary of observed themes.

Phase 2. The team met to discuss the themes each analyst found. In random order each analyst shared a theme and its supporting data. Themes with multiple references from multiple interviews were given more weight. Through a interpersonal process of feedback and collaboration, the team reached consensus concerning key themes. As noted above, in order for a theme to be considered a key theme, advocacy from at least two members and a consensus from the third was reached.

Phase 3. Again working separately, each analyst reviewed the transcripts. They searched for data supportive of the themes. They were open to dismissing a theme if adequate support was not found. Once again, analysts wrote summaries that included supporting data, which also further clarified and elaborated the themes.

Phase 4. The analysts met again to review and discuss the information from each individual review and for the elaboration of the key themes. The goal was to determine a final consensus regarding the themes, how the various themes might fit together into a coherent framework, and the data from the interviews that supported the themes. In order to accomplish this goal, team members were given the opportunity to comment on the appropriateness of each theme, resulting in the removal of those themes that are determined insubstantial or lacking clear support from the data.

Chapter IV

Results

Primary Themes Included in the Process of Recovery

Results describe the clients' perception of the therapy process for married couples recovering from addictive use of pornography. Results confirm that clinicians are able to help organize the relationship to sponsor recovery while helping both members of the relationship heal individually through conjoint marital therapy.

The individual findings of the members of the analytic team proved to be highly consistent. Thus, phase two of the analytic process primarily involved collaboration and negotiation in the development of a coherent organization of themes and an elaboration of sub-themes.

Five major themes arose from the analysts interface with the data. The major themes (and sub-themes) included the following: 1) trust (a second witness, honest and open conversations, supportive wife's reactions, overt signs of effort and progress, an invitation to participate, and letting go of control – no more policing); 2) softening (education and understanding, wife separating self from problem, in-session communication, and end in sight); 3) overcoming the addiction (mutual support, watchtower work, disclosing the secret, shifting from "I'll do it myself" thinking, growth perspective of recovery, refocusing on life goals, and specific interventions); 4) recovering from the marital damage (distancing between spouses, and sex life); and 5) overall marital enhancement (honest and effective communication, and increased unity). Included are both descriptives of these issues as well as the therapeutic processes that

benefited the couples' healing process, whether these processes occurred inside or outside of the therapy session.

Major Themes	Sub-themes
Trust	A second witness Honest and open conversations Supportive wife's reactions Overt signs of effort and progress An invitation to participate Letting go of control
Softening	Education and understanding Wife separating self from problem In-session communication End in sight
Overcoming the Addiction	Mutual support Watchtower work Disclosing the secret Shifting from "I'll do it myself" thinking Growth perspective of recovery Refocusing on life goals Specific interventions
Recovering from the marital damage	Distancing between spouses Sex life
Overall marital enhancement	Honest and effective communication Increased unity

Trust

All couples reported a need to work on trust in their relationship as a result of the pornography problem. Adam and Amy both reported that rebuilding trust was the main challenge that each had to work on. Adam stated:

I knew that I had pretty much lost her trust and that caused a lot of issues. It was not very happy there for a while. That was just a major issue for her being able to trust that what I was saying was the truth."

Amy agreed with Adam and added that "trust affected our whole relationship: physical, emotionally, everything."

A second witness. An element of trust that four of the couples reported was what some termed a “second witness.” This “second witness” was from an outside, non-biased, professional source (either publications or their therapist). Couples explained that this “second witness” confirmed ideas that the husband had previously tried to convey, but were difficult for the wife to accept.

Carrie explained that the therapist becomes a “third party, a neutral party, that we trusted and could quote and would say, ‘well now remember what [the therapist] said.’” David talked about the type of information that was important for Diane to hear from this second witness was “stuff that helped her understand this side ... something that is hard to explain that, coming from the addicted person, is probably hard to hear.

David also described why he felt it was important for this second witness: “the addicted person is going to say anything that he can to hold on. It is a conflict of interest, basically.” This conflict of interest made the addicted spouse’s words along suspect. Steve also described a similar concern. He stated that his explanations resulted in Sarah thinking, “He is just setting me up.” He added, “I think the whole validation this is ... having somebody else say, ‘This is how it is going to be.’” This confirmation from an outside, professional source authenticated that “it is not me trying to cover it up or set something up for the future, manipulate the situation.”

Kathy explained a similar idea from the wife’s perspective:

I think, as women, they don’t understand what is happening or why there is an addiction there. So, it was nice to be able to meet with a therapist, outside of just Kevin telling me what was happening. And someone on a professional level saying, “This is what goes on and this is how it works and this is why.”

She also added that reading articles (written by professionals in community magazines) helped give an additional witness. She stated that multiple confirmations of the same concepts (such as pornography use not being the wife's fault) helped her trust what Kevin had been trying to tell her.

Sarah also mentioned that this second witness given to the wife about the husband's situation was not only trust building for the wife, but validating for the husband: "He felt validated, too, to have someone talk to me about what he is going through and about addiction."

Honest and open conversations. Another key step for rebuilding trust mentioned by five of the couples was a willingness "to talk about [addiction] openly and honestly." As with David and Diane, however, "it took a long time to be absolutely, completely open about absolutely everything." For them such honesty and openness was not reached until "near the end [of therapy]" but that was the main obstacle between them and recovery. David's conviction about the importance of honesty and openness is related in the following statement: "Nothing will happen. I guarantee that nothing will happen until it is open. You cannot solve it unless there are no more secrets or lies."

Amy also talked about the importance of honesty in the following statement: "He had kept it hidden for so long and had lied about things." She explained, "I had asked him just point blank about how things were going and he would mislead me." She added that she began to regain trust when they were able to everything out in the open.

Diane also felt that "when it [was] hidden, that is when a lot of the trust issues were bad." Additionally, she recognized that "it is hard, though, because there is a big ... it is scary for him to have to tell me things. It is hard to have to hear those things."

Adam also mentioned that his wife's trust seemed to be correlated with his willingness to be open and honest:

I think that the major thing was being able to talk to Amy and be able to tell her what I was feeling and thinking, not hiding everything. The hiding part was a huge factor in my guilt and caused more relapses than the addiction itself. The hiding it all the time made it really difficult to get through things. I could tell there was a significant difference when I was being honest and straightforward, even if I had relapsed, if I was straightforward and discussed it and how it affected each of us, I could tell a difference in how we related to each other and especially her trust in me.

The husband's honesty and openness incorporated not only relapses, but also challenging moments. Sarah stated, "He started telling me when he was feeling the temptation. That built up a lot more trust. I didn't feel like I just had to worry about it and I wasn't going to find out until after the fact."

In addition to being open and honest with one's spouse, Steve also explained that being open and honest with the therapist, in his wife's presence, increased her trust of him. He explained this trend as follows: "It is different when you are talking to someone else because then they are telling someone else the same thing that they are telling you."

Diane mentioned that becoming open and honest was "a process." David explained, "It takes a while to get to that point. You've tried everything and nothing works. It is not something you just say, 'We'd like to try that. Just drop all our walls.' It doesn't happen that way." David added, "If you could just stop saying, 'You don't understand' and start talking about helping the person understand." He explained that,

for him, this change was linked with “a *real* effort to get rid of it instead of, ‘How long can I keep that person away from talking about it. How long can I keep the addiction without really giving it up?’”

Along with protecting the pornography use, another thing that can keep a husband from being open and honest is protection of a spouse. This seemed particularly true when the spouse already knew about the pornography use and the couples was already working on recovery. David said:

For a person who cares about their spouse, that is hard to do, too. For the person talking, not only is it embarrassing, personally, but you don’t want to hurt the other person. And the problem is that sometimes you get away with it and it is successful.”

When discussing honesty, there was a distinction that the couples made. One level of honesty mentioned incorporated honestly answering questions, particularly about relapse. For example, Mary said, “If I confronted him with it, he was honest about telling me that it was happening He answers those questions. He just doesn’t readily give info.” None the less, she felt that Mike’s honest responses about relapse increased her trust: “So that helps because I know that he has always been honest in that respect, that he tells me if I ask him.”

Diane mentioned that David’s honesty at this level also incorporated a lot of effort from her part.

David has always been willing to answer my questions and that is huge. It is an embarrassing and a hard thing to talk about and, for me, I was pushing for him to be able to tell me straight up when it was a hard day. That was really hard for

him. But if I could ask him the questions and push enough, he would talk about it.

Although David was not dishonest, per say, about events at the beginning of the process, he simply was not willing to talk about certain topics.

In addition to the husband's preparation, David mentioned this about the wife's preparation: "The other person has to be ready to hear a lot of ugly details It hurts. It is painful and embarrassing."

Diane also reported that complete honesty could be beneficial: "That [complete honesty] helped a lot and I think that was one of the strengths that helped us throughout the whole process." Diane further explained the importance of open and honest communication: "When we finally started communicating about [the addiction], there was a lot more trust."

This statement highlights what distinguishes the most beneficial level of honesty that some couples reached: volunteering information freely. Some husbands were honest regardless of the questions or pressure asserted on them by their wives. Sarah further explained this level of honest:

In a truly honest relationship Steve would come to me when he was feeling tempted instead of ... anything else is protecting the addiction. I think that made a big difference for Steve, too, because all of a sudden he realized that he wasn't being quite as honest as he thought he was. So, he started practicing that. He started telling me when he was feeling the temptation. That built up a lot more trust. I didn't feel like I just had to worry about it and I wasn't going to find out until after the fact.

Supportive wife's reactions. In addition to being open and honest, two couples noted that a positive and supportive response from the wife increased trust. Kevin talked about this in the following statement:

This kind of thing you always worry about, obviously, when you tell your spouse that they are not going to trust you anymore. So that is always difficult. But at the same time, having her know about it and her reaction to me was trust building. She tried really hard not to be angry or accusatory or anything like that. It made it easier for me to start the process of getting over it.

Kathy added her perspective on this matter:

For me personally the biggest challenge was just trying to put it all together, to look at it from a different perspective and to deal with it that way. When he did have a relapse, to deal with that. It is hard because ... well, it is. Probably the biggest challenge was knowing how to react. Like I said, you want to be angry, but all I could do was to tell him I love him. Not to say that it is okay, because it is not okay and it is not acceptable. But, showing my love to him and making sure that he understands that I love him no matter what.

For Kathy, this “different perspective” meant trying to “put yourself in their situation”, as well as “looking at the good instead of the bad.”

David also talked about having a supportive response from his wife: “When they can say, ‘I am glad you told me that. Thank you. I am sorry that happened. How can we fix the solution?’” His perception was that “if one of them is not supportive, it doesn’t work.”

Overt signs of effort and progress. Another common theme that resulted in increased trust noted by four of the couples was wives seeing their husband's efforts and progress. The particular actions that each wife denoted as a sign of effort and progress varied. The most common and expected sign of progress was noted by Kathy: "By him going to therapy and then reducing the frequency of the relapses, that has helped build trust." Mike also said, "As she sees that I am progressing – I am not having any problems, I am staying off the computer at certain times and I am working towards those things – I think she continually gives a little bit [of trust]." Others mentioned reparations directly related to the negative effects of pornography use. For example, Mary noted that Mike "having a steady job" was a sign of effort and progress that strengthened her trust in him.

Another part of trust-building was consistency in recovery. Mary said, "I am a person that just needed some time to kind of see that things were going to be worked through." Mike added, "I think it was a matter of time and seeing me progress and recover that helped her to forgive and let go of it."

In talking about a need for effort and progress, David described the challenges that a husband might feel during recovery, giving insight into what might make consistent effort so meaningful to wives:

That day, that hour, that session they might honestly want to give it up and they might feel that way, honestly But ... you'll wake up the next morning and it is not the same desire That kind of commitment is not going to get it done.

Mary also added insight into how joint marital therapy coordinates with recognizing progress:

I never would have known that [his progress and how he felt about addiction] if I hadn't gone [to therapy with Mike]. I think that helped us out ... as a couple because it helped me kind of see that part that I never would have seen.

An invitation to participate. Two wives commented that simply being invited to participate in therapy helped build trust. As Kathy stated, "Even that he trusted me to know about it and to help him and go with him to therapy sessions has helped build the trust a little bit." Later she added, as advice to other wives, "Appreciate that they are trusting you to know this. A huge step in recovering is you knowing and them wanting to go to therapy and wanting to overcome it and having you be a part of that."

Sarah mentioned why being invited to participate, along with the interventions of their therapist, built trust. She explained how being a part of the recovery process was validating and added the following:

Once I felt validated in my feelings, I felt like it was easier for me to rebuild the trust. For [the therapist] to say to Steve, "Do you understand why she has trust issues? Do you understand that you need to work on that?"

Letting go of control – No more policing. The final theme included in rebuilding trust dealt with the wife letting go of control when it came to her husband's recovery (mentioned by two of the wives). Kathy said, "When he first told me about it I wanted to be able to police him in every situation. But that is not possible."

Diane also explained a similar dynamic in their marriage: "When I was playing the cop ... the trust was being ... underplayed because I didn't trust him enough to ask him about it and he didn't trust me enough to tell me about it."

Softening.

Another common issue that all six couples dealt with was a process of softening in order to become more united and mutually supportive in the recovery process. Whether the process occurred previous to or during therapy, all couples admitted a need to work through the initial feelings of anger, bitterness, etc. Most commonly these harder emotions were a part of the wife's experience; some husbands, however, also admitted to a similar process of softening emotions. With regards to this process, a number of sub-themes were evident.

Education and understanding. The most prevalent theme related to softening (mentioned in four of the interviews) was that of gaining an education and understanding about pornography use and its addictive dynamics which their husband was struggling to overcome. One of the couples where this was most evident was with Adam and Amy. When describing her attitude towards recovery and her husband's pornography use, Amy said, "I was more like, 'Just stop, who cares.' I did not see the need to get professional help. I just figured he could do it on his own, not knowing that it was actually an addiction." Initially, Amy refused to come to therapy, but after Adam's initial session (alone) he was able to successfully invite her to attend the subsequent sessions. Following her initial experiences with therapy, Amy had this to say:

I remember one of the sessions that we had that was educational, just getting really interested It was really interesting to me how it was really turning a light on for me [about] what's going on, and that was kind of like realizing that "wow that's really cool" and starting to see how things are playing out within our marriage, and kind of going, "I would like to come back to find out more" It made me more compassionate, because I understood what he was going through

.... You don't just stop and just don't do it anymore. It made me compassionate
.... It did bring ... compassion that, "Yeah, he does need this fixed time to be
supportive."

Carrie experienced a similar shift as a result education and understanding during
the therapy sessions:

I was more like, 'just stop, who cares.' I did not see the need to get professional
help; I just figured he could do it on his own, not knowing that it was actually an
addiction I think [the therapist] did a good job at pointing out the need to have
both of us involved and that there really was a reason that this was happening, it
wasn't just him being a dork. There was a mental addiction that had happened
that there was, I guess, a physical reaction to this. And so we could see the need
... had more compassion, which made you want to work together It made me
more compassionate, because I understood what he was going through more than,
and not just you don't just stop and just don't do it anymore. It made me
compassionate.

Continuing to talk about this process, Carrie added this comment in reference to the
specific concepts of education that benefited her: "It did also then open my eyes to say
'Oh yeah, well this then is a result from that.' All these other things that I had no idea
that were related."

Mary's experience was also very similar. She, too, did not want to be involved in
the therapy process; however, after Mike talked with the therapist to set up the first
session and received encouragement to invite Mary to the therapy sessions, Mary decided
to participate. She recounted the following experience:

For me I think it was good that I was there, even if I didn't want to be because I did understand a lot more about where he was coming from and a lot more about the fact that it is an addiction. I did see that because he has had this problem from years and years, way before he ever met me. So it helped me see it more like that, like more of a disease almost in a way He is not a bad person.

Mary also talked about the specific ideas that, through understanding, influenced the process of softening for her:

I realized how in depth it was. I didn't realize how much he had seen, how much he knew, and all that kind of stuff and how deeply involved he was. I don't know. How early it had all started. I didn't know how it started and I learned that all.

David and Diane talked about a comparable experience. Included in their experience, David also mentioned his need to go through a process of softening. David stated, "We had gotten married and she found out like a month, two months later. I mean, it was right after. It did start with resentment, both of us. She was angry. I was resentful." Diane agreed that there was "a lot of hurt and a lot of understanding." David continued, "She started understanding it because I tried to explain it better and stop being so defensive." Diane added, "There was an understanding. Not that the emotions of the anger and the resentment ... it didn't go away, it just ... I think we understood each other a little bit better." David further summarized the experience in the following statements:

Once we started understanding and talking about it, it has gotten easier. It hasn't been very easy to talk about. We even talked about it last night. It is still ... it is not the best thing to talk about. It is not what you talk about every day She has also done a lot to understand. She has understood it. She's become a lot

more understanding and less angry ... She has understood some of the concepts that are really important to understand; and when that happens I get less defensive because she is less angry. It has been a process.

As noted previously, David mentioned that he also had to go through a process of softening. When asked about this process, he said:

Yeah, the person with the addiction will also do the same thing. It is a defense. I said, “Look, you don’t understand.” And I found myself saying that – “You don’t understand the problem. You don’t understand what I go through every day. You don’t understand what it is like having an addiction.” Although it is true, she could turn back and say the same thing – “Look, you don’t understand how it is being the wife of the person with the addiction. You don’t understand.” If you could just stop saying “you don’t understand” and start talking about helping the person understand.

Wife separating self from problem. One of the other primary results of education that benefited the softening process, noted by four of the couples, was that of the wife separating herself from the problem or externalizing rather than personalizing it, as related both to her husband and herself. As Carrie mentioned, this step begins by “realizing there is a problem here; it’s serious, you need to not feel sorry for yourself and feel picked on and fix it. So pretty much just realizing he had an addiction and that it was a real issue.” After recognizing that the problem was serious and, as many referred to it, an addictive problem, Amy signaled the next step: “Realizing that I can’t do it for him, and just letting go of the sadness, the feelings, and the hurt.”

Diane explained, “Taking myself or my feelings out of it ... was my personal, hardest challenge.” She continued to explain this process in greater detail:

That one is probably the hardest one, and there are still moments when you kind of question and when you kind of look in the mirror and don't like what you see because you're comparing to other things. But, him repeatedly saying that it is not you; understanding that the problem started a long time ago; understanding that it is not 'being chosen over', that you are not being replaced ... I guess reading some things has helped me and just as David has become more open about things, I have been able to understand that it takes a lot to take my emotions out of it. But when I was able to do that, it helped tons. It is one of the hardest things to do – to *put yourself outside of it*. But when you realize this isn't about you, it is about him and how to help him, it is completely different. Not that my feelings don't count, but it is a whole different thing to talk about. When we are talking about [addiction, it] is over there. That helped a lot ... But *you have to take yourself out of it*. When I finally stopped thinking, “Me, me, me” and how I am being hurt and how I am ... that helped tons.

Kathy also had a similar challenge of separating herself from the problem. She explained:

That really helped for me to ... finally come to terms that it is not my fault. It is a problem that he has and I can help him deal with it rather than kind of putting the shame on myself instead of letting us deal with it together.

Talking further on her motivation for softening, she said, “But I don't want to be angry at him because I just don't want that to enter into the relationship. This is hard as it is

without me being mad at him.” With regards to how she separated herself from the problem, she added the following:

For me personally the biggest challenge was just trying to put it all together, to look at it from a different perspective and to deal with it that way. When he did have a relapse, to deal with that. It is hard because ... well, it is. Probably the biggest challenge was knowing how to react. Like I said, you want to be angry, but all I could do was to tell him I love him. Not to say that it is okay, because it is not okay and it is not acceptable. But, showing my love to him and making sure that he understands that I love him no matter what.

In-session communication. One of the key interventions that three of the couples referred to when talking about their softening process was that of in-session communication. Referring to softening experiences, Adam explained:

One of the things that I remember the most is that in sessions, [the therapist] would always have us do role play [enactments], actually talking to each other, and giving us a little bit of instruction and letting us do our thing, letting us talk and be able to try and figure out between *us* what we can do to be happier and work through things.

Amy added, “Those times talking to each other helped get everything out.”

Kevin also talked about enactments in therapy sessions. He mentioned why, for him, these moments were so helpful when he said, “One of the biggest things for me was actually telling her, that way the secret was out and the support can come.” For Diane, one of the other things that made these moments of communication so effective was that they offered a chance “to validate each other’s feelings.”

Sarah also talked about softening resulting from feeling validation through the in-session conversations because of both the things that Steve would say and the comments and questions directed from the therapist. She explained that the process of validation was equally important for her and for Steve:

He would turn to me and say, “It doesn’t have anything to do with you,” and then he would turn to Steve and say, “But do you see why she feels like it does? Do you understand that it doesn’t have anything to do with her now, but it will affect your relationship with her and it will become about her.” So it validated both of us at the same time and helped us understand the other person and where they were coming from.

Kevin also described the following personal effects: “Some feelings came out there and I think that maybe that helped me a little better to view what it was [the nature of the pornography].” He added the following effect that these moments had on Kathy: “It gave her some insight into what I was thinking about. So, it was kind of interesting, the role-playing thing.”

End in sight. The final factor that three of the couples reported as a factor in the process of softening was recognizing that there was an end to addiction in sight, or at least that it was possible and foreseeable. Carrie commented, “I think he’s probably more relieved that there’s an end in sight. Don’t you think? When you read some things about why it was still an addiction. It was like, there is an end.” Similar to Craig’s experience, Kathy mentioned, “It also helped me think that it can be overcome because people have done it before.”

For Mary, the sign that there was an end in sight was when she noted Mike's progress: "He got job and we started working through those things. That kind of thing is what I think helped with the anger more than anything else."

For Craig, therapy was the first time where hope was offered through a perspective that his challenges could be overcome. Speaking of an experience (prior to therapy) with an ecclesiastical leader, he said, "The [church leader] said, 'Maybe this is the cross you have to bear,' and I was thinking maybe there's just no way. This is just the way I'm going to be." Throughout therapy, Craig was able to gain hope that he could overcome his challenges and make his desired changes. Such hope of an end to the process helped both wives and husbands soften toward each other and approach recovery in a spirit of mutual collaboration against a temporary condition they saw as external to their "true"/best selves.

Overcoming the Addictive Behavior.

The third major theme that was common between the couples was the need to overcome the addictive behavior of pornography use. For the couples interviewed, overcoming the addiction meant having a goal of completely discontinuing any use of pornographic materials. Common to all of the couples, this was the presenting problem which brought them to therapy.

Mutual support. The first sub-theme that was present among the couples was that of mutual support, or as some couples referred to it, a team effort or being on the same page. Subsequent to externalizing the problem came a dynamic unity and team effort in overcoming it. Very significantly, every couple reported this same dynamic as beneficial to breaking their addictive cycle.

With regards to this concept, Amy stated, “It’s also helpful because we were in the same room, same session. It wasn’t that we were in separate rooms, having the same discussion. Having done it together, we had the same experience.” Adam added, “Being there together, she could understand me and the feelings I was going through as we talked about stuff and [it was] the same for her.”

Two of the husbands whose wives expressed a lack of desire to come into therapy also discussed what it meant for them to have their wives participate. Craig said, “She did express willingness to come the second time and at that point I was just looking for any help I could get.” Mike commented the following:

For me it was nice to have Mary there, because I could see that maybe she wasn’t happy to be there, but she was making an effort to say, “Okay, I do support you, I do love you and I do want our marriage to work. I am not happy having to be here because it is your problem.” That helped ... me to see that she [was] willing to be there. Not to come in half-way down the road and say, ‘okay, here I am to show you that I support you.’ She was there right at the beginning. That meant a lot to me and that helped.

As stated, Mary openly did not want to participate in the therapy process. Regardless, Mike reported that her participation and support were beneficial. Further expanding on this concept, he said:

I wanted her to be there and ... because she was angry and upset and sick and frustrated and stressed ... she would ... [throw] up massive barricades and sometimes ... she didn’t want to be there. I know that and understand that, but it meant a lot to me to have her there.

From Mary's perspective, she added:

Just being there, even though there were sometimes things that I really didn't want to hear, I think it was good for me to hear because I understood a little more where he was coming from and where it started.

In response to what helped Craig overcome the addiction, Craig and Carrie also talked about how shared homework also engendered couple-based cooperation and collaboration. Craig explained:

I think him giving an assignment to do outside of therapy that we both needed to do and talk about and bring back in gave you something to do in your own time so you just weren't both coming in separately It was something that we were actually doing as a couple.

Kevin also mentioned that "having [Kathy] come was an additional support." He continued, "I can sort of rely on her to strengthen me to a certain degree There is mutual support, so they can be there for you emotionally."

David and Diane experienced similar benefits of "mutual support." Diane said, "I think a lot of this was very dependent on us approaching it as a team. He went through some severe temptation as he progressed. Had he been alone through that ... I don't know." David also stated:

It is useless unless you know the other person is on the same page. You go home and you could have an entire world of information open up here and your spouse knows nothing. Especially if I am the one receiving the information and she is not. I go home and I can tell her the same exact things. I can tell her what I learned and it is not going to be as effective as if we heard it together. We are on

the same page. We go home and that is the natural environment We can talk about the dialogues We are on the same page. It is not like I go home and try to explain it.

When talking with Steve and Sarah about what made going to therapy as a couple (team) so beneficial, Steve added accountability to the list:

There was accountability when you were going together. If you are just going by yourself, the other person doesn't ... know what tips or suggestions you have been given. You can just cheat your way at everything. Not that I did, but there is always that thought, "I don't need to really work on this," versus, "she was there and she knows what was going on." We both heard the same thing and she knows what to expect.

Watchtower work. Another key concept discussed by four of the couples was what Craig described as "watchtower work." He explained this as "having someone else that can help you identify signs [of relapse]", or what he learned in therapy to call "first steps." He said that it was helpful to have Carrie "trying to block those first steps" and "help me to see that [the first steps] are leading me down a path I don't want to be on." When Carrie talked about specific times when she has cautioned Craig about movies that could be "first steps," Craig explained how such "watchtower work" had been very helpful:

I still struggle with it. What really are first steps and what really aren't? What's appropriate for me? It became clear that things that are appropriate for other people or things that other people can deal with without any difficulty are things that could trigger me or cause problems for me.

Carrie mentioned that Craig “has still been very open to letting me” caution him about triggers or first steps that she notices, which is an important prerequisite to “watchtower work.” When talking about a similar dynamic in their marriage, Kevin explained what he does in order to invite Kathy to help out and to let her know that he is open to her help. He said, “[The therapist] talked about having me tell her how I am feeling right now – ‘I’m stressed and I need to deal with it in a healthy way’ Then we could deal with it together.” He then explained that Kathy helps him do something enjoyable and “avoid getting into situations where you might [relapse].”

Adam also commented that being in therapy together made it so that they “were able to remind each other of stuff, especially her reminding me of stuff.” Amy also added that “we could say, ‘remember we learned this ... we talked about that.’”

Disclosing the secret. Four of the couples also mentioned that disclosing both the initial secret and current temptations and challenges was helpful in overcoming the addiction. David’s experience is that “you cannot solve it unless there are no more secrets or lies.” He reported that getting to that point in his relationship, through therapy, was possibly the most important step towards recovery.

Kevin also mentioned that “letting the secret out” by telling Kathy kept it from being a “secretive problem” made it “easier to deal with.” This process took place both in therapy and at home. In their therapy sessions they participated in “role-playing” where they talked about their feelings about pornography and how Kevin felt during and after relapse. Kevin stated that these conversations helped change his view of “the nature of pornography.” He mentioned that having those conversations in therapy helped them talk about topics that they were having difficulty talking about at home.

Kathy mentioned that eventually Kevin would tell her every time that he had a relapse. They both reported that having to admit to a relapse, and the resulting guilt, “made it harder to relapse.” Kevin also explained that talking about pornography and relapses allowed him to “rely on her to strengthen me to a certain degree.”

Adam also discussed the benefit of disclosing to Amy “what I was feeling and thinking” instead of “hiding everything.” He explained, “The hiding part was a huge factor in my guilt and caused more relapses than the addiction itself. Hiding it all the time made it really difficult to get through things.” He later added this explanation:

I hated my addiction so much that I even tried to hide it from myself. I hated to think about it. As soon as it happened, as soon as I relapsed, I tried to convince myself that it didn’t exist and it all just backfired. I couldn’t be honest with Amy and I couldn’t be honest with myself. Just getting over that guilt and begin able to open up about it and being able to talk to Amy about it was definitely one of the ... biggest hurdles that I had to get over.

Adam also attributed his ability to talk openly to coming in for therapy together. He said, “It gave us a lot of opportunity to talk to each other I think that if I would have come in alone, it would have just helped facilitate my hiding.”

Shifting from “I’ll do it myself” thinking. Another sub-theme that five husbands talked about was a shift from an “I’ll do it myself” way of thinking to a shared recovery. Like Adam, many admitted, “I had spent way too many years trying to figure out how to stop this myself I have always been very independent and hated to rely on other people I was trying to control it all.” Adam continued, “It is a daily thing, reminding myself that I am not going to be able to do this by myself Every time I have tried I

have failed.” For Adam, as well as other participants, this shift meant relying on his wife, as well as a higher source of spiritual power.

Carrie also mentioned that Craig had “tried to overcome it all by himself.” Craig explained, “The process that I was in I would go for months with not having any problem and thinking things were going well, then boom, something would happen and then I would fall back down.” He added that he hadn’t involved Carrie because he “didn’t want to embarrass [her].” Once he did talk with Carrie about the problem, she prolonged the “do-it-yourself” thinking. She said, “I did not see the need to get professional help; I just figured he could do it on his own, not knowing that it was actually an addiction.” By the time Craig decided to come in for therapy, however, he admitted, “I was just looking for any help I could get.”

When discussing this shift, Adam also explained that even his successful moments were less satisfying when he went through them alone before sharing his recovery with Amy:

Any time I had success [alone], it wasn’t this huge victory It was very difficult for me. It wasn’t satisfying. I didn’t get anything from ... those successes.

Growth perspective of recovery. The next sub-theme mentioned by two couples in relation to overcoming the addictive behaviors was that of a growth perspective, or normalizing a progressive recovery process. Sarah explained:

I think one thing that really made a big difference was that he told both of us what to expect. He said, “The chance that you will relapse is so high, but that is okay We talked about how you need to handle this You’re prepared if [you do relapse].” I think that made a really big difference because all of a sudden ... it

wasn't like Steve felt like he gave him permission to go, but instead it took a lot of pressure off. I think it almost made it easier to stay away, don't you think, because there is not as much pressure to stay away?

Steve also talked about "keeping things in perspective":

Just kind of telling myself that I am a good person, regardless of what my problems are, and that no matter where I am in the process, as long as I am trying, even if I am failing, I shouldn't be beating myself up.

Couples mentioned that this "growth perspective" was not only beneficial for the addicts, but for their spouses. Kathy talked about how having a "growth perspective" helped her with "knowing how to react." She explained:

[The therapist] would always help me put things back into perspective by what he was saying Instead of saying, "I can't believe this happened again," ... [the therapist] would say, "Look at how far you have come from when you started therapy from where you are now."

Refocusing on life goals. Four of the husbands referred to a refocusing on life goals (individual and couple) as a key motivator to overcome their addiction. Most talked about some aspect of being a good father or husband. For example, Kevin said, "You want to be a good father and that sort of your life doesn't mesh with being a good father, even if you are not religiously inclined."

Craig explained how this process took place for him. He said, "At one point, I don't know, 5, 6, 7 years ago, I had decided that I really wanted to become a better husband, father, and person." He then told about how he tried to make changes towards his "personal development" with goals at home and through his church. He then said:

But I would go on this path and I would be thinking I was doing really well and then, boom, I would relapse again somewhere At that point it was, “I am really tired of this accumulation of not being able to be the person I want to be so let’s go do therapy.”

Adam summarized his motivation to change when he said, “Pretty much in a nutshell I have an addiction to pornography and it was affecting our marriage and our lives together – my happiness, her happiness I wanted to fix that – all of it.” One of the specific life events that helped Adam make his transition was the birth of his son. He said, “I really don’t know how that all works out, but when he was born it was like I rejuvenated, woke up, and snapped out of it.” He continued, “[It was] just a re-focus because one of my biggest goals in life was to have a happy family. To be a good husband, a good father, that was a major goal for me.” Adam also stated how this goal continues to be an aide:

I run into the crib or something on the way to the computer. It is a reminder of my responsibilities, my goals, the things I want to do that I know are going to make me happy, make Amy happy, and make my son happy.

Specific interventions. The final sub-theme that arose regarding what helped with overcoming the addiction was that of specific interventions. While there were some common interventions between couples (all of whom included this theme in their discussion), most were briefly mentioned by just one or two couples. Only concise notation of the specific interventions, therefore, will be made here.

The key noted amongst the couples was best described by David. When asked about what the therapist did to help him overcome his addiction, he responded, “He

worked at trying different avenues. If something wasn't making enough progress fast enough, he would try something else He said, "What about this ... and let's talk about this" He was always researching *our* problem."

One of the interventions that David mentioned he learned in therapy was "dispelling a lot of the lies [about] pornography itself." He explained how he learned to recognize the "lies" he would tell himself as he prepared to relapse, lies that would erode recovery motivation and resolve. He stated that once he learned to dispel the lies, "it really started to be a quick recovery." He added, "Whenever I have a thought now, I still have to do it. I still have to say, 'Look, this is how that is a lie.'"

Adam mentioned a key intervention he learned from his therapist was to make home a "sanctuary." He said, "I never had a place where I could feel safe." He described the intervention as setting up things at home (i.e., removing triggers) "so I wasn't constantly thinking I had to fight it all the time." For Adam, this translated into "being able to rest" from the struggle against temptation. Amy added that she remembered this as "one of the biggest steps."

Another intervention included identifying what were referred to as "triggers." Kevin explained that his therapist had him "identify some stressors in [his] life that cause [him] to maybe go to pornography to relieve the stress ... and then [find] alternative ways of dealing with it." Craig also mentioned the difficult task of identifying triggers. He said, "It became clear that things that are appropriate for other people or things that other people can deal with without any difficulty are things that could trigger me or cause problems for me."

Kevin and Kathy also mentioned that their therapist had them externalize pornography. They explained that he had them envision an object in the room as if it were pornography and asked them “what they would say to it.”

Finally, Mike talked about establishing ground rules. He gave the following example: “[The therapist] said [we] should set up ground rules. I don’t go on the computer past [a certain] hour at night or early in the morning when she is asleep.”

Recovering from the Marital Damage

All of the couples explained that the effects of pornography addiction reverberated throughout their marriage. Amy stated that the pornography addiction “affected our whole relationship: physically, emotionally – everything.”

Distancing between spouses. Three couples discussed how, during the addictive period, the husband distanced himself from his wife and family. Mary explained, “He never wanted to come home. When he was home, he was really mean and angry He didn’t want to be involved with anything when it came to the family.” She added, “I did everything by myself at that point He just didn’t want to be a part of anything.”

Adam had a similar experience: “We had a hard time spending even normal time together.” He explained further:

We had a hard time ... being able to have normal, relaxed conversations. A lot of times I felt like I was straining to find something to talk to her about. That was one of the things that I loved the most about our relationship When my whole focus was on my addiction, it was hard to come up with anything worthwhile to talk about.

Craig talked about the purpose behind his distancing: “Distancing your spouse is like this giant signal that you are about ready to have problems or you’re starting to have problems.”

Sex life. Three couples also talked about how ironically the addictive period negatively affected their sex life even as the husband was provoking appetite with pornography. Adam mentioned that it “caused our sex life to be pretty much non-existent.”

Steve and Sarah also discussed a similar effect in their marriage: “Usually in a situation like that it is the woman who is uninterested and pulls away, and [in our case] it was actually Steve, because of guilt.”

Craig described how his use of pornography influenced his expectations concerning his sexual relationship with Carrie. He said, “One of the things that we discussed that was kind of an eye opener for me is that I kind of expected women to behave like they did in movies.” Carrie added that pornography portrays that “[women] always want it, they just don’t know they want it.” Craig then continued, “I always thought, ‘Why doesn’t she behave like that?’ It was a point of frustration for me.”

Overall Marital Enhancement

The final theme identified by the research team was that through participating in conjoint marital therapy all of the couples reported a perceived marital benefit beyond simply recovering from a sexual addiction. They described that they had learned skills and created new dynamics that not only benefited the addiction recovery, but also their overall marital relationship (e.g., new abilities to resolve marital concerns, increased

attachment, etc.). Several experiences were shared regarding the influence therapy had on the overall strength of their relationship. Carrie said:

It's actually been better for us and our relationship. I think it's been a strengthening experience It's brought us a lot closer together – that's kind of been maintained throughout, so it kind of was a next step up for us.

Mike explained that it “helped to strengthen my relationship to her because she was there even if she didn't want be.” He added, “I still think I would have overcome my problems had she not been in therapy. It would have just been an extra step I would have had to take to rebuild my relationship with her.”

Amy hypothesized what her experience might have been had she and Adam only received individual therapy:

I think [individual therapy] wouldn't have opened the doors for trust and communication. It might even make me more bitter, or something like that, if I were having some type of other counseling for myself If we [wives] were in one room and the guys in the other room, I could say to myself, “I wish he were here to listen to that,” and I would never have the courage to say it to him. I could see that happening.

Honest and effective communication. One specific area of improvement mentioned by five of the couples was communication. Craig stated that they learned to have “really good, long conversations” and problem solve effectively. Therapy was a safe place where they could learn to talk “openly and honestly” (Kathy) and “get everything out” (Amy). During marital therapy, couples also learned what it means to be completely honest.

[The therapist] talked to us about honesty and he talked to us about the different levels of honesty. In a truly honest relationship, Steve would come to me when he was feeling tempted Anything else is protecting the addiction. I think that made a big difference for Steve, too, because all of a sudden he realized that he wasn't being quite as honest as he thought he was. So, he started practicing [being more honest and open]. (Sarah)

Having worked on honest and effective communication as a couple in therapy, couples noted how it became a natural transition to continue to work on those issues at home.

Increased unity. Another aspect of overall marital enhancement was an increased unity experienced and reported by the couples' interviews (noted both in the content as well as the specific language used by the couples). Couples spoke about the benefits of cooperating "as a couple" or "team." Carrie specifically commented that through the completion of "assignments to do outside of therapy" they learned to talk about and accomplish work "as a couple." She added, "It [recovery] became a goal for both of us."

The research team also described a distinction expressed as "We-versus-I thinking." It was observed that couples talked about the problems and solutions as if they owned them as a couple, not individually. Some of the couples also explicitly noted this change: "When you first start out both parties are like, 'It is all about me and you don't understand'" (David). Diane added that she was able to recognize that relapses weren't "an attack against me", but a "severe temptation" or struggle that David is fighting against.

Summary

A collective analysis of the results demonstrates that those clients interviewed perceive a beneficial influence from conjoint marital therapy. Both individual and marital benefits were reported. Most notably are the benefits reported in relationship to rebuilding trust, softening emotions (as a preparation for mutual support), overcoming the addictive behavior, healing the marriage relationship, and other marital benefits. It is also important to recognize that clients' comments were consistently rooted within the context of their experiences in conjoint marital therapy.

Chapter V

Discussion

Marital Therapy and Sexual Addictions

The current qualitative study provides a possible nascent profile of conjoint couple therapy for sexual addiction and frames important questions for future qualitative investigation. Results from this study raise the possibility that couples generally view conjoint marital therapy as a beneficial treatment process for couples with the presenting problem of a sexual addiction to pornography. Specifically, couples reported that conjoint marital therapy resulted in an increase in trust, a softening of emotions, an increased ability to reduce the addictive behaviors, marital/relationship healing, and an overall enhancement in their marriage. The comments from these couples combine with previous theoretical guidelines to recommend investigation of conjoint marital therapy as a potentially effective treatment model with important dimensions and contributions that perhaps cannot be attained by less systemic, more individualized approaches.

Reducing Relapse

Our findings suggest a research hypothesis that creating a relationship with mutual support and a context of softened emotions (i.e., minimizing marital discord and enabling effective methods of conflict management) are related to overcoming the addictive behavior. Couples related numerous experiences that demonstrated that positive couple interaction and a sense of support have a positive influence on recovery from addiction. Previous research has also suggested that negative family interaction is correlated with increases in relapse behavior (Earle et al., 1995; van der Kolk et al.,

1991). Tays et al. (1999) have also recommended the inclusion of an empathic and caring support system in order help prevent relapse.

Adams and Robinson (2001) propose that the connecting factor between mutual support and reducing relapse is a reduction of shame. Shame or guilt is commonly a motivating reason for the husband's secrecy (both with regards to the problem and attempts at recovery). Adams and Robinson define unhealthy guilt and shame as feelings that promote alienation and isolation (especially from intimate relationships). Shame is "experienced as self-contempt, feelings of inadequacy, and painful disapproval" (p. 24). What ensues is a loss of intimate connections and added dependency on the addiction. It is possible, then, that open disclosure and discussion, such as occurred in these cases of conjoint couple therapy, may play a critical role in facilitating recovery.

By disclosing the secret and continuing to discuss the details of the pornography addiction along with the recovery process in conjoint marital therapy, husbands lose the secrecy that protects and encourages pornography use (Young et al., 2000), sustains shame, and impairs intimacy. Sharing their experiences with a supportive wife "allows the client to expose shameful events in an accepting atmosphere" (p. 28). Part of this "accepting atmosphere" can include a spouse who can add another person's perspective, even one that buffers feelings of unhealthy or excessive guilt and shame.

Conjoint marital therapy can be used as a controlled situation where the therapist can guide such healthy interactions of sharing and acceptance (Christensen, Jacobson, & Babcock, 1995; Greenberg & Johnson, 1988). As a result, "shame reduces its grip when exposed in an understanding context" (Adams & Robinson, 2001, p. 30). Furthermore, when done properly, sharing of experiences with an accepting and understanding spouse

“eliminates the double-life phenomenon, and increases responsibility and healthy guilt. These are experiences necessary for the addict to successfully recover” (p. 28).

Disclosing the secret in conjoint marital therapy also allows the wife to gain understanding, increasing her ability to provide channeled, intimate support (both immediately and through the entire process of recovery), an aspect associated with sustained recovery (Tays et al., 1999; Salmon, 1995). Furthermore, finally being able to talk openly about the secret allows the husband to process his emotions, which lessens the likelihood that he will utilize pornography as an escape from negative emotions (Adams & Robinson, 2001).

The couples in this study discussed another factor as to why disclosure to a spouse and spouse involvement is important to recovery. Johnson and Lebow (2000) have made the claim that an ability to seek assistance from another results in higher levels of resilience. A common process relating to overcoming the addictive behavior that couples reported was what we termed “watchtower work.” This idea consists of both spouses learning the various emotional, cognitive, and contextual triggers, cues, and associations that relate to pornography use. Couples related how, with this knowledge, the wife could assist the husband in recognizing and then either avoiding or otherwise preparing to handle potentially dangerous situations. The application of “watchtower work” from a spouse can also be related to the practice of using sponsors in many 12-step programs. Literature discussing the use of sponsors also asserts a positive correlation with reducing relapse (Salmon, 1995).

During the process of learning the triggers, cues, and associations that relate to pornography use, one of those that is commonly discussed is marital discord. In a study

conducted by Corley and Alvarez (1996), 100% of the married participants (n = 56) “cited marital discord as one of the five most powerful stimuli or triggers for wanting to act out” (see also Edwards & Steinglass, 1995). Conjoint marital therapy provides the opportunity for couples to learn appropriate ways to manage marital discord. In contrast to processing marital discord in conjoint marital therapy (including recognition and acceptance of a wife’s experiences and concerns), Tays et al. (1999) add that “not involving the family ... promotes narcissism, which can trigger additional sexually (sic) acting out” (p. 286).

Directly related to disclosing the secret and the process of “watchtower work” is the shift that husbands had to make from believing that they could solve their problem on their own to believing that full recovery could only come through a shared recovery with their spouse. Common to all husbands was a process of trying to end their pornography use without involving family or professional help. After several failed attempts and continued frustration, however, each realized the need to involve others. Such a process and developmental progression towards a more complete recovery strategy may be common among sexual addicts (Tays et al., 1999; Wolfe, 2000; Young et al., 2000).

Finally, many husbands discussed how the initial motivator for change was a refocusing on their wife’s happiness and the goals that they had as a husband and father. A catalyst for this refocus and motivation to change for two of the husbands was a recent or upcoming birth of a child. This pattern of “sadness and loss” leads to “making amends” (Adams & Robinson, 2001, p. 38). By including a spouse in therapy, the therapist can also demonstrate his or her recognition that the spouse/family is a significant part of the recovery process (Tays et al., 1999) and the recovery unit.

Beyond Abstinence

Another important observation of theoretical models of recovery is that of the definition of recovery. “The mistaken belief is that abstinence is the equivalent of recovery” (Adams & Robinson, 2001). Marital therapy for spousal and marital issues arising from addiction is a direct example of the need for recovery work to accomplish more than abstinence. As noted in the results, couples repeatedly noted the importance of many other aspects of recovery. Two primary themes were rebuilding trust and softening.

Trust. One of the themes that was most important to couples was that of rebuilding trust. This is consistent with Schneider and Schneider’s (1996) report that the most common issue reported by couples was rebuilding trust. A common first step to rebuilding trust was simply the invitation to the wife to participate in therapy. This demonstration of concern for her and willingness to include her participation gave wives a reason to believe that trust could be reestablished. During participation in therapy and the recovery process, wives were then able to better understand addiction and discern a true commitment to recovery from their husbands, by identifying overt signs of recovery effort and progress. The comments made during these interviews support the conclusion made in Schneider and Schneider’s (1996) study that when both spouses attended therapy their were higher levels of trust and a decrease in marital problems.

One of the main influences upon husband trust was the recognition of supportive reactions from his wife. Husbands explained that they were more likely to share their challenges and concerns when they assessed that they would receive a supportive response. While such a response does not take away the wife’s right to be hurt or

troubled by her husband's pornography use, it does mean that the focus is on learning from the problems, recognizing progress and sincere efforts, and moving forward (as opposed to a condemning, punitive, or hostile response). This dynamic then invites increased openness and honesty, resulting in further trust gains.

Literature supports that such a dynamic is most commonly found among couples who participate in conjoint marital therapy (Scneider & Schneider, 1996; Laaser, 1996). A possible explanation for such a connection between spousal support and conjoint marital therapy is due to the influence of a second witness. Many of the wives mentioned the reassurance and validation that they received from having a second, professional witness. For most wives, this was limited to explanations and comments made by their therapist. Other wives also included professional writings on the subject of sexual addiction. The main topics mentioned from these second witnesses included an explanation of the addictive nature of pornography, common challenges faced by those recovering from sexual addiction, and personal experiences shared from other couples who had experienced a husband's sexual addiction. Many of the ideas shared were similar to previous comments or attempted explanations from their husband. Receiving similar, confirming information from an outside, non-biased source, however, validated the statements, improved understanding and empathy, and increased trust and the desire to be supportive.

Softening. Another major theme common to all couples was that of softening or emotional healing. Literature discussing sexual addictions frequently recognizes the importance of addressing emotional issues such as self-blaming, hurt, resentment,

insecurity, anger, emotional withdrawal, and shame (Goodman, 1993; Laaser, 1996; Milrad, 1999; Schneider & Schneider, 1991).

The participating couples frequently referred to the process of education and understanding sexual addictions as a key to softening. While this has not been discussed as a part of conjoint marital therapy for sexual addictions, other programs have incorporated psychoeducational groups (Stratton & Newbold, 1995).

Another part of the process of softening mentioned by the wives was separating herself from the problem. Many wives explained that they had to work to remove constraining beliefs (Wright et al., 1996) such as judging that the pornography use was a result of not being attractive enough or not being a good enough wife. Shaming beliefs such as these are common among wives whose husbands have a sexual addiction (Schneider, 1989).

In order to accomplish this process of softening, couples commonly noted the therapeutic intervention of in-session communication, or enactments. Couples related experiences where the therapist guided their discussions during the session in order to facilitate and teach relationship-strengthening communication. When this process is used during therapy, spouses are motivated and feel more able to reach out for the kind of comfort and support from their spouse (van der Kolk et al., 1991; Johnson et al., 1999) that sponsors and sustains recovery.

Marital Enhancement: An Added Advantage

In discussing how therapy aided recovery from the sexual addiction and its effects on the marriage, it was apparent that through participating in marital therapy the couple's marriage benefited beyond recovering from a sexual addiction. Many couples expressed

that their experiences in therapy strengthened their relationship. Those who had not had previous experiences in individual counseling hypothesized that individual counseling might have helped them overcome addictive behaviors, but recognized that they would have missed out on marital healing and improvement generally. It is possible thus that marital therapy for sexual addiction is similar to findings of marital therapy for depression; namely, that individual and marital therapy can possibly be equally effective in treating the presenting problem, yet marital therapy “has the added advantage of improving the ... person’s relationship” (Johnson, 2002, p. 176).

Honest and effective communication. One of the specific areas of improvement mentioned was communication. Along with improvements in softening and supportiveness, couples mentioned that marital therapy became an opportunity to bring up topics which they previously were not able to talk about.

Therapists have recognized the development of constraining couple communication patterns among couples struggling with sexual addiction (Tray et al. 1999; Schneider & Schneider, 1996). One of the negative patterns that is created is that of dishonesty or secrecy. This pattern commonly spreads beyond hiding the sexual addiction. During marital therapy, however, couples can learn what it means to be completely honest, and re-socialize themselves to its practice in session.

Having worked on honest and effective communication as a couple in therapy, it then became a natural transition to continue to work on those issues as a couple at home. Once the habit of discussing sensitive issues on their own is formed, couples are able to increase their rate of recovery as they increase and improve at-home interventions. Furthermore, facilitating healthy conflict resolution and communication skills can help

various facets of couples' marriage (as well as the recovery work) continue to improve post-therapy.

Increased Unity. Another dynamic that was noted during the team analysis was that of increased unity. Couples talked about the problems and solutions as if they owned them as a couple, not individually. Couples discussed how they were more united and spoke about things “as a couple” or “team.” The research team specifically noted the frequent use of ‘we’ rather than ‘I’ thinking. It seems reasonable to infer that participation in conjoint marital therapy involving high levels of therapist-guided cooperative couple interaction, emotional disclosure, and problem solving (enactments) may be the primary modality and mechanism for realizing these critical outcomes.

Suggestions for Clinical Practice

The following suggestions are based on concerns expressed by the couples when they were asked what was not helpful in therapy or what they felt should have been included but was not. Responses were also generated by asking the couple what advice they would give to therapists regarding the treatment of a sexual addiction to pornography.

Allow the Wife to Share Her Story in Conjoint Marital Therapy

Three of the six husbands had attended individual therapy (with different therapists) prior to their experiences in marital therapy. The wives in these couples talked about their experience of not being able to participate in their husband's individual therapy sessions. All three of the wives reported having negative experiences.

Disempowerment and distress were two negative effects. Two of the wives talked about how they felt “helpless” when they were not being invited to participate and

therefore were in the dark regarding what was occurring in therapy. They described experiences of feeling much more involved and empowered when participating in conjoint marital therapy. Being in conjoint marital therapy, knowing what was happening, and being able to be a source of support was described as “comforting.”

One wife also mentioned that she was angry because she felt she was being overlooked. She was upset that she was not being seen as a potential participant in the recovery process. Another aspect of being overlooked was being treated as if the problem is his and it shouldn't bother the wife. These spouses then added that going into therapy together felt validating.

Another description offered of individual therapy was that it felt “secretive and separate” (Diane). One wife even mentioned a desire to be involved but that she did not feel very comfortable asking her husband about it because she didn't want to interfere. That a spouse should feel she was “interfering” by wanting to participate in her husband's recovery runs directly counter to research and theory confirming her critical role and contribution to recovery.

While certain steps toward a more inclusive individual therapy could perhaps be taken to help a spouse feel involved and potentially eliminate or minimize these experiences, it seems apparent that conjoint marital therapy is the only completely inclusive remedy. This held true even in the cases where the wife did not initially desire to participate in conjoint marital therapy.

One exception to this dynamic was when the wife did not feel that her issues were addressed in therapy. The perception shared was that everything was geared towards the husband's recovery. The caution for therapists which can be concluded from her

experience is to directly and explicitly attend to spouses' needs in healing and recovery. Simply recognizing and validating the wife's experience and inviting her story proved to be a powerful intervention and inclusion in and of itself, and one consistent with findings related to softening in EFT (Greenberg & Johnson, 1988).

Balanced Use of Psychoeducation

Another concern that couples discussed with regards to therapy was over-education. This was an experience that was reported as both a part of individual and marital therapy. It is important to note first the previously mentioned benefits of education. The research team, in fact, noted that education about sexual addiction was one of the most beneficial steps in creating softening and increasing mutual support. At the same time, the same couples that talked about the benefit of education also mentioned this concept of over-education as it related to sexually addictive behavior.

The distinction as to where education crosses over into over-education is difficult to make. It seems, however, that the dissimilarity that leads to a negative experience referred to as over-education is when the therapist is not able to make or fails to make a clear connection between the information and the recovery process. There is a need to demonstrate to the clients the importance of such education in connection with their goal of recovery from a sexual addiction.

Another delicate issue of education was that of discussing the history of the presenting problem during early sessions of marital therapy. The wives' experiences demonstrate the importance of preparing the couple before discussing certain topics. Specifically, therapists might need to reframe the discussion of the husband's sexual history, what some wives could see as simply "unloading" and "rehashing" (especially if

she feels she has already heard this information from her husband) into a step that is beneficial to the couple's progress (e.g., learning of experiences that influenced the development of the addiction and give insight into the healing process, ensuring full and honest disclosure, and assisting in the development of understanding and empathy).

Including Others' Stories

Given the social stigma of sexual addictions and the guilt and shame that is commonly felt by addicts, it readily leads to alienation and isolation that complicates and hinders recovery. Furthermore, the silence surrounding this topic results in a lack of hope as couples are not aware of success stories from other couples. Many participants expressed interest in hearing others' success stories. When asked what they would have liked more of, it was common for them to respond with a desire to know what other people had been through and that they were feeling similar things and that it was normal to be angry and frustrated. The benefit of such stories was confirmed by those few who had been given literature that incorporated others' personal experiences.

Enactments

Recent publications have suggested the benefit of enactments as a common factor in marriage and family therapy (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2001; Butler, 1996; Butler & Bird, 2000; Butler & Gardner, 2003; Davis, 2002; Nichols & Fellenberg, 2000). Enactments are defined as "therapist behaviors which stimulate and guide couple interaction as opposed to channeling interaction through the therapist" (Butler, 1996, pp. 27-28) and as a "therapeutic process where the couple talks directly to each other and the therapist coaches the content and process of the couple's interactions" (Woolley, 1995, pp. 1-2). Understanding the importance of communication in the

process of recovery and general marital functioning leads to a clinical implication for the use of enactments in a conjoint couple therapy approach to treating sexual addiction. Through enactments, then, couples in recovery can be encouraged and guided to become increasingly self-reliant and the primary agents of their own healing and recovery.

Suggestions for Clinical Research

Given the small sample size here and inherent limitations of qualitative methods our conclusions are offered only as reliable, nascent clinical observations and cannot represent more than a framework for future research and clinical consideration. Further research is needed to validate the findings. Increased sample size would also increase the diversity of the clients and of the treatment sources/methods, yielding greater external validity. Given these limitations, however, this study hopes to add to the understanding of sexual addiction treatment with its empirical foundation and rich data and to contribute towards future research and theory development.

Summary

Our conclusion is that conjoint marital therapy is viewed by couples as a preferred and essential treatment modality for system wide healing and recovery from a sexual compulsion or addiction. The participants' self-reports confirm that "a systemic, integrative approach ... provides change on the cognitive, emotional, and behavioral levels, as well as impacting the systems in which the patient is a part" (Tays et al., 1999, p. 287). Conjoint marital therapy, therefore, shows promise for improving recovery outcomes. In addition, marital therapy treats not only the addictive behavior, but also addresses healing of the spouse and the marriage. Finally, for the six couples studied,

conjoint marital therapy was reported to be helpful in treating the sexual addiction and all resulting systemic effects, as well as strengthening the overall quality of the marriage.

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Appendix A

Guidelines for Therapist's Initial Contact to Solicit Participants

When contacting potential participants for the study, please explain the following items:

Purpose of the Study: A study is being conducted by Dr. Mark H. Butler, an Associate Professor in BYU's School of Family Life, together with Spencer T. Zitzman, a Master's Student in the Graduate Program of Marriage and Family Therapy. The purpose of the study is to interview couples regarding the marital therapy that they received concerning pornography addiction in order to understand the perceived benefits, or lack thereof, from the therapy experience. Furthermore, the study is focused on understanding the role of the therapy process in the recovery from a sexual addiction, as perceived by the clients.

Participation in the Study: Inform the clients that they have been selected based on their previous experiences in therapy. Participation in the study, however, is completely voluntary. Explain that accepting or declining to participate in this study will not affect any therapy they are currently receiving.

Invitation for Future Contact: Ask the clients if they agree to be contacted by the researcher to further explain the purpose of the study and answer any questions. Explain that the researcher will be given their contact information in order to send a Participant Letter of Explanation and to then contact them by phone. Further explain that permission to give their contact information does not require them to participate in the study. If the individuals agree to be contacted regarding further information and participation in this study, obtain their name, address, and phone number for future contact by the research team.

Contact Information for Participant Questions: The individuals may contact Dr. Mark H. Butler (801-422-8786; 262 TLRB, P.O. Box 28601, Provo, UT 84602), Spencer Zitzman (801-422-7759), or Dr. Shane Schulties, Chair of the Human Subjects Institutional Review Board (801-422-5490) for any questions regarding this study or their rights as a research participant.

Participant Letter of Explanation

Date

Dear Prospective Participant,

Dr. Mark Butler, Associate Professor in Brigham Young University's School of Family Life, together with Spencer T. Zitzman, Master's Student in the Graduate Program of Marriage and Family Therapy, is conducting research examining **the process of recovering from a compulsive or addictive behavior**.

You have been recommended as a couple who may be willing and qualified to participate in this important research. Your **participation** would include taking part in a recorded interview in which you and your spouse will be asked about previous experiences with regard to healing from a sexual addiction.

Because your privacy is of great importance, **all materials used in this study will be kept strictly confidential**. The interviews will be coded numerically, allowing for the removal of all names and identifying information of all individuals interviewed prior to any analysis (assuring that only Dr. Butler and Spencer T. Zitzman, the interviewer, will be aware of the names of those participating). Any names of individuals participating in this study will be kept locked for confidentiality and no names will be used in the publication of the results.

Your participation in the study will assist in the development of interventions **for therapists helping couples who are healing from a compulsive or addictive behavior**.

As this study is completed, the **conclusions and benefits** will be released to the public in hopes of providing assistance for all therapists who work with couples who are healing from sexual addictions. Again, the information released to the public will in no way identify any participants or in any way compromise the confidentiality of the participants.

Your participation will be greatly appreciated, and will help further an important effort in the field of marriage and family therapy.

Sincerely,

Mark H. Butler, Ph.D.
Associate Professor, School of Family Life
Marriage and Family Therapy Graduate Programs
Brigham Young University
262 TLRB, PO Box 28601
Provo, UT 84602-8601
(801) 422-8786

INFORMED CONSENT TO PARTICIPATE AS RESEARCH SUBJECT

Dr. Mark Butler, Associate Professor in Brigham Young University's School of Family Life, together with Spencer T. Zitzman, graduate student in Marriage and Family Therapy, School of Family Life, are conducting **research examining how therapists can better help couples who have had to recover from a spouse's compulsive or addictive behavior.**

You have been recommended as a couple who may be willing and qualified to participate in this important research. You were selected for participation in part because your therapist identified you as a couple who have had a success in managing the crisis of a compulsive or addictive behavior through the completion of therapy. Your participation would include taking part in a recorded interview in which you and your spouse will be asked about previous therapy experiences. Your participation is completely voluntary. Declining to participate in the research will not affect any therapy you are currently receiving or might receive in the future.

Your participation may further our understanding of how therapists can better help couples who have had at least one spouse with a sexual addiction. **The results of this research may specifically help other couples who come to therapy to resolve problems due to a compulsive or addictive behavior.** As this study is completed, the conclusions and benefits will be released to the public in hopes of providing assistance for all couples who have or will experience a compulsive or addictive behavior.

Participation involves completing an interview and a brief, written questionnaire at a mutually determined location. The interview (including completion of the questionnaire) is anticipated to take **approximately one hour** to complete. In the interview, you will be asked various questions regarding your experience in therapy. The interview will be recorded in its entirety for later transcription. Because your privacy is of great importance, the transcription process and all handling of the data will be kept **strictly confidential.**

Due to the fact that participants will be asked to recall previous experiences within their marital relationship, it is possible that emotional discomfort or distress could result. Couples who experience undue emotional distress as a result of participation in the study will be referred to a qualified therapist. If the couple feels therapy is necessary, therapy will be paid for by the couple.

YOU MAY REFUSE TO CONTINUE YOUR PARTICIPATION IN THIS RESEARCH AT ANY TIME.

Possible benefits of this experience may include a strengthening experience by reviewing and recollecting the benefits from previous therapy experiences. Further benefits include a better understanding of how therapists can better help couples who have experienced a sexual addiction. However, it should be understood that this is not a therapeutic session.

Although the cassette tape used to record the interview becomes property of Brigham Young University's School of Family Life, **full confidentiality is guaranteed**. The tape and all other materials will be marked by identification number only and will be maintained in a locked file cabinet. The tapes will only be used to develop transcripts, which will then be analyzed. No identifying information will accompany any transcripts. After completing the transcripts, the audio tapes will be destroyed in order to eliminate any identification of the participants' voices. Only research project staff will have access to this material without your prior written consent.

Questions regarding this research may be directed to the following person.

Mark H. Butler, Ph.D.
Associate Professor, School of Family Life
Marriage and Family Therapy Graduate Programs
Brigham Young University
262 TLRB, PO Box 28601
Provo, UT 84602-8601
(801) 422-8786

By signing this form you acknowledge that your participation in this research study is voluntary.

I have read, understood, and received a copy of the above consent, and desire of my own free will and volition to participate in this study and accept the benefits and risks relating to this study.

Research Participant Date

Witness Date

If you have any further questions regarding your rights as a participant in this research study, you may contact Dr. Shane Schulties, Chair of the Human Subjects Institutional Review Board, phone 801-422-5490.

Appendix B

Demographic Questionnaire

1. What is your gender?
 - a. Male
 - b. Female

2. What is your age?
 - a. 18-25
 - b. 26-35
 - c. 36-45
 - d. 46-55
 - e. 56 or above

3. What is your ethnicity?
 - a. White/Caucasian
 - b. African-American
 - c. Asian/Pacific Islander
 - d. Hispanic
 - e. Other _____

4. What is the highest level of education that you have completed?
 - a. No formal education/some high school
 - b. High school diploma/GED
 - c. Some college
 - d. Associates/Bachelor's degree
 - e. Graduate studies/graduate degree

5. What is your annual income?
 - a. 0-9,999
 - b. 10,000-29,000
 - c. 30,000-49,000
 - d. 50,000-69,000
 - e. 70,000 or above

6. How long have you been married?
 - a. Years _____ Months _____

7. How many times have you been married?

8. How many children do you have?
- 0
 - 1-2
 - 3-4
 - 5-6
 - 7 or more
9. What is your religious affiliation?
- Buddhist/Hindu
 - Christian
 - Islamic
 - Jewish
 - Other _____
10. Which partner had the sexual addiction?
- Wife
 - Husband
 - Both
11. How long ago did the sexual addiction occur?
- _____
12. The sexual addiction ended after...
- 1 to 6 months
 - 7 to 12 months
 - 1-2 years
 - 2-5 years
 - 5-10 years
 - More than 10 years
 - Other _____
13. How was the sexual addiction revealed?
- By the spouse who had the addiction
 - Discovered by the other spouse
 - In therapy
 - Other _____

Appendix C

Structured Interview Questions

Preface to questions 1-3.

Often when couples enter therapy they are angry or upset at their spouse. These powerful emotions often make it difficult to share feelings, trust each other, and even make couples wonder if it is worth the effort to continue in the marriage.

1. Why did you decide to come in to therapy?
2. Do you feel like there was a moment or moments in therapy that helped or hindered you to let go of the anger or hurt a little but and begin to soften your emotions toward your spouse? Can you describe what happened? Did the therapist do or say anything that helped?
 - a. If no specific moment(s) are identified:
 - i. Do you feel like there was a general softening of emotion through the course of therapy? If so, how did the therapist help to make that possible?
3. Did you feel like there was a moment or moments in therapy that helped or hindered trust to be re-established? Can you describe what happened? How did the therapist help, if at all, in that process?
4. How did your experience of both of you coming to therapy together affect your healing process?
 - a. Probing (to each partner): How did it affect you to participate with your partner in therapy?
5. What experience or experiences in therapy, if any, first indicated to you that therapy would be helpful? Could you describe what happened at that time? What did the therapist do to help you to feel that way?
6. We've talked about a lot of things already. After taking these past few moments to review your therapy experience, what do you now see as the main challenges you had to face as a couple as a result of the sexual addiction? What do you see as the main challenges you had to face individually as a result of the sexual addiction?
 - a. As they answer, clarify each response with the following question: What did the therapist do or say to help you meet those challenges successfully?
7. Were there other ways that the therapist helped or hindered you in taking the steps required for healing your marriage?
 - a. Probing: In other words, what additional things, if any, did the therapist do or say that helped change occur?

8. What took place outside of therapy that helped or hindered in the healing process?
 - a. Probing: These things could include homework assignments from therapy, individual accomplishments, things you did as a couple, or events that happened outside of therapy that had a significant impact on the healing of the relationship.

9. Interviewer Reminder: This question should take no longer than five minutes.
 - a. Before we finish, it is helpful to know some basic information about your pre-therapy experiences. Could you briefly describe what events initiated your decision to come to therapy (together)?