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ABSTRACT

Despite the prominence of 12-step recovery as an approach to addressing compulsive sexual behavior (CSB) worldwide, little is known about the phenomenological experiences of recovery from CSB among individuals who participate in 12-step groups for CSB (known as 'S' groups). The present qualitative study used in-depth interviews to explore lived experiences of recovery from CSB among 14 members (13 males and one female) of an 'S' group, Sex and Love Addicts Anonymous (SLAA). Inductive thematic analysis of the interview data yielded five themes: (i) unmanageability of life as impetus for change, (ii) addiction as a symptom of a deeper problem, (iii) recovery is more than just abstinence, (iv) maintaining a new lifestyle and ongoing work on the self, and (v) the gifts of recovery. Participants typically described their initiation into recovery as being precipitated by the escalating negative consequences of their sexual behavior. Over time in recovery, they came to see their sexual acting out as a manifestation of unresolved underlying issues that would need to be addressed in recovery. They also came to believe that to achieve lasting abstinence from their problematic sexual behaviors, their overarching recovery goal would need to expand beyond just abstinence to the long-term maintenance of the quality of their recovery as a whole. This was achieved primarily through the creation and maintenance of a new lifestyle and engagement in ongoing work on the self. This new way of living was described as resulting in positive changes beyond just the alleviation of CSB symptoms, including personal transformation and improvements in overall quality of life. This qualitative study is the first to analyze recovery experiences of 'S' group members using a bottom-up approach and provides insights into how SLAA members describe and make sense of their recovery journeys.

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Introduction

Although the clinical phenomenon of compulsive sexual behavior (CSB; also conceptualized as 'sex addiction', 'hypersexuality', 'sexual impulsivity' or 'out-of-control-sexual-behavior') has been described and theorized about in the literature for decades (e.g., Barth & Kinder, 1987; Carnes, 1983; Coleman, 1991; Goodman, 1992; Grubbs et al., 2020; Kafka, 2010), it has only recently received formal recognition as a clinical disorder. In 2019, the World Health Organization (WHO) included the diagnosis of compulsive sexual behavior disorder (CSBD) as an impulse control disorder in the eleventh revision of the *International Classification of Diseases* (ICD-11; World Health Organization [WHO], 2019). A conservative approach was taken for the ICD-11 in categorizing it as an impulse control disorder instead of an addictive disorder because there is (to date) insufficient clinical evidence to determine whether the processes involved in the development and maintenance of the disorder are equivalent to other recognized forms of addiction (Kraus et al., 2018).

The prevalence of CSB in the adult population has been estimated to be between 3% and 8.6% (Bőthe et al., 2020; Dickenson, Gleason, Coleman, & Miner, 2018; Klein, Rettenberger, & Briken, 2014; Sussman, Lisha, & Griffiths, 2011). According to the ICD-11, CSBD is characterized by *"a persistent pattern of failure to control intense, repetitive sexual impulses or urges, resulting in repetitive sexual behavior… over an extended period (e.g., six months or more) and causes marked distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning"* (World Health Organization, 2019, p. 1). CSB encompasses various types of compulsive solo or relational sexual behaviors such as masturbation, pornography use, cybersex, casual sex with multiple partners, use of escort services and sex workers, or frequenting of strip clubs (Karila et al., 2014; Reid, Carpenter, & Lloyd, 2009). Moreover, individuals with CSB may engage in more than one sexual behavior that is compulsive (Derbyshire & Grant, 2015). These compulsive behaviors lead to significant negative consequences for the individual, including (but not limited to) emotional distress, relationship difficulties (e.g., betrayal of trust in romantic relationships), diminished self-esteem and self-respect, unintended pregnancies, and risk of HIV and sexually transmitted infections (McBride, Reece, & Sanders, 2008; Muench et al., 2007; Reid, Garos, & Fong, 2012). While rigorous outcome studies on CSB treatments using gold-standard approaches such as randomized controlled trials are scarce, likely due to CSB only recently receiving formal recognition as a clinical disorder (Grubbs et al., 2020), various treatments have nonetheless been delivered to treatment-seekers over the years. Treatment approaches (for reviews, see Briken, 2020; Dhuffar & Griffiths, 2015a; Efrati & Gola, 2018b; Garcia

et al., 2016; Malandain, Blanc, Ferreri, & Thibaut, 2020; Miles, Cooper, Nugent, & Ellis, 2016) include individual and/or group psychotherapies, pharmacotherapies, and mutual-help support groups such as 12-step groups, which is the focus of the present study.

The 12-step program

The 12-step program was originally pioneered by Alcoholics Anonymous (AA), which was founded in the 1930s (Alcoholics Anonymous, 1939). The program has since been adapted for substance addictions (e.g., Narcotics Anonymous [NA], Cocaine Anonymous [CA]) and various other compulsive and addictive behaviors (e.g., Gamblers Anonymous [GA], Overeaters Anonymous [OA]). The 12-step recovery process consists of two elements: (i) fellowship and (ii) practice of the 12-step program (Tonigan, Toscova, & Connors, 1999). 'Fellowship' involves engaging in mutual support with other members through attending meetings, keeping in touch outside of meetings, and sponsorship (a sponsor is an experienced member who guides newer members in their recovery). The 12-step program can be understood as program of change that facilitates the overcoming of addictive/compulsive behavior through the cultivation of spirituality[1] and a new way of living (Stein & Carnes, 2017), and members are encouraged to work on the 12 steps with a sponsor. The 12 steps can be summarized as follows: admitting 'powerlessness' (that one cannot control one's addiction/compulsion) and deriving hope that a power greater than oneself can help overcome the addiction/compulsion (Steps 1–3), engaging in self-examination, disclosure and making amends to harmed individuals (Steps 4–9), maintaining a new way of living and helping other individuals who struggle with the addiction/compulsion (Steps 10–12; Parker & Guest, 1999; Tonigan et al., 1999). A central feature of 12-step ideology is its emphasis on abstinence from the problematic behavior as a means of recovery, which is an outcome of its adoption of the disease concept of addiction and the belief that the afflicted individual is powerless over the addiction/compulsion (Parker & Guest, 2002; Wallace, 1996).

12-Step groups for CSB – 'S' groups

12-step groups adapted for CSB, known within the 12-step community as 'S' groups, include Sex and Love Addicts Anonymous (SLAA; founded in 1976), Sex Addicts Anonymous (SAA; founded in 1977), Sexaholics Anonymous (SA; founded in 1979), Sexual Compulsives Anonymous (SCA; founded in 1982) and Sexual Recovery Anonymous (SRA; founded in 1990) (see Salmon, 1995 for a history of the development of 'S' groups).

'S' groups follow the basic structure of AA, but differ in one important respect – while AA defines abstinence as complete abstinence from alcohol, 'S' groups do not define abstinence as complete abstinence from sex. The various 'S' groups have differing definitions of 'bottom-line' behaviors, which refer to specific problematic behaviors that the individual would need to abstain from (Ziff, 2019). Some groups (SA and SRA) have fixed and predefined definitions of bottom-line behavior for all members. SA has the narrowest definition of bottom-line behavior of all the groups, which is any sexual activity outside of a heterosexual, monogamous marriage, while SRA broadens this definition slightly to include any sexual activity outside of a committed monogamous relationship. The other three groups (SLAA, SAA and SCA) allow members to define a unique set of bottom-line behaviors for themselves, typically in consultation with a sponsor (Ziff, 2019).

While there is currently no data on the estimated total worldwide membership of 'S' groups, it can be reasonably expected that a considerable number of individuals in recovery from CSB around the world are engaged in 12-step recovery in some capacity. For example, in terms of SLAA alone, there are currently hundreds of in-person meetings across 56 countries worldwide (Sex & Love Addicts Anonymous Fellowship-Wide Services (SLAA FWS), 2021). Furthermore, participation in 'S' groups has long been recommended as an adjunct to therapy by clinicians who specialize in treating CSB (e.g., Carnes, 2000; Parker & Guest, 2002; Rosenberg, Carnes, & O'Connor, 2014; Schneider & Irons, 2001; Weiss, 2015; Ziff, 2019), with some recommending integrating 12-step-related tasks and principles into therapy and treatment plans (e.g., Carnes; 2000; Stein & Carnes, 2017).

Some limited prior research has suggested that engagement in specific 12-step activities could be helpful in the CSB recovery process, although findings have been arguably inconclusive. Wright (2010), using a retrospective two-wave panel design, found that meeting attendance and sponsor work among members of an unspecified 'S' group ($N = 97$) at T1 were associated with lower levels of sexual compulsivity at T2, suggesting that involvement in these 12-step activities could be responsible for the alleviation of CSB symptoms. However, these activities at T1 did not explain significant variance in T2 sexual compulsivity after T1 levels of sexual compulsivity were accounted for, which weakens support for the efficacy of the 12 steps. Efrati and Gola (2018a) found that advancement in the 12-step program (operationalized by current step in the program) among SA members ($N = 97$) significantly predicted beneficial outcomes including lower levels of CSB symptoms, sexually-related feelings of helplessness, avoidant help-seeking and sexual suppression, and higher levels of

self-control and well-being, above and beyond the contribution of overall duration in the program and sociodemographic factors. However, the cross-sectional nature of the study meant that the reverse interpretation could also be true (i.e., that members who experience these benefits in their recovery may be more motivated to advance through the 12 steps).

Despite the prominence of 12-step recovery as an approach to addressing CSB worldwide, little is known about the phenomenological experiences of recovery from CSB among individuals who participate in 'S' groups, and how they make sense of their recovery experiences. In-depth qualitative research exploring the lived experience of recovery from CSB among these individuals is lacking within the empirical literature. To date, most qualitative studies examining experiences of recovery from CSB have utilized non-12-step samples (Burke & Haltom, 2020; Cavaglion, 2008, 2009; Corley, Pollard, Hook, & Schneider, 2013; Fernandez, Kuss, & Griffiths, 2021; Perry, 2019; Sniewski & Farvid, 2019; Zitzman & Butler, 2005) or clinical samples where only a proportion of the sample attended 'S' meetings (Schneider & Schneider, 1996; Schneider, Corley, & Irons, 1998). Additionally, these studies have either focused only on individual aspects of the recovery experience, including marital challenges during recovery (Schneider & Schneider, 1996), disclosure of infidelity and/or relapse to partners (Corley et al., 2013; Schneider et al., 1998) and experiences of progress through specific clinical interventions (Sniewski & Farvid, 2019; Zitzman & Butler, 2005), or have restricted their focus solely to recovery from problematic pornography use within religious communities (Burke & Haltom, 2020; Perry, 2019) or online recovery forums (Cavaglion, 2008, 2009; Fernandez et al., 2021).

To date, there have only been three qualitative studies exploring recovery experiences from CSB that have focused exclusively on individuals who participate in 'S' groups (i.e., Dhuffar & Griffiths, 2015b; Ševčíková, Blinka, & Soukalová, 2018; Yamamoto, 2020). However, these studies are also limited in that they focused only on very specific aspects of the recovery experience and/or had narrow inclusion criteria for participants. Dhuffar and Griffiths (2015b), analyzing recovery experiences of three SLAA members from the UK, restricted their sample to female-only participants. Ševčíková et al. (2018), analyzing recovery experiences of 18 Czech and Slovak members of SA and SAA, restricted their sample to members who were seeking help specifically for problematic online sexual activities. In addition, they used a deductive approach to data analysis to answer specific research questions about particular aspects of the recovery process (i.e., whether manifestations of the problematic behavior corresponded to behavioral addiction symptomatology and which coping strategies participants used to deal with these symptoms). Yamamoto (2020), analyzing

recovery experiences of four heterosexual men from unspecified 'S' groups, restricted her sample to participants who had more than three-year concurrent engagement in weekly psychotherapy for CSB and regular 12-step program participation, plus more than two years of continuous abstinence from their problematic sexual behavior. Her aim was to examine a specific aspect of participants' recovery, i.e., their experiences of combination treatment for CSB (which was psychotherapy plus 12-step participation) and their perceptions of its effectiveness. Taken together, while these analyses provide valuable insights into specific aspects of the recovery experience or about specific subsets of individuals within 'S' groups, qualitative studies that use a bottom-up approach to explore the recovery experience as a whole among individuals who attend 'S' groups, with broader inclusion criteria for participants, are also needed.

The present study

The present study sought to fill the aforementioned gap within the empirical literature by conducting an inductive thematic analysis of phenomenological experiences of recovery from CSB among members of 'S' groups. Two broad, open-ended research questions were used to guide the analysis: (i) how do members of 'S' groups describe their experiences of recovery from CSB? and (ii) how do they make sense of their recovery experiences?

Method

Participants

Participants were recruited by means of purposive and snowball sampling through the first author's professional network. A one-page study advertisement containing basic study information was forwarded to members of 'S' groups acquainted with the first author, who in turn forwarded the advertisement to other members through their respective networks. The advertisement invited members of 'S' groups to take part in one-on-one online interviews about their recovery from CSB. Eligibility criteria for participation listed on the advertisement included (i) being at least 18 years old, (ii) identifying as being in recovery from sex or pornography addiction[2], (iii) currently being an active member of an 'S' group, and (iv) having attended at least six 'S' group meetings before. This last criterion was to ensure that all participants considered themselves long-term members of an 'S' group, as most 'S' groups recommend that newcomers attend at least six meetings before deciding if they want to participate in the group long-term (SLAA FWS, 2004). Prospective participants who were interested in participating contacted the research team directly. Before

proceeding with the interview, participants were asked to sign an online consent form and fill out a short online survey containing questions pertaining to background information about themselves to provide context for the interview (i.e., demographic information, compulsive sexual behaviors, comorbid mental health conditions, current bottom-line behaviors, and 'S' group membership history). Key participant characteristics are summarized in Table 1.

The final study sample comprised 14 participants (13 males and one female; M_{age} = 43.86 years, SD = 11.23). The sample comprised individuals from eight nationalities including Dutch (n = 3), British (n = 3), American (n = 2), Malaysian (n = 2), French (n = 1), Irish (n = 1), Mexican (n = 1), and Syrian (n = 1). Some participants were living abroad and were attending 'S' meetings in their current country of residence. Countries of residence included Malaysia (n = 4), Netherlands (n = 3), Singapore (n = 2), United Kingdom (n = 2), China (n = 1) Indonesia (n = 1) and the United States (n = 1). To protect participants' anonymity, participant nationality and country of residence are omitted from Table 1.

Although the study was open to members of any 'S' group, all 14 participants were members of SLAA. Of these, eleven attended SLAA exclusively, two also attended SA and SAA, while one also attended SAA. Therefore, the present analysis is best framed as an analysis of SLAA members specifically. Duration of active 'S' group membership ranged from seven months to ten years, with a median of approximately three years. Given participants' membership in SLAA, whether or not they also identified as having love addiction[3] was explored at some point during 12 of the 14 interviews. Eleven participants stated that they identify as also having love addiction, while one denied having love addiction. In terms of CSBs reported, visiting escorts (n = 12) and pornography use (n = 12) were the most common, followed by masturbation (n = 11). Twelve participants reported a history of comorbid mental health difficulties and/or substance use disorders. All eight members with a history of substance use disorders reported currently being in recovery from substance use disorders and had either previously attended or were currently attending 12-step groups for substance use disorders (i.e., AA and/or NA).

Data collection

Interviews with all 14 participants were carried out between May and June of 2020 via *Zoom* video call (except for one participant who expressed preference for a *Zoom* audio call instead). All interviews were conducted by the first author, and ranged from approximately 60 to 100 minutes in length, with most being around 75 minutes. All interviews were

Table 1. Key participant characteristics

Participant number/'S' group(s) attending	Age/ gender	Sexual orientation	Relationship status	Sexual behaviors reported as compulsive	Self-identify as having love addiction?	Self-reported history of comorbid substance use disorders/mental health difficulties	Length of active membership in 'S' group(s)
P01/SLAA	38/M	H	Divorced	Visiting escorts, group sex, casual sex with multiple partners, pornography use, masturbation	Y	Methamphetamine, cocaine, and alcohol use	3 years 7 months
P02/SLAA	28/M	H	Single	Visiting escorts and strip clubs, cybersex, public sex, sex with strangers, pornography use, masturbation, telephone sex	Y	Cyclothymic disorder	1 year 10 months
P03/SLAA	41/M	H	Divorced	Visiting escorts, group sex, anonymous sex with strangers, cybersex, pornography use, masturbation	ND	Depression and anxiety	7 months
P04/SLAA	44/M	H	Married	Visiting escorts, pornography use, masturbation	Y	Bipolar disorder	5 years
P05/SLAA	22/M	H	Single	Pornography use, masturbation, stimulant-enhanced anal masturbation while watching pornography	Y	Alcohol, cannabis, steroid, nicotine, 3-MMC and MDMA use	10 months
P06/SLAA	40/F	B	In a relationship	Casual sex with multiple partners, group sex, swinging, cybersex	N	Cannabis and amphetamine use	1 year
P07/SLAA	57/M	G	Single	Public sex with strangers, visiting escorts, cybersex, pornography use, masturbation	Y	Alcohol, cannabis and nicotine use, anxiety, insomnia	2 years
P08/SLAA, SAA	52/M	H/P	Divorced, in relationships	Cuckolding, group sex, anonymous sex with strangers, swinging, pegging, underwear fetishism, bondage and submission, sexting, visiting escorts, pornography use, masturbation	Y	None	2 years 6 months
P09/SLAA, SA, SAA	49/M	H	Separated	Visiting escorts, casual sex with multiple partners	Y	Cocaine, cannabis and alcohol use, bipolar disorder	10 years
P10/SLAA	54/M	H	Married	Visiting escorts, massage parlors and strip clubs, pornography use, masturbation	Y	None	5 years
P11/SLAA	42/M	H	Divorced, in a relationship	Visiting escorts, pornography use, masturbation, telephone sex	Y	Post-traumatic stress disorder, anxiety	4 years
P12/SLAA	33/M	H	Married	Visiting escorts and massage parlors, cybersex, pornography use, masturbation, telephone sex	Y	Cannabis use, anxiety	4 years 9 months
P13/SLAA, SA, SAA	60/M	H	Divorced	Visiting escorts and strip clubs, pornography use, masturbation	ND	Alcohol, cannabis, amphetamine and cocaine use, attention-deficit/ hyperactivity disorder	1 year 2 months
P14/SLAA	54/M	H	Divorced, married	Visiting escorts, pornography use	Y	Alcohol use	7 years 4 months

Note: 3-MMC: 3-Methylmethcathinone; F: female; G: gay; H: heterosexual; M: male; MDMA: 3,4-Methylenedioxymethamphetamine; N: no; ND: not discussed; P: pansexual; Y: yes

semi-structured in nature, and the interview schedule (see Appendix A) consisted of open-ended questions pertaining to participants' CSB history, motivations for initiating recovery, goals in recovery, challenges in recovery, strategies used in recovery, and how life in recovery was different compared to the past. It should be noted that the interview schedule was merely used as a rough guide to provide a general structure for the interview, and its structure was not adhered to rigidly to ensure that the flow of the interview developed organically and dynamically depending on participants' responses to the open-ended questions. All interviews were audio recorded with participants' permission. The data collection process was concluded once it was determined that data saturation had been reached (Saunders et al., 2018).

Data analysis

Data were analyzed using a phenomenologically informed thematic analysis (TA; Braun & Clarke, 2006, 2013). TA is a theoretically flexible method which allows researchers to conduct a rich, detailed analysis of patterned meaning across a data set. Given the phenomenological approach to data analysis, the goal of the analysis was to explore how individuals with the lived experience of a phenomenon describe and make sense of the phenomenon (Patton, 2014) – in this case, how individuals from 'S' groups describe and make sense of the experience of recovery from CSB. The present analysis was conducted within a critical realist epistemological framework, which *"assumes an ultimate reality, but claims that the way reality is experienced and interpreted is shaped by culture, language, and political interests"* (Braun & Clarke, 2013, p. 329). This means that participants' accounts were taken at face value and were considered to be generally accurate representations of the reality of their experiences, while acknowledging possible influences of the sociocultural context in which they occur.

NVivo12 software was used throughout the entire data analysis process to organize the data and to facilitate ease of coding and thematic organization. The iterative process of data analysis outlined by Braun and Clarke (2006) was followed. After transcribing all the interviews verbatim, the first author read and re-read all transcripts while making initial notes for data familiarization. Next, the entire dataset was systematically coded by the first author, in consultation with the second and third authors. Given the inductive approach to data analysis, codes were derived using a bottom-up process and preconceived coding categories were not imposed upon the data. This allowed for a prioritization of participants' own meanings and perceptions in the analysis. Data were coded at a semantic level

(Braun & Clarke, 2013), resulting in 1154 unique data-derived codes. Codes were then merged to form higher-level categories (see Appendix B for an illustrative example of the progression of coding from a basic code to a higher-level category). Candidate themes were then generated from the codes by the first author, guided by the research questions of the study. Themes were refined after review by the second and third authors and finalized once a consensus was reached by all three members of the research team.

Ethical considerations

The ethics committee of the research team's university approved the study. Before each interview was carried out, full informed consent was obtained from participants. Participants consented to the interviews being audio recorded and transcribed. All audio files and transcripts were fully anonymized and stored on a password-protected database. Any information that could potentially identify participants (e.g., names of individuals and places) have been anonymized in the findings.

Results and preliminary discussion

A total of five themes were identified from the data analysis: (i) unmanageability of life as impetus for change, (ii) addiction as a symptom of a deeper problem, (iii) recovery is more than just abstinence, (iv) maintaining a new lifestyle and ongoing work on the self, and (v) the gifts of recovery. To elucidate each theme, a selection of illustrative quotes is provided, with accompanying participant number (P01-P14). In the analysis, frequency counts or terms denoting frequency are sometimes reported. The term 'some' refers to six or fewer participants, 'many' refers to between seven and ten participants, and 'most' refers to between eleven and fourteen participants.

Theme 1: Unmanageability of life as impetus for change

Most participants described their initiation into recovery as being precipitated primarily by the negative consequences of their sexual behavior becoming so severe that life was no longer perceived to be manageable (e.g., "*yeah, my life was unmanageable…there was nothing left of my life*" [P06]). From a 12-step perspective, admission of 'powerlessness' (i.e., loss of control over the addiction) and the 'unmanageability' of life (i.e., due to the severe negative consequences of the addiction) is the first step that begins the process of recovery. While participants described at length the

experience of powerlessness over their behavior in the form of obsessive preoccupation with the behavior, repeated broken promises to stop the behavior and escalation of the behavior (in terms of increased amount of time spent on the behavior or progression to more extreme or stimulating behaviors to achieve the same desired effect), it is interesting to note that the experience of powerlessness alone did not appear to be sufficient to spur recovery initiation for most participants. Rather, the perception of some form of unmanageability in the form of negative consequences appeared to be a necessary condition for motivating change. As noted by one participant:

> *It's the consequences, one hundred percent. Yeah like I said if the consequences were not so dire, I would probably continue to try to get away with it.* (P09)

The most commonly reported negative consequence was negative impact on marital or romantic relationships ($n = 11$), which included causing emotional pain to partners, dissatisfaction with partners, a lack of trust in the relationship, and breakdown of the relationship or divorce. Other negative consequences reported included engaging in behavior that went against their moral values, such as engaging in infidelity ($n = 9$), shame and regret ($n = 8$), financial costs ($n = 6$), self-loathing and loss of self-esteem ($n = 4$), occupational impairment ($n = 4$), negative impact on sex life with partner ($n = 3$), contracting and/or spreading sexually transmitted infections ($n = 3$) and suicidal ideation ($n = 2$).

Of note, for most participants ($n = 11$) the turning point happened only once some kind of crisis hit – either an external crisis (precipitated by an external intervening event; $n = 8$) or an internal crisis (having an emotional breakdown; $n = 3$). The most common external intervening event was their secret sexual behavior being discovered by their partner ($n = 4$). One participant even described feeling relieved at being discovered by his wife, indicating a desire to change deep down but feeling helpless to do so without external intervention:

> *So, when my wife found out, it was basically… I don't know, maybe it was just a matter of…a cry for help. I don't know. So, when my wife found out she actually confronted me, it was actually quite a bit of relief actually.* (P04)

All three participants who experienced an emotional breakdown (broadly defined as the experience of overwhelming emotional distress leading to a feeling of not being able to cope any longer with the present circumstances) attributed it to the incongruence and exhaustion felt at living a double life for so long. For example, one participant described feeling inexplicable panic attacks which he later realized was because of his double life:

> *I think it [the reason for the panic attacks] was uh…the fact that I could not cope with the deception, the lying, the constant lying to everybody…my body was telling me what my brain was trying to avoid…the body was saying no, this is not alright, this is not okay.* (P14)

While shame (which involves evaluation of the self as a bad person) has been suggested to play a role in the maintenance of CSB, guilt (which involves evaluation of the behavior as wrong), in contrast, may play a functional role in effecting motivation to change the behavior (Gilliland, South, Carpenter, & Hardy, 2011). For all three participants the emotional breakdown appeared to be brought about by accumulated feelings of guilt about their double lives, and was followed by the decision to address the behavior and come clean about the behavior (e.g., "*…and that was the point that I um… discovered that I cannot do this any longer…when I came home I told my wife about my secret life, about everything*" [P03]).

Participants' experiences suggest that motivations for initiation into recovery are no different for individuals who attend 'S' groups when compared to individuals with substance use disorder and gambling disorder, as previous qualitative research has found that initiation into recovery from these disorders is also often precipitated by an external or internal crisis (Stokes, Schultz, & Alpaslan, 2018; Vasiliadis & Thomas, 2018). While 'hitting rock bottom' is not necessary for initiating recovery from substance use disorders (Chen, 2018) and likely for CSB as well, the perception of life as unmanageable, often precipitated by a crisis, appears to be a common pathway into recovery initiation from CSB for 'S' group members.

Theme 2: Addiction as a symptom of a deeper problem

Arguably the most prominent theme that emerged across participants' reflections about their addiction was that their addiction was a symptom of a deeper problem. From the vantage point of recovery, they now saw their sexual acting out as a manifestation of unresolved underlying issues that would need to be addressed in recovery:

> *And that's why I am trying to go deeper into the issues because [the addiction] is just a symptom of what the real problem is.* (P03)

Their sexual acting out was believed to be, at least in part, a manifestation of one of three non-mutually exclusive issues: (i) unresolved developmental trauma, (ii) a disordered search for validation and attention, and (iii) a disordered search for intimacy and love.

Unresolved developmental trauma

First, many participants ($n = 9$) viewed their addiction developing as a consequence of unresolved developmental trauma (e.g., "*Addiction, where it comes from… I can say that I have identified that the origin is in trauma*" [P14]), a perception that is consistent with findings from studies suggesting that early life trauma could be a contributing factor in the development of CSB (Chatzittofis et al., 2017; Efrati & Gola, 2019; McPherson, Clayton, Wood, Hiskey, & Andrews, 2013). The nine participants reported a range of early adverse experiences including witnessing domestic violence, being bullied, being sexually abused, and having parents who were addicted to psychoactive substances, but most common ($n = 5$) was the experience of abandonment or neglect from early caregivers (e.g., "*Um, had a sense of abandonment from like my father leaving and uh… yeah there's just a lot of dysfunction in the home…it certainly affected me*" [P09]).

Some participants inferred that these early adverse experiences contributed to the development of CSB through learning from an early age that sexual behavior could provide effective (albeit short-term) relief from distressing emotions resulting from these experiences (e.g., "*I was being bullied at school a lot, and I used to come home from school and masturbate immediately right, very fast right, right after. It would calm me down*" [P11]). Over time, the sexual behavior became the primary coping mechanism for dealing with distressing emotions, as described by one participant:

> *I used to use [pornography] as an escape because at home it wasn't always very pleasant and my dad was then also drinking a lot and was always fighting and screaming and beating my mother up and stuff… That time it felt like my savior…I found something that's gonna fix my life again.* (P05)

This explanation makes sense in light of previous research suggesting that because individuals with unresolved traumatic experiences tend to experience chronically elevated levels of anxiety and emotion dysregulation throughout their lives, CSB may develop if sexual behavior is continually used as a primary regulatory mechanism (Katehakis, 2009; Lew-Starowicz, Lewczuk, Nowakowska, Kraus, & Gola, 2020). It is also plausible that using sexual behavior as a primary emotion regulation strategy could have been similarly responsible for the development of CSB among participants who reported having comorbid mood and/or anxiety disorders (whether trauma-related or otherwise), although this hypothesis was not explicitly explored by participants during the interviews.

Disordered search for validation and attention

Second, many participants ($n = 7$) saw their sexual acting out as resulting from a disordered search for validation and attention:

> *I think it was a degree of validation…In terms of sort of like I felt I was recognized, I felt I was being listened to. I felt that someone was attracted to me, even if I knew it was fake, I felt that that was at least happening.* (P12).

Some participants even saw themselves as being more addicted to attention from objects of desire than to the sex itself (e.g., "*when I was in rehab, I said oh yeah maybe I'm addicted to attention, you know…it's not so much the sex, it's the attention*" [P14]), with one participant describing the attention as giving him even more of a high than sex (i.e., "*in fact, attention is more important for me than sex. If I get attention from a beautiful woman, I think that is more of a high than the sex*" [P11]).

Seeking validation and attention through these interactions was generally seen as stemming from feelings of inadequacy and low self-worth: (e.g., "*it was all to do with low self-esteem, low self-worth, no self-respect*" [P06]), which aligns with previous qualitative findings showing that some individuals with CSB see their sexual acting out as compensating for feelings of low self-esteem (Giugliano, 2006).

Disordered search for intimacy and love

Third, many participants ($n = 7$) understood their sexual acting out to be a manifestation of a disordered search for intimacy and love. As described by one participant:

> *I knew my acting out occurred via sex but I think what I desperately wanted even through that extensive sexual acting out… was love and affection. I just didn't know how to attain it in a healthy way. Yes, it came out sexually but really what I was after was love.* (P12)

This description of sex as a disordered search for love and intimacy is echoed in findings from previous qualitative research showing that some individuals with CSB attribute their sexual behavior to a desire for connection, where the feeling of connection with another human being during sexual acting out, however fleeting and illusory, acts as a substitute for real intimacy (Giugliano, 2006; Turner-Shults, 2002). Crocker (2015) postulates that individuals with CSB often act out their emotional needs sexually because it allows them to attempt to meet their need for connection without the risk of vulnerability that is needed in the context of real intimacy. Some authors have called CSB an 'intimacy disorder' (e.g., Adams & Robinson, 2001; Schwartz & Southern, 2017), proposing that a defining characteristic of individuals with CSB is an impairment in capacity for real intimacy that results from early traumatic experiences and insecure attachment, although other authors have argued that this may not the case for all individuals with CSB (Hall, 2013; Riemersma & Sytsma, 2013). Notably, two of the seven participants spoke at length about a history of

avoidance of intimacy in relationships. While one participant cited fear of vulnerability as the primary reason for his avoidance of intimacy (i.e., "*when it comes to the real stuff, when I'm about to be emotional or vulnerable, I stay away*" [P01]), the other participant made explicit use of attachment theory (Bowlby, 1982) to explain how a sense of abandonment in his childhood led to attachment issues and an avoidance of intimate relationships, which in turn contributed to the development of his addiction:

> *Addiction is, you know, an attachment disorder…It is trying to fill in the spaces where there hasn't been proper attachment.* (P07)

Of note, all seven participants who attributed their sexual acting out to a disordered search for love and intimacy reported identifying as having love addiction, with four mentioning that they identify more with love addiction than sex addiction. Interestingly, four of these seven participants (including the three who identified more with love addiction) saw their sex addiction as being a manifestation of love addiction (e.g., "*[Love addiction] manifests itself through sexual ways, you see. I act out sexually just to feel loved. Just to either feel loved or to overcompensate for the lack of love, you know*" [P01]).

Participants did not provide clear definitions of their love addiction, but from their descriptions it appeared that they referred broadly to any engagement in interactions that went beyond just sexual pleasure, that either elicited feelings of affection and/or attraction, or had an emotional connection component to them (e.g., "*…love addiction…even with escorts, it wasn't really always just the sex. It was having some emotional connection with that person…shared experiences, shared mutual satisfaction and maybe some attraction*" [P10]). However, the extent to which these participants actually experienced compulsive patterns of romance or emotional dependency was unclear. It is possible that due to exposure to the love addiction concept in SLAA, some SLAA members may more readily use the 'love addiction' label to explain their desire for intimacy, or be more sensitive to any tendency in themselves to search for intimacy in disordered ways beyond sex. Further qualitative research is needed to better understand what having 'love addiction' means to members of SLAA who identify with this label, whether they believe that their sex addiction and love addiction are related, and if so, how.

Theme 3: Recovery is more than just abstinence

Many participants reported that when first beginning their recovery journey, their goal was simply to stop the problematic behavior (e.g., *"I suppose initially I just wanted to stop acting out"* [P12]). However, over

time in recovery, participants' goals evolved to include goals beyond abstinence because they gradually came to believe that while abstinence from bottom-line behavior (called 'sobriety' within SLAA; see SLAA FWS, 2012) is foundational to recovery, recovery is more than just abstinence. The primary way that participants appeared to be led to this belief was through learning from experience that paradoxically, in order to achieve lasting abstinence, what was needed was not so much focusing attention on stopping the behavior, but on getting one's life in order, because lasting abstinence is achieved as a byproduct of improving one's life as a whole:

> *What I learned after a year or so at SLAA is it's not fighting the addiction, it's just getting your life in order that's important…And over time, the obsession for sex or needing that closeness or that love relationship dissipates.* (P10)

> *We're not talking about fixing that… hey you stop watching pornography. It's not about that. It's about fixing all the amazing things that I can have in my life… And that helps me to stay away from pornography.* (P02)

> *Yeah, first was more just to stop the behavior.… But I must say at some point it also more shifted like… That I was more working on creating a life I didn't want to escape from anymore. So, it was also more about not doing something but more about… yeah, working on all the other parts of my life.* (P03)

Specific recovery goals beyond abstinence articulated by participants included increasing self-acceptance and/or loving/liking oneself more ($n = 5$), working on trauma-related issues ($n = 4$), developing or improving one's connection with a higher power ($n = 3$), loving or having an increased connection with other individuals ($n = 2$), learning to have a healthy relationship with sex and love based on intimacy ($n = 2$), living in peace and serenity ($n = 2$), making amends to loved ones ($n = 1$), restoring dignity of the self ($n = 1$), and achieving personal growth ($n = 1$). Of note, some of these goals (i.e., increasing self-acceptance, trauma work, and learning intimacy-related skills) directly address the underlying issues mentioned by participants in Theme 2, while other goals (e.g., restoring dignity of the self and living in peace and serenity) appear to represent attempts to undo negative consequences of the addiction. These goals illustrate how recovery takes on a broader and deeper meaning beyond just abstaining from the behavior because recovery now also becomes about working on the self to achieve personal growth and regaining what has been lost as a consequence of the addiction.

Overall, this theme of recovery being more than just abstinence is mirrored in findings from previous qualitative research investigating meanings of recovery among individuals with substance use disorders who are engaged in abstinence-based recovery (Costello, Sousa, Ropp, & Rush,

2020; Laudet, 2007), which suggests that the overarching meaning of recovery is likely to be similar regardless of the addictive or compulsive behavior an individual is trying to overcome. Participants' narratives within this theme also corroborate Helm's (2019) observation that while abstinence is as an important component of recovery in all 12-step programs, 12-step members across various 12-step groups tend to emphasize the quality of their recovery as a whole (which manifests in 'emotional and mental sobriety' – Helm, 2019, p. 29) as being more central to the meaning of recovery over just a physical state of being abstinent. An important implication of this is that someone could be abstinent from the behavior at a given moment, and yet be regressing in recovery and at risk of relapse if not vigilant about maintaining the quality of their recovery. In line with this, one participant who reported successfully achieving long-term abstinence from bottom-line behaviors for the past few years stated that he still has to be cautious in maintaining the quality of his recovery, or risk relapse (i.e., *"No, I mean like I said I still have to be careful… [the addiction's] still always in the long grass"* [P12]). In this sense, recovery was also seen as a lifestyle that must be nurtured and maintained for the long-term, even lifelong, because there is always a risk of relapse:

> *It's not a quick fix. It's something I need to work on regularly. Like someone said it's like keeping a garden. Keeping a garden, you have to consistently water, cut things and everything. (P05).*

> *I haven't been to the stage in recovery where [the addiction] just goes away… I don't think that ever happens, I think it's just we spend the rest of our lives just trying to manage it, and managing it, and that. (P09).*

Theme 4: Maintaining a new lifestyle and ongoing work on the self

Since achievement of long-term abstinence was believed to be contingent upon maintenance of quality of recovery, the key task for participants was to develop and execute a strategy that offered them the best chance of continuing to maintain the quality of their recovery for the long-term. Participants' descriptions of what helped them maintain the quality of their recovery can be best summarized as a combination of maintaining a new lifestyle and engaging in ongoing work on the self.

Maintaining a new lifestyle

Two aspects of the SLAA recovery process provided participants with a structure from which to build a new lifestyle that could be maintained throughout their recovery: (i) the three circles framework, and (ii) regular connection with the fellowship.

The three circles framework. The 'three circles' framework (International Service Organization of SAA, 2016) was originally developed and popularized by SAA, but appeared to be informally adopted by many participants even within SLAA. Within this framework, behaviors are allocated into three concentric circles typically in consultation with a sponsor. Behaviors within the inner circle (also known as 'bottom-line' behaviors within SLAA) are behaviors that members want to abstain from, and engaging in these behaviors would be considered a slip or relapse. Example behaviors allocated to this circle by participants included visiting escorts, watching pornography, and having sex outside of a committed relationship. Behaviors within the middle circle are behaviors that are triggering or 'slippery' such that if engaged in, might lead back to inner circle behaviors. Example behaviors allocated to this circle by participants included watching videos with sexually arousing content, not engaging in proper self-care, and dishonesty. Behaviors within the outer circle (also known as 'top line' behaviors within SLAA) are healthy behaviors that enhance recovery. Example behaviors allocated to this circle by participants included exercising, meditating, praying, maintaining a healthy sleep routine, investing time in new hobbies, attending 'S' group meetings regularly, and making regular phone calls to other members.

The three circles framework appeared to provide a sense of clarity to participants about how to structure their lives behaviorally on a day-to-day basis – in essence, avoid inner circle and middle circle behaviors, and focus on practicing outer circle behaviors. Notably, sexual boundary plans using this same framework have been recommended for CSB treatment by clinicians who treat CSB (e.g., Carnes, 2007; Hall, 2019; Weiss, 2015). Weiss (2015) argues that unambiguous definitions of behaviors within inner and middle circles is necessary to avoid impulsive decisions being made during moments of vulnerability about whether certain behaviors are acceptable or not within one's recovery. It should be noted that lists of inner and middle circle behaviors were not inflexible once set – many participants reported modifying and refining these lists over time, in consultation with their sponsors. For example, some participants removed masturbation from their inner circle when it was determined that they were ready to integrate it back into their sexual lives in a healthy way:

> *Masturbation was like a complete 'no' at the beginning…And then over time…I got to relax the masturbation because I was single for most of the time…what I found myself is like once a week is a pretty healthy frequency. (P14).*

Importantly, the middle circle concept was cited by some participants as being particularly instrumental to their recovery, because slipping into

middle circle behaviors was a visible warning sign that the individual was backsliding in recovery. As described by one participant, slips could often be traced back to not being vigilant about avoiding middle circle behaviors:

> *And these middle circles are just bringing me down, and I acted out or I masturbated or I'm watching porn because of these middle circles.* (P02).

It is worth noting that while many participants appeared to benefit from the three circles framework, two participants reported some uneasiness specifically about the process of deciding on their bottom-line behaviors because they perceived that their sponsors' opinions of what should be included as bottom-line behaviors were overly restrictive. For example, one participant described feeling imposed upon by her sponsor to include pornography use and masturbation as bottom-line behaviors although she did not feel these behaviors were a problem in her own life:

> *I don't know if it's SLAA or it's just my sponsor, like… But I thought the bottom lines is for every person it's different. And if like me, I think I don't have a problem right now with porn or masturbating, so I don't want to put it on my bottom lines… But like my sponsor, he really disagrees…that is something that I find quite difficult.* (P06).

This indicates that although some 'S' groups (e.g., SLAA) ostensibly allow for autonomy and flexibility in definition of personal bottom-line behaviors, in practice some attendees might feel pressure to conform to specific norms in definitions of bottom-line behaviors (e.g., pornography use always being included as a bottom-line behavior) that may have developed as a result of the idiosyncratic beliefs and culture of specific groups (since each local group is autonomous and is made up of a unique composition of individuals at any given time – Salmon, 1995). These members might feel reluctant to freely explore what healthy sexuality means to them personally for fear of the group not being supportive of atypical definitions of bottom-line behaviors.

Regular connection with the fellowship. The second aspect of the SLAA recovery process that contributed to a new lifestyle was ensuring that regular contact with the SLAA fellowship was built into the individual's weekly routine. This was achieved through regular meeting attendance (typically once to three times weekly) and phone calls with sponsors and other members. Some members described being part of *WhatsApp* groups with other 'S' group members, which allowed them to set up immediate phone calls with members who happened to be available at the time (e.g., "*The [WhatsApp] group helped a lot because you know since it's distributed and there's so many people, I knew there'll always be someone to help*" [P13]). Phone calls acted either as a coping strategy, to seek support while feeling an urge to act out on bottom line behaviors and/

or while experiencing challenging situations or emotions, or as a recovery maintenance strategy, where calls were built into one's daily routine to 'check in' with other members (called 'outreach calls'). Some members reported that engaging in multiple outreach calls as part of their daily routine was particularly helpful (e.g., *"the regular outreach calls, I was doing three calls a day, every day…that just really helped keep me focused and straight* [P08]").

Regular meetings and phone calls provided avenues for participants to share openly and honestly about themselves and their lives, but also to listen to other members' stories and learn from their experiences:

> *I do believe SLAA works on multiple levels of improvement…One of them is sharing about yourself, creating a level of honesty and being less afraid to voice out exactly what's going on in your life. I spent so many times smothering up and keeping hidden what was going on for fear of further shame and further criticism, so yeah. Learning to talk about me. Hearing from the other stories from others and practical advice from others about dealing with their obsessions. (P10).*

Other benefits of regular interaction with other members commonly described by participants included a sense of identification and belonging (e.g., "*I find people with the same problem…I had a feeling that I was not crazy anymore, and I was not alone*" [P03]) and sustaining motivation in one's recovery through feeling inspired by other (usually senior) members (e.g., "*…how I stayed sober yeah…like those people that are multiple years clean. It's like they really motivate me, and when I see them it's just…I want what they have*" [P05]). Clinicians who treat CSB have suggested that authentic interaction with other recovering individuals within a group setting can be particularly therapeutic for individuals with CSB, because it gives them an opportunity to learn to build intimate relationships with other individuals in a healthy way (Benfield, 2018; Coleman et al., 2018). In line with this, some participants in the present study felt that connection with the fellowship provided a sense of intimacy and connection that they were looking for through their sexual acting out. As described by one participant:

> *I guess it's the same kind of warmth that I was looking for when I was going high I guess…Because yeah you go there now, familiar faces… And it's nice to know each other and help each other and whenever I have problems or when I feel anxious now or whenever I feel something I can do things. I can call someone. I can reach out.* (P05).

Importantly, staying connected to the fellowship through meetings and phone calls was perceived to be so essential to recovery that some participants directly attributed their lapses to not staying sufficiently connected to the fellowship:

> *But like when I was slipping the most, is when I was way more lenient on it. These last few months I've been way more diligent with it, like I've only missed a handful of days where I didn't make all those things, three calls a day, call my sponsor, three meetings a week.* (P09).

> *I haven't used reaching out so much where I've felt in a slippery place. I haven't used a sponsor in the way I should have, and there are probably two reasons why I haven't had a length a sobriety.* (P10)

Participants' experiences generally align with those of SA and SAA members from a previous qualitative study (Ševčíková et al., 2018) who described the three circles framework and phone calls to other members as being particularly effective for dealing with addiction-related symptomatology (e.g., salience, mood modification, and relapse – Griffiths, 2005) during abstinence. Of note, participants in the present study described these tools as useful not just for dealing with these addiction symptoms, but for minimizing the occurrence of these symptoms in the first place through the maintenance of a new lifestyle.

Ongoing work on the self

Many participants reported that in parallel to maintaining a new lifestyle, engaging in ongoing work on the self was key to their recovery. The two main ways by which participants described engaging in ongoing work on the self was through (i) 12-step work, and (ii) psychotherapy.

12-step work. The primary way by which participants reported working on the self was through working the 12 steps with a sponsor. While some participants emphasized 12-step work as being about connection with a higher power (e.g., "*There's 12 steps, right, and the end result, the 12th step, is we had a spiritual awakening. It's all about connecting with a higher power*" [P09]"), other participants also described 12-step work as being about the facilitation of self-examination in order to achieve personal growth and self-improvement (e.g., "*you need to make some steps in the program, what they suggest…within lies personal growth*" [P05]). This is consistent with the idea that cultivation of spirituality within the 12-step recovery process is not only about connecting with a higher power, but also about spiritual growth and character-building (Carroll, 1993). Participants typically highlighted working Steps 4–9 as being particularly transformative, as the process of letting go of their resentment and fears, being aware of their personal weaknesses, and making amends to individuals in their lives that they had harmed was deeply therapeutic and effective for building character. For example, one participant described Step 6 work (where personal weaknesses are explored) as facilitating insight into a major trigger for his sexual acting out:

> *Getting to you know the sort of Step 5 and Step 6 work of getting to know your flaws, your weaknesses, your character defects, I found particularly important because… some real core defects were driving me to what I did and get me into those negative mindset situations which ultimately led to me seeking relief through acting out. (P10)*

Psychotherapy. Apart from 12-step work, most participants also reported engaging in work on the self by receiving psychotherapy for their CSB and underlying issues. Thirteen of the 14 participants reported receiving therapy for CSB at some point in their recovery. Of these, two participants explicitly stated that they received therapy from clinicians who specialized in treating CSB. One of these participants felt that seeing a specialist clinician was particularly crucial to his recovery:

> *Therapy was massive for me, I mean I'm very grateful for the 12 steps, but I think a lot of my big work was done in seeing a specialist sex addiction counselor. I think that was massive for me. Having a professional ear to listen to my issues and help me work my emotions through them… Helping me to look at my family of origin and the patterns that they had since childhood, and how I was repeating these patterns as an adult… They were massive things for me.* (P12).

Although some participants felt that 12-step work was sufficiently therapeutic for addressing their underlying issues and therefore stopped receiving therapy (e.g., "*Now that now I'm no longer in the [therapy] program, I actually don't believe I need more because basically in Step 4 you also go back in the past and talk about it*" [P05]), other participants felt that the 12 steps could not adequately address their underlying issues, especially unresolved trauma:

> *So, psychotherapy. Because trauma is not so well addressed you know in the 12 steps… It's not a direct approach to trauma where we need more strategies to deal with the trauma. It's good to have other tools to be able to cope with that while we work the steps.* (P14).

This perception aligns with those of 'S' group members from a recent qualitative study who perceived therapy as being able to address underlying issues that the 12 steps were not able to (Yamamoto, 2020). Notably, five of seven participants in the present study who reported at the time of the interview that they were still receiving ongoing therapy on a weekly basis described working primarily on trauma-related issues in therapy. For these participants, a combination of 12-step work and professional psychological treatment formed the basis for ongoing work on the self that was a key component of their recovery.

Theme 5: the gifts of recovery

All participants noted significant positive changes in their lives, or 'gifts of recovery' (DeLucia, Bergman, Formoso, & Weinberg, 2015) after being

in recovery for some time. Most of these positive changes can be framed as gifts because these were changes that were not pursued directly, but appeared to manifest in their lives as an effect of their continued practice of their program of recovery. Many participants ($n = 9$) described regaining a sense of control over their sexual behavior as a key change. Some participants highlighted that their compulsion to engage in bottom-line behaviors had largely diminished (e.g., "*those kind of worse behaviors from my acting out have abated. I don't have the compulsion toward them*" [P12]), while others emphasized a sense of self-efficacy in being able to deal with urges even if they were to arise (e.g., "*I mean sometimes I get urges to act out…but I also know that okay, fine, these urges will come and go if I don't act on them*" [P11]).

Importantly, many participants described undergoing profound personal transformation that went beyond just being able to abstain from their bottom-line behaviors. One participant felt that he was even a better version of himself than before the onset of his addiction:

> *I have to say I'm grateful for my addiction because I believe I'm a better version of myself before I even picked up my first drug or acted out.* (P01).

Positive changes relating to increased strength of character and resilience ($n = 6$), greater emotional stability ($n = 5$), increased sense of gratitude ($n = 5$), increased self-acceptance ($n = 4$) and increased sense of meaning ($n = 1$) were described by participants. However, the most frequently cited change was an increase in other-centeredness and love ($n = 10$), which might be an outcome of the emphasis on the overcoming of self-centeredness as a key aspect of spiritual growth within the 12-step program (Tonigan et al., 1999). This was described by one participant:

> *So as long as I'm in my addiction, I'm thinking about myself. You know, I'm worried about what's happening to me, what can I get for myself. But when I'm in recovery, I start thinking about other people, what can I do, how can I contribute… How can I help this other person, how can I become a better father, better husband, better friend.* (P09).

Some participants ($n = 6$) also reported that the overall quality of their lives had improved, where increase in life satisfaction, increase in positive emotions, improvement in occupational functioning, and a sense of life flourishing (Keyes, 2002) were described. For instance, one participant described that the extent to which his whole life was different now compared to the past was previously beyond his "wildest dreams":

> *But I'd say right now I have a life beyond my wildest dreams. I'm married, I love my wife, um I enjoy her company. I express my feelings and my emotions to her. And God willing, we'll have a baby boy in three months' time… These are things I couldn't have imagined.* (P12).

Collectively, the positive changes in participants' lives appeared to not only be about the alleviation of CSB symptoms. Because a holistic plan of recovery (that focused on maintenance of a new lifestyle and ongoing work on the self) was needed in the first place, the outcome appeared to be holistic transformation of themselves, and by extension, their lives. For some participants, these positive changes were somewhat reminiscent of the "better than well" phenomenon (Best & Aston, 2015, p. 177; Hibbert & Best, 2011) previously observed among individuals recovering from substance use disorders, where the recovery process appears to lead the individual not merely back to a 'normal' state, but to a quality of life that may even transcend that of the general population. Finally, it also appeared that because these positive changes were so rewarding, they served to further reinforce participants' motivation to sustain commitment to their recovery and abstinence from bottom-line behaviors.

General discussion

The present qualitative study used inductive thematic analysis to explore how members of an 'S' group (i.e., SLAA), describe and make sense of their experiences of recovery from CSB. A key contribution of the present study is that an open-ended, bottom-up approach to data collection and analysis was used in exploring the CSB recovery experience as a whole among SLAA members. One advantage of this approach was that it was possible to observe how participants made sense of the entirety of their recovery experience without feeling restricted to speak about it only within a narrow context (e.g., a 12-step context). Since all participants were active long-term members of SLAA, it is unsurprising that they made sense of their recovery experiences primarily from a 12-step lens. At the same time, it is noteworthy that most participants appeared to have sophisticated views of recovery that drew upon not only 12-step spiritual concepts, but psychological concepts likely assimilated through their experiences in therapy (e.g., CSB developing as a result of underlying psychological problems such as unresolved developmental trauma or insecure attachment). This observation makes sense in light of the fact that almost all participants reported undergoing some kind of psychological treatment for CSB either in the past or present. Participants tended to emphasize the holistic and multidimensional nature of their recovery (Costello et al., 2020; Dodge, Krantz, & Kenny, 2010), which involved change across cognitive, affective, behavioral, social, and spiritual dimensions. Data on 'S' group membership are scarce, but a recent membership survey of SAA ($N = 2{,}190$) found that 67% of members had undergone therapy before attending SAA, and 81% were still undergoing therapy while attending SAA (International Service

Organization of SAA, 2019). Taken together, this suggests that many 'S' group members do not take a purely 12-step perspective of recovery, but use the 12-step program as one tool among many in their recovery.

Nonetheless, with regards to the 12-step recovery process itself, regular connection with the fellowship was emphasized by most participants as being particularly instrumental in their recovery, in line with previous qualitative studies that have shown that individuals recovering from CSB across various recovery communities (e.g., religious communities – Perry, 2019; online recovery forums – Cavaglion, 2008; Fernandez et al., 2021; individuals receiving group treatment for CSB – Hall & Larkin, 2020) tend to highlight receiving ongoing support from other recovering individuals as being crucial to their recovery. Beyond meeting attendance, frequent (sometimes daily) phone calls with other 'S' group members appeared to play an important role in the SLAA recovery process. The present analysis suggests that social support received from other members in the fellowship, especially in between meetings, could be an important mechanism of change in 'S' groups beyond 12-step work (cf. Efrati & Gola, 2018a), and warrants further exploration in future quantitative studies of 'S' groups.

Overall, the present analysis indicates that 'S' groups such as SLAA appear to be an invaluable resource for individuals recovering from CSB, particularly due to the virtually constant social support available to members by other members. At the same time, it is important to note that the present analysis also suggests that 'S' group participation might not be suitable for all individuals with CSB. While all 14 participants appeared to benefit from the 12-step recovery process overall, two participants expressed difficulties with one aspect of the SLAA program in particular – the subjectivity of the process of defining bottom-line behaviors with a sponsor (i.e., both felt that their sponsor's opinion on what should be considered acceptable behavior in recovery was overly restrictive). This suggests that some 'S' group attendees could feel pressure to conform to specific norms in definitions of bottom-line behaviors that may have developed as a result of the idiosyncratic beliefs and culture within individual 'S' groups. Therefore, individuals who wish to explore atypical definitions of bottom-line behaviors or non-abstinence goals (e.g., moderation in lieu of complete abstinence from problematic sexual behaviors) might not feel comfortable participating in a specific 'S' group if they perceive that these goals will not be supported by other members. In addition, because the present sample was self-selected and comprised individuals who were long-term, active 'S' group members, the present analysis is likely to emphasize positive experiences over negative experiences within 'S' groups. As such, there may be other potential deterrents to 'S' group participation that have not been captured by the analysis.

Qualitative research that purposively samples members who have had predominantly negative experiences within 'S' groups (see, for example, Glassman, Rhodes, & Buus, 2020) is needed to more fully understand further potential limitations and/or harms of 'S' groups.

Study limitations

This study has some limitations that warrant acknowledgement. First, although all participants self-identified as being in recovery from 'sex addiction' or CSBD, no clinical interview was conducted to verify whether participants did indeed meet CSBD criteria as outlined in the ICD-11. Second, the sample comprised primarily heterosexual male members of a specific 'S' group (i.e., SLAA) who identified as having 'love addiction' in addition to 'sex addiction' or CSBD, many of whom also had a history of co-occurring mental health conditions and/or substance use disorders. Recent research has shown that the majority (91.2%) of individuals with CSBD report a history of comorbid Axis I clinical conditions, while a smaller proportion (16.2–22.1%) report a history of substance use disorders specifically (Ballester-Arnal, Castro-Calvo, Giménez-García, Gil-Juliá, & Gil-Llario, 2020). This suggests that while having co-occurring mental health conditions is generally representative of the typical individual with CSBD, there may be an overrepresentation of individuals with a history of co-occurring substance use disorders in the sample. Therefore, the present findings may be limited in their transferability to 'S' group members who do not match these aforementioned sample characteristics. Finally, the present study's focus on mapping out patterned meaning across the dataset meant that individual differences in various aspects of the recovery experience could not adequately be accounted for in the analysis. Future qualitative studies employing idiographic methods (e.g., interpretative phenomenological analysis) with smaller sample sizes are needed to address this specific limitation.

Conclusion

Although many individuals recovering from compulsive sexual behavior (CSB) worldwide participate in 'S' groups, there has been a paucity of empirical research on 'S' groups when compared with 12-step groups for substance use (e.g., AA and NA). The present qualitative study contributes to the this gap in the literature by analyzing the lived experiences of CSB among members of a specific 'S' group (i.e., SLAA) using a bottom-up approach, and provides insights into how SLAA members describe and make sense of their recovery journeys. Moving forward, more qualitative and quantitative research on 'S' groups in general is needed to continue

to build a deeper and more complete understanding of the recovery experiences of 'S' group members and the specific 'S' group processes that contribute to successful CSB recovery.

Notes

1. Although the 12-step program often refers to a 'God' or a 'higher power' of one's own understanding, religious affiliation or belief in a personal God is not required for 12-step membership. Members are encouraged to establish a connection to a 'power greater than oneself' that can guide and provide inspiration for their recovery – for some this might be a personal God, but for others this may be trust in the 12-step fellowship, or connecting to a sense of one's fullest potential, humanity or to the universe (Borman & Dixon, 1998; Parker & Guest, 2002; Ziff, 2019). Spirituality within the 12-step recovery process also consists of the practicing of 'spiritual principles' such as honesty, open-mindedness, and willingness (AA, 1939; Carroll, 1993).
2. Since 'S' groups primarily conceptualize their problematic sexual behavior using an addiction model, the terms 'sex addiction' or 'pornography addiction' were used instead of 'compulsive sexual behavior' when interacting with participants throughout the study. Language of addiction is also used throughout the data analysis to stay true to terminology used by participants in the interviews.
3. SLAA is the only 'S' group that makes explicit reference to 'love addiction' in addition to (and in tandem with) sex addiction in their program (see SLAA FWS, 1990). Love addiction as a construct has not been clearly defined in the scientific and clinical literature. In existing conceptualizations of love addiction, what exactly someone is addicted to when addicted to 'love' has ranged anywhere from the feelings of romantic love present in the early phases of a new relationship, to a single object (or multiple objects) of desire, or to the romantic relationship itself (Costa, Barberis, Griffiths, Benedetto & Ingrassia, 2021; Hall, 2019; Redcay & Simonetti, 2018; Sanches & John, 2019; Sussman, 2010; Weiss, 2015). SLAA takes a broad view of love addiction – seeing it as manifesting in unhealthy emotional dependency on one or more love objects, preoccupation with romantic fantasies, having serial relationships, or any combination of these (Parker & Guest, 1999).

Disclosure statement

The authors declare that they have no conflict of interest.

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Appendix A

Interview schedule

1. Could you share a little bit about your sex addiction history?
2. What made you realize you had an addiction?
3. What were the consequences of not being able to regulate your sexual behavior?
4. What motivated you to start trying to change your behavior/recover from your addiction?
5. What are your goals in recovery?
6. What are some challenges you have faced so far in your recovery? How have you been attempting to overcome them?
7. What specific resources/strategies have you been using in helping you to achieve your goals in recovery?
8. What has life in recovery been like for you? What is life like now, compared to the past?

Appendix B

Illustrative example of the progression of coding from a basic code to a higher-level category

Interview excerpt	Basic code	Basic codes merged to form higher-level category
"I remember like, as an addict, my life was terrible… I had a package of missing things at work… Missing things in a relationship, my faith, my school… So, everything was terrible. We're not talking about fixing that… hey you stop watching pornography. It's not about that. It's about fixing all the amazing things that I can have in my life… Then yes, I can move on to stop watching pornography. And that's what I'm experiencing today. Because I'm fixing all the things that I just missed with in the past… And that helps me to stay away from pornography…" (P02)	Fixing life first, then abstinence comes	Recovery is about getting one's life in order
"Yeah, first was more just to stop the behavior… stop the pornography and the chatting and I didn't want to do that anymore. But I must say at some point it also more shifted like… Um… That I was more working on creating a life I didn't want to escape from anymore. So, it was also more about not doing something but more about… yeah, working on all the other parts of my life… my relations, my financial situation, my work, my whole work-life balance my… so, work on all of those a lot." (P03)	Goal in recovery to create a life he didn't want to escape from anymore	Recovery is about getting one's life in order
"What I learned after a year or so at SLAA is it's not fighting the addiction, it's just getting your life in order that's important. It's about regulating, it's about doing positive things. And over time, the obsession for sex or needing that closeness or that love relationship dissipates, and you get on with your life and doing the things you should be doing, and having much more positive mindset, far more mindful." (P10)	Recovery not about fighting the addiction but getting life in order	Recovery is about getting one's life in order