Internet Infidelity: An Examination of Family Therapist Treatment Decisions and Gender Biases

by

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(ABSTRACT)

The Internet is being used more and more frequently as a way for people to meet. The Internet also provides increased opportunities to initiate couple relationships, as well as affairs. The present study adds to the existing literature base in Internet infidelity treatment as well as therapist conceptualization processes.

The present study investigated how family therapists assess and treat Internet infidelity. It assessed whether gender and other social background variables of therapists are operating in treatment decisions. Specifically, this study provided three clinical vignettes to 508 practicing marriage and family therapists and asked them several treatment and assessment questions about the cases while manipulating the gender of the clients in the vignettes. The questions asked of clinicians assess the clinician's prognosis of the case, the clinician's treatment strategy, how many sessions might be necessary, and how severe the clinician perceives the problem. Results include:

a) treatment decisions of therapists regarding Internet infidelity cases
b) information as to whether the assessment and treatment decisions vary according to the gender of the clients in Internet infidelity vignettes
c) whether the treatment decisions vary depending on the clinician's social background characteristics (such as age, religiosity, gender).

The results indicate that therapists who are more religious tended to view Internet infidelity as that which might require a greater individual focus. Age and gender of the clinicians also affected how therapists used treated cases, with younger clinicians more likely to alter environmental issues and female clinicians more likely to focus on couple processes in treatment. Further, clinicians also viewed men as more likely to be sex addicted, while women engaging in the same behavior were viewed as atypical for engaging in the same behavior. Clinicians also

made differential decisions in treatment based on client needs, client gender, client health, and their personal theoretical orientation.

This study sheds light on the role of specific identity variables in treatment decisions. It also provides a foundational knowledge of the treatment of Internet infidelity that will serve as a springboard for future projects to examine the effectiveness of different treatments, develop treatment protocols, and elevate the standard of care for this increasingly prevalent presenting problem.

For Shirley

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CHAPTER I: INTRODUCTION

"I liken an affair to the shattering of a Waterford crystal vase. You can glue it back together, but it will never be the same again."

- John Gottman

Statement of the problem

Infidelity has long been a concern for couples, families, and martial and family therapists (Atkins, Baucom, & Jacobson, 2001). Though a relationship with someone other than one's partner might manifest itself physically or emotionally, the bottom line is the amount of shared time between one spouse and another individual outside of marriage (Glass, personal communication, September, 2002). The issues that become problematic between the primary couple are often the time, energy, and resources that are spent to maintain another relationship while the primary relationship, starved of attention, intimacy, and energy, suffers (Moultrup, 1990).

Though the incidence of extramarital affairs in our society changes from study to study, one aspect of these relationships remains stable: the impact created by extramarital relationships on the marriages of their participants can significantly damage relationships. In addition to the psychological impact of infidelity on both partners, such as guilt, betrayal, loss of trust, loss of identity, and anger (Spring, 1996), there are additional physiological impacts, such as stress, exhaustion, and chronic agitation (Spring, 1996). As a result, it is important for marital and family therapists to understand the processes in families and marriages in which at least one person has engaged in infidelity.

Technology can enhance a couple's life together. Therapists can use the Internet for sexual or marital enrichment of their couples in therapy (Schnarch, 1997). Technology has allowed couples to communicate via email or instant messenger during a busy workday. The coupling of the personal computer and access to the Internet allows couples to send pictures and other digital images such as short movies to each other as well as to friends and family across the globe. Couples can enjoy sending e-cards to one another or love letters through an instant medium. Long distance relationships become easier to maintain in an age of instant communication. Couples can even enjoy free time together interacting via online games or an

MMORPG (Massively Multiplayer Online Game). Couples have the opportunity to stay connected in a way they never have had before.

Nevertheless, just as technology can benefit a couple's relationship, it has also demonstrated it can complicate a couple's life. One of the uses involves its role in facilitating Internet infidelity. Recently, the Chicago Tribune reported the story of a couple recovering from Internet infidelity (Kampert, 2002). The relationship between one of the spouses and another individual began simply enough – deriving from everyday conversation over the computer with one another. But this relationship became more personal and eventually turned toward cybersex, which Kampert (2002) defines as an "Internet practice in which people send instant messages to each other with the details of what they would do to each other if they were face to face at that moment." When the affair was discovered, the implications were devastating for the married couple.

The Internet has three factors that contribute to Internet infidelity. First, computers with Internet service are easily accessible, and therefore provide a medium for easily engaging in building emotional and physical intimacy with another person (Cooper, 2000; Cooper, 2002). Internet access can be found in the home, in the workplace, airports, hotels, in Internet cafes, and can even be a service with laptops. Since laptops are easily portable, the access to the Internet can travel with an individual.

Secondly, the Internet is affordable (Cooper, 2000; Cooper, 2002). The cost of Internet service presently ranges anywhere from $10/month to $60/month, considerably cheaper than dating. Finally, the Internet provides anonymity (Cooper, 2000; Cooper, 2002). Computer users can type, backspace, and retype messages in a way to present themselves in any manner they wish. Rarely, in face-to-face communication does one have the opportunity to edit words and actions without reaction from another person. Additionally, individuals using the Internet as a form of communication can choose to represent themselves any way they wish.

Internet relationships fit well into the definition of emotional infidelity by having emotional infidelity's three components – emotional intimacy, secrecy, and sexual chemistry. (Glass, 2002). One's level of emotional intimacy with another online is in some ways determined by how much each shares with the other. One can discuss a hectic workday, reflect on their innermost feelings and thoughts, or share things which lie somewhere in the middle.

Secrecy is also critical in that the individual engaging in the Internet infidelity can quickly close chat windows being used, delete transcripts, and purge their email boxes (Schneider, 2000). Additionally, what might appear as one typically working in their cubical or at on a home PC may actually be an individual secretly engaging in cybersex. Finally, sexual chemistry is present when it becomes easy to flirt or share sexual fantasies online.

As in conventional infidelity, the partner who has been affected by Internet infidelity has the burden of wondering whether the affair was actually stopped (Glass, personal communication). Not only is the Internet accessible to many in many different places, but there are no receipts from hotel rooms, from dinner dates, or any other evidence of the affair. Internet affairs are often discovered because the trace of emails and chat room conversations can be found by suspicious partners (Glass, personal communication). This level of secrecy can also impact the ability to build trust between the individuals in a relationship.

Given the recency of Internet use, there is no consensus on the treatment of Internet infidelity and the incidence of Internet infidelity cases is increasing (Harris Poll, 2001). Since there is presently no agreement on how to treat Internet infidelity based on the variety of frameworks in the literature, clinicians might rely on personal values and/or biases in assessment and treatment of Internet infidelity. The purpose of this project is to identify the impact of social background characteristics such as gender of clinicians and clients in the assessment and treatment of Internet infidelity cases. The completed results will be used to develop a treatment protocol for Internet infidelity cases.

Two theories emerge as relevant in the context of discussing how therapists conceptualize and treat Internet infidelity cases: postmodernism and feminism. Postmodernism challenges the notion of objectivity and provides a different view of looking at phenomena (Doherty, 1999). As far as its relationship to Internet infidelity, postmodernism tests the definition of infidelity and allows therapists to consider Internet infidelity as a legitimate type of infidelity.

Feminism informs the present study since therapists' biases toward the gender of the extramaritally involved individual might affect the conceptualization and treatment of Internet infidelity cases. A growing body of literature indicates therapists perceive and therefore treat men and women differently (e.g., Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972). One example is in the treatment of presenting problems that are sexual in nature (Hecker, Trepper, Wetchler, & Fontaine, 1995). Differential treatment might also affect how therapists

assess Internet infidelity cases. In Internet infidelity cases, therapists might treat women differently than men, as they may expect infidelity behavior more from men (based on percentages publicized in the popular press) but not from women.

Significance of the Problem

Internet Extradyadic Relationships

Recent statistics indicate individuals visiting romantic websites increased almost 50% in the last year, with 30 million people on these sites (Maheu & Subotnik, 2001). There is little empirical data on the phenomenon of Internet infidelity (Hatala, Milewski, & Baack, 1999). Initial studies suggest that computer users are displaying more uninhibited behavior than in face-to-face communications (Cooper & Sportolari, 1997). One survey found that 75% of US adults report they use email to flirt with someone to whom they are attracted ("The Email Dating Game", 2001). Cooper, Scherer, and Mathy (2001) found that approximately 20% of all Internet users report engaging in some sexual activity online.

Likewise, Internet Infidelity is also becoming a primary concern for clinicians (Shaw, 1997). It is incumbent upon therapists to examine the validity of case conceptualizations and assessments of Internet infidelity cases, as well as to connect how the assessments and case conceptualizations affect intervention strategies.

Statements of Hypotheses

The research seeks to answer two broad sets of questions. The first asks, "What do therapists do when they assess and treat Internet infidelity?" The second question asks, "Do social background characteristics of the clinician or client influence therapists' treatment decisions?" Based on these questions, the hypotheses are as follows:

H_1 = Assessment and treatment of Internet infidelity cases will be affected by social background factors of clinicians.

H_2 = Therapists will treat cases where a woman is engaging in Internet infidelity differently from those where a man is engaging in Internet infidelity.

More specifically, this study seeks to understand the influence of client gender on assessment and treatment in Internet infidelity cases. This project also seeks to know whether the therapist's gender, age, and religion affect assessment and treatment decisions in Internet infidelity cases.

The objectives of this project are:

1) To learn how therapists assess and treat three examples of Internet infidelity:
    a) Flirtatious conversation
    b) One spouse engaging in intercourse with an individual s/he met online
    c) One spouse exploring pornography sites online;
2) To examine if therapists' assessments and proposed interventions are related to the gender of the involved spouse;
3) To examine if therapists' assessments and proposed interventions of the seriousness of a case vary according to the clinician's a) gender, b) age, and c) religiosity.

The present study will inform marriage and family therapists as to what therapists do when they assess and treat Internet infidelity, as well as whether gender of the identified client or social background variables of the clinician affect clinicians' treatment decisions.

Research Questions

i) Do marriage and family therapists' assessment and treatment decisions in cases of Internet infidelity change depending on the gender of the identified client?
ii) Do the assessment and treatment decisions made in cases of Internet infidelity vary when examined in terms of therapist social background variables, such as age, gender, religion, marital status, and whether they report they have been impacted by infidelity in their lives?

These questions were answered through both quantitative and qualitative methods.

CHAPTER II: REVIEW OF THE LITERATURE

"Now, just what is infidelity and how can we get involved?"

- Dabney Coleman (Pittman, 1989)

"…aside from the cheating, we were a great couple. I mean, that's what high school was about – algebra, bad lunch, and infidelity."

- Dante, from the movie, "Clerks"

Infidelity and its Meaning

Infidelity, in its most basic form, refers to the breaking of trust (Lusterman, 1998). Historically, infidelity has been viewed several different ways over cultures and over time. In present society, it refers to a situation when one partner in a committed relationship engages in a relationship with someone other than the spouse, whether that involvement is emotional, physical, or has components of both (Thompson, 1983).

Infidelity has been viewed as the vehicle that disrupts marriages (Atkins, Baucom, & Jacobson, 2001) but also as a context for passionate relationships (Pittman, 1989). Infidelity has been tied to pathology, unsatisfactory marriages, passionate romances, and complex relationships (Moultrup, 1990). Moultrup (1990) stated infidelity might give couples variety in their sexual lives. Additionally, others have tied infidelity to being critical to marital survival because it gives couples much needed space (i.e., Weil, 1975). Due to the varying nature of infidelity and its definitions, researchers have sought to understand the phenomenon behind infidelity.

Marital infidelity is not always about sex (Moultrup, 1990). [1] Infidelity can occur in a number of ways as well as in a number of situations. Moultrup (1990) stated: "An affair can be defined more clearly in terms of the behavior involved." (p. 10). In this light, infidelity takes on different meaning for couples and therapists. The varying ideas about the nature of infidelity is partially linked to the ever-changing societal contexts in which "couples" and "sexuality" are embedded. Specifically, infidelity and its research have been viewed as impacted by the

[1] The definition of infidelity is not restricted to extramarital sex. Glass and Wright (1988; 1997) note that extramarital sex and extramarital involvement are not interchangeable terms. Extramarital sex is restricted to sexual intercourse, where extramarital involvement includes other sexual behaviors and emotional involvement. The definition of infidelity is discussed at a later point.

predominant philosophical theories during which the research is conducted (Lindenbaum, 1995). The path of infidelity research in varying contexts is discussed below.

The Path of Infidelity Research

As aforementioned, research in sex has been influenced by philosophical changes and changes in society's views (Lindenbaum, 1995). Just as context changes, the way individuals, couples, and therapists view sexual behavior changes. Infidelity research has evolved over time in a similar fashion. The beginnings of infidelity research attempted to understand epidemiological status of infidelity among people and how other demographic factors affected infidelity (Lindenbaum, 1995).

From the start of the research in sexuality (and infidelity included), researchers have attempted to determine concrete incidence and prevalence of infidelity. More recently, research in sexuality has moved to promote social change through turning attention from demographic variables to examining individuals in context (Gagnon, 1975). The evolution from demographic influences on sexual behavior to other systemic factors has occurred in the areas of theoretical orientation and methodology.

As far as theory evolvement in infidelity research, the research has shifted from using early behavioral theories to explain infidelity to theories that are more postmodern in nature, such as narratives. For example, research in infidelity has started with some of the behavioral equity theories and has now moved into the area of narratives and other treatments (Atwood & Seifer, 1997).

Early researchers in sexuality include Freud, Ellis, Sanger, Mead, Kinsey, and Masters and Johnson (Bullough, 1998; Gagnon, 1975; Gagnon & Parker, 1995). The methodology used by these early researchers was impacted by world economy and politics (Gagnon & Parker, 1995). For example, as a result of the difficulty that Eastern Europe was experiencing after World War II, the center of sex research moved from Europe to the United States (Gagnon, 1975). As a result, research in sexuality was influenced by American values. For example, consistent with American values of individualism and autonomy, sex researchers moved from qualitative methods such as interviews and life histories as a way to study sexuality to using surveys as the primary method of gathering data (Gagnon & Parker, 1995). Another example of sexuality research influenced by American society and context was the emphasis in the 1960s

and 1970s on examining sex and pleasure, thus reflecting similar cultural values at the time (Gagnon, 1975).

The primary emphasis on collecting data through surveys had a great deal of emphasis during the 1940s through the 1960s. In the 1960s and 1970s, sexuality researchers added lab observation and experimentation to the methodology tool bag. Additionally, the 1970s, with their postmodern emphasis, introduced ethnography as a method for studying sexuality. Finally, the 1980s brought other existing methodologies in the social sciences for application to the study of sexuality (Gagnon & Parker, 1995).

Infidelity studies, specifically, began to change what was being explored. Studies moved from an emphasis on how social background characteristics are related to infidelity toward understanding what variables (systemic and individual) contribute to infidelity. Thompson (1983) challenged research in infidelity to move beyond just looking at incidence and prevalence of engaging in infidelity:

> It is unlikely there is much more to be gained than currently exists from large surveys that have as their major objective the investigation of incidence rates and wholesale correlates. Such efforts are best saved until there are considerable empirical and theoretical advances in the understanding of extramarital behaviors. (p. 7).

In response to the call for further theoretical and empirical research in infidelity, researchers have used path diagrams in an attempt to understand infidelity and related variables such as extramarital sexual permissiveness (i.e., Reiss, Anderson, & Sponaugle, 1980).

The Problem of Infidelity in Clinical Work

Infidelity has been a concern for couples coming to therapy. Whisman, Dixon, and Johnson (1997) randomly selected couples therapists and asked them to complete a survey regarding what couple issues are prevalent in therapy. The couple's therapists reported that infidelity was one of the most common problems faced by couples in therapy.

Sprenkle and Weis (1978) reported 30% of their couple cases were impacted by infidelity at initial intake. However, after the therapist and couple joined, 60% of the cases reported infidelity as a concern. Infidelity continues to be a significant and important concern in the therapy room (Atkins, Baucom, & Jacobson, 2001).

Incidence and Prevalence of Infidelity

The incidence and prevalence of infidelity vary from study to study. When Kinsey (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) published their studies on sexual behavior in the late 1940s and early 1950s, not much was reported or known about the sexual behavior of everyday citizens. Kinsey and his colleagues performed one of the first inclusive studies on human sexual behavior (Bullough, 1998; Kinsey, et al., 1948; 1953). In doing so, Kinsey et al. (1948; 1953) established a baseline for further studies and research in the field of human sexuality.

Within the sexuality studies, Kinsey et al. (1948; 1953) reported prevalence of infidelity cases at approximately 30%. The percentages varied based on the gender of the involved spouse, but also varies from study to study. For example, in the 1970s, the Hite report indicated the number of women engaging in infidelity was closer to 70% as opposed to the approximate 30% established by Kinsey et al. (1953). Nass, Libby, and Fisher (1981) cited the percentage of persons who had engaged in infidelity as 45% for women and 55% for men.

Laumann, Gagnon, Michael, and Michaels (1994) explored trends of engaging in infidelity for a variety of cohorts as well as providing a total among the cohorts. The Laumann et al. (1994) study also provided evidence of the individuals reporting extramarital involvement. Approximately one quarter (24.5%) of the men in the Laumann study reported they engaged in infidelity, where 15% of women reported the same thing.

Finding Meaning in Incidence Statistics

In the previous section, the incidence of engaging in infidelity is presented and varies from study to study. However, infidelity studies have fallen short at exploring why the incidences differ for men and women from study to study. The variability of incidence from investigation to investigation is likely due to several factors. First, the sample from which the researchers obtained their information has changed from study to study. Kinsey (1948; 1953), for example, did not use a random or representative sample (Terman, 1948). Athanasiou and Sarkin (1974) used individuals who responded to a magazine call advertising the study and asking for participants. Likewise, Athanasiou and Sarkin's (1974) participants (those who volunteered to discuss their sexual habits and readers of the magazine) may constitute a non-representative sample.

Another idea that might be behind the discrepant statistics is the underreporting of extramarital behavior. First, not reporting extramarital infidelity might relate to social desirability (Thompson, 1983). Respondents in these surveys may be less willing to provide information about engaging in infidelity, given the negative light in which infidelity is commonly viewed. As a result, infidelity researchers have used strategies such as the foot-in-the-door technique (Freedman & Fraser, 1966) to combat the social desirability problem (e.g., Drigotas, Safstrom, & Gentilia, 1999).

Another factor potentially affecting incidence of engaging in infidelity is the lack of longitudinal studies and inability to account for "accumulative incidence" (Thompson, 1983). Typically, studies in infidelity do not calculate one's likelihood of engaging in infidelity through one's lifetime. As a result, someone married one year participating in a survey might engage in infidelity later in his/her life, but not at the time of the study. Longitudinal studies would address this problem, but few are done in infidelity research (Thompson, 1983).

The definition of infidelity from study to study may affect incidence rates from respondent to respondent and study to study. For example, asking someone "Have you engaged in infidelity?" might get a different answer than "Would you want your spouse to see the way that you interact with a specific co-worker?" Thompson (1983) addressed this issue when he states,

> Although the authors of [infidelity] surveys appear to have been predominately referring to non-consensual, extramarital sexual intercourse, it cannot be assumed that respondents always took this meaning. (p. 4).

Thompson (1983) presented a solution to the dilemma of reporting incidence rates. Rather than considering the incidence of infidelity from an individual perspective, it may be better to consider incidence within relationships. Calculating the percentage of relationships in which infidelity has occurred may provide more accurate incidence reports as well as be more helpful for marriage and family therapists when considering the context of infidelity.

Social Background Characteristics Related to Infidelity

The attempt to connect social background variables with sexual behavior, known as "sexual demography," is used a great deal in attempting to understand infidelity (Liu, 2000). Much work has been done using social background characteristics to attempt to identify the "predictors" of engaging in infidelity. Such work has often pointed to identifying social

background characteristics as those factors significantly related to infidelity. Thompson (1983) reported, however, there have been no consistent results when considering the impact of social background characteristics and their relation to infidelity. Researchers have yet to identify the consistent contribution of therapist education, age, gender, and other social background variables in the assessment and treatment of Internet infidelity cases.

Reiss, Anderson, and Sponaugle (1980) identified nine variables that correlated with the onset of extramarital coitus through a regression analysis. Social background characteristics such as age, political liberty, marital satisfaction, premarital sexual permissiveness, and gender equality in the relationship accounted for 17% of the variance related to infidelity.

The information regarding social background characteristics is related to the present research project. One of the hypotheses is that the social background characteristics of both the client and the therapist affect the assessment and treatment of the case. Gender, geography, educational level, religion, and age are discussed below.

Gender

Gender was initially the most consistent predictor of infidelity (Greeley, 1994; Johnson, 1970). Previously, men were thought to be much more likely to engage in extradyadic behavior than women, and are more willing to disregard their own relationship when presented with the opportunity to engage in extradyadic relationships (Seal, Agonstinelli, & Hannett, 1994). The reason for this may be opportunity. Since men typically worked outside of the home and women stayed home, it was believed men might have had more opportunity to find partners (Greeley, 1994). In other words, opportunity influenced likelihood of infidelity for men, but not for women (Liu, 2000).

Other authors and researchers disagree. Norment (1998) stated women may engage in infidelity just as much as men their age. Hurlbert (1992) reports that women younger than 25 are more likely to engage in extradyadic sex than women older then 25. Proposed reasons are: loneliness, to escape the monotony of marriage, revenge, sexual excitement, a desire for emotional intimacy, a self-esteem boost, or what he termed the “little woman syndrome”, where a woman works outside of the home just as the man, but is still expected to care for all of the household duties (Norment, 1998).

Finally, other authors suggested the reason men are more likely to engage in infidelity is biological in nature, influenced by different reproductive strategies (Treas & Giesen, 2000).

However, accurate statistics regarding gender are more difficult to ascertain because more women respond to surveys about infidelity (Brown, 1991). Additionally, women and men may have different sexual permissiveness values, possibly leading to gender differences (Treas & Giesen, 2000).

However, other research has determined there is little difference between men and women in the likelihood of engaging in infidelity. Oliver and Hyde (1993) examined several studies looking at gender in infidelity. Their meta-analysis revealed that the difference between men and women decreased as the age of the respondents was younger. In other words, the difference between men and women in likelihood of engaging in infidelity is diminishing. Weiderman (1997) found no difference in engaging in infidelity for men and women who were less than 40 years old.

In relation to the present study, both men and women have access to the Internet – at home and/or at work. Either spouse can access the Internet relatively easily. No longer is the profile of a working man with a wife at home the only type of individual engaging in infidelity. Women, working either out of the home or in the home, might have equal opportunity for engaging in Infidelity online.

Gender is important to consider as a factor in infidelity, because it is important when considering how clinicians assess cases. For example, if a therapist believes that men tend to engage in infidelity more often than women and is seeing a couple where a woman has engaged in infidelity, the therapist might view the women as more pathological because it does not fit the norm (Hecker, Trepper, Wetchler, & Fontaine, 1995).

Geography

Women from the mountain or prairie states tend to be more conservative, and therefore the least likely to engage in extramarital sex (Bell, Turner, & Rosen, 1975; Kim, 1969; Kinsey et al., 1948; Thompson, 1983). Although researchers have found people living closer to a city are more likely to engage in extradyadic relationships (Bell, Turner, & Rosen, 1975; Kinsey et al., 1948; Thompson, 1983), this may be a result of the different and more permissive sex values associated with a city more than geography (Treas & Giesen, 2000).

Education

Education has also been found to be a significant predictor in extramarital coitus, but with conflicting results. The higher the education, the more likely a female engaged in

extramarital coitus (Buunk, 1980; Kim, 1969; Kinsey et al., 1948; Thompson, 1983). Reiss, Anderson, and Sponaugle (1980) found those with higher educational levels were also shown to be more likely to engage in infidelity, supporting Thompson's (1983) and Buunk's (1980) results. In other studies, the lower the education, the more likely a female engaged in extradyadic sex (Johnson, 1972; Wyatt, Peters, & Guthrie, 1988a; 1988b). Due to the conflicting results, the present study does not set limitations of the educational status of individuals in the infidelity vignettes.

Religion

Another factor identified in the literature of conventional infidelity is religion. Lower levels of church attendance are significantly related to engaging in an affair (Buunk, 1980; Greeley, 1994; Kim, 1969; Kinsey et al., 1948; Kinsey et al., 1953; Thompson, 1982; 1983; Treas & Giesen, 2000). The more devout respondents reported they were, the less likely they were to engage in extradyadic relationships. Liu (2000) found attending church was related to a lower likelihood of engaging in infidelity for men, but not for women.

The current project also seeks to understand the impact of the therapist's religiosity on the assessment of cases. Researchers have examined the relationship between religiosity and assessment of sexual behavior on the part of the clinicians (i.e., Hecker, Trepper, Wetchler, & Fontaine, 1995) and found highly religious clinicians rated clients in sexuality vignettes as more pathological than clinicians with lower levels of religiosity.

Age

Age is another identity variable on the part of the clinician of interest in the present research. Edwards and Booth (1976) found age was related to infidelity for husbands, but not for wives. In fact, they state that age was the only variable of the 18 they examined which was "consistently predictive of male-female behavior…" (p. 80).

Atkins, Baucom, and Jacobson (2001) examined infidelity and data from the General Social Survey from 1991-1996. They found men between the ages of 55-65 were most likely to have engaged in infidelity, and women in the age group of 40-45 were more likely to have engaged in infidelity than other age groups.

Duration of relationship

Liu (2000) explored the duration of relationship and its impact on infidelity for men and women. Liu (2000) found a curvilinear relationship predicting when men are more likely to

engage in infidelity. Specifically, the likelihood of engaging in infidelity for men decreases until approximately the 18th wedding anniversary, and then increases continuously after that. For women, the likelihood of engaging in infidelity decreases over the time they are married.

Socialization Factors Related to Infidelity

Atwater (1979), in discussing the social background characteristics related to infidelity, proposed that some of the social background characteristics considered were more or less factors related to socialization. Sexual permissiveness is an attitudinal characteristic proposed to affect involvement in infidelity (i.e., Reiss, Anderson, & Sponaugle, 1980; Roscoe, Cavanaugh, & Kennedy, 1988). Social norms also affect whether a person will engage in infidelity (i.e., Buunk & Bakker, 1995). Each is described below.

Sexual permissiveness

Several researchers have identified permissive sexual values to be associated with the likelihood of extramarital sex (Bell, Turner, & Rosen, 1975; Brown, 1991; Buunk & Bakker, 1995; Edwards & Booth, 1976; Kim, 1969; Kinsey et al., 1953; Maykovich, 1976; Reiss, Anderson, & Sponaugle, 1980; Roscoe, Cavanaugh, & Kennedy, 1988; Singh, Walton, & Williams, 1976; Thompson, 1982; 1983; Treas & Giesen, 2000). One aspect of sexual permissiveness is one's values around whether or not one believes extramarital sex is wrong. For example, Oliver and Hyde (1993) found men to be more sexually permissive than women in their meta-analysis on sexual attitudes.

Sexual permissiveness relates to the current project in therapists' assessment of cases. Since extramarital sexual permissiveness is related to engaging in infidelity, it is possible that therapist assumptions about the extramarital sexual permissiveness of their clients influences their treatment decisions. As a result, therapist may make attributions based on who they think is more sexually permissive based on social background characteristics.

Social norms

Buunk and Bakker (1995) discussed the importance of injunctive and descriptive social norms on the likelihood of engaging in infidelity. Injunctive norms are those held by a group who deviates from the norm. In this case, the norms of the popular group are not necessarily perceived as the only valid views; hence, the other group deviates from the norm. In relation to extradyadic activity, sexual relationships may occur outside of the normal reference group. When one is dependent on a group or the behavior is subject to another's influence, one may be socially

influenced in to act in the same way. In relationship to infidelity, if one's peers/parents engaged in infidelity and one was dependent on the group for approval or acceptance, s/he may also be more likely to engage in infidelity. Engaging in an affair is, after all, what the other group members approve.

The above statement of norms affecting the likelihood of engaging in infidelity has found empirical support. A female knowing someone else who engaged in infidelity increases the likelihood of her engaging in infidelity (Atwater, 1979; Buunk, 1980; Thompson, 1982; 1983). Further, Atwater (1979) stated that talking about extramarital sex and thinking about it are precursors for women, in addition to being aware of someone who engaged in extramarital sex.

Relationship Dynamics Related to Infidelity

Because infidelity occurs within the context of a relationship, it makes sense to consider relationship dynamics that are related to infidelity in some fashion. Revenge toward one's partner is one reason a person might cite for cheating on their partner (Mongeau, Hale, & Alles, 1994). Relationship satisfaction has been consistently explored as a factor related to infidelity, but has been met with inconsistent results (i.e., Bell, Turner, & Rosen, 1975; Reiss, Anderson, & Sponaugle, 1984).

Revenge

Some authors have cited revenge as a motive for persons engaging in extradyadic relationships (Greene, Lee, & Lustig, 1974; Mongeau, Hale, & Alles, 1994). Thirty percent of spouses participating in an interview about their extradyadic behavior stated they had engaged in extradyadic affairs because of revenge (Greene, Lee, & Lustig, 1974). It is likely that the partner who did not engage in infidelity may do so after finding out, known as a retaliatory affair (Lusterman, 1998).

Relationship satisfaction

Many authors cite relationship dissatisfaction as a factor of becoming involved in an extradyadic relationship. Kinsey et al. (1953) implied there might be a link to marital instability and extramarital coitus (Kinsey et al., 1953; Mowrer, 1954). In a study of 2200 married women and using a multivariate analysis of factors, Bell, Turner, & Rosen (1975) demonstrated that extramarital sex is more of a pattern for women than a single experience. Therefore, a continual dissatisfaction with a relationship may be related to infidelity as opposed to a single dissatisfying

event. Similarly, Reiss, Anderson, and Sponaugle (1980) found women who were rated as unhappily married were more likely to engage in infidelity.

Glass and Wright (1977; 1988) found that individuals who have engaged in extramarital sex reported less happy marriages that those who did not engage in extramarital sex; however, this was not found to be true for men in older relationships and women in younger relationships. In another study, Glass and Wright (1985) reported women who were involved in extramarital relationships described a lower level of marital satisfaction than men involved in extramarital relationships did. Again, men and women who were engaged in the combined-type of infidelity (with both sexual and emotional components) reported less marital satisfaction (Glass & Wright, 1985).

Buss and Shackelford (1997) used a sample of young couples to determine their susceptibility to infidelity within their first year of marriage. Through self-reports and interviews, martial satisfaction, along with other factors, was related to infidelity susceptibility. Additionally, Atkins, Baucom, and Jacobson (2001) found respondents who rated their marriage as "pretty happy" and "not happy" were significantly more likely to engage in infidelity than those who reported they were "very happy" in their relationship.

Neubeck and Schletzer (1962), however, found different results. Nine percent of respondents who rated themselves in a "great marriage" engaged in extradyadic sex, whereas 20% of those who rated themselves in a "good marriage" engaged in such activity. The more vulnerable females were those who had rated their marriages as less-satisfying, were defined as sexually liberal, and were married longer (chances of engaging in extramarital coitus are more likely the longer one is married) (Bell, Turner, & Rosen, 1975; Thompson, 1983).

Blumstein and Schwartz (1983) performed a survey of American couples. They, too, found no relationship between martial satisfaction and infidelity. This corresponds with the work of couples therapists stating problems in the primary relationship are not necessarily prone to having infidelity occur (Elbaum, 1981). Another piece of relationship satisfaction is sexual satisfaction with one's partners. Blumstein and Schwartz (1983) and Spanier and Margolis (1983) did not find relationship between the quality of the sexual relationship between spouses and likelihood of engaging in infidelity. In contrast, Liu (2000) discovered that spouses who found sex with their spouse less pleasurable were more likely to engage in infidelity.

Diffuse intimacy conception

In diffuse intimacy conception, a person places all of his or her energies into providing for one's partner and neglecting personal needs (Reiss, Anderson, & Sponaugle, 1980; Saunders & Edwards, 1984). Individuals with diffuse intimacy conception experience difficulties sharing personal and private feelings with their partner, spending their energy focusing on meeting the perceived needs of their partner, not providing for their own needs (Saunders & Edwards, 1984).

This is similar to fusion (Bowen 1978). Individuals with high levels of fusion, or a high level of involvement with others, are characterized revolving their life around persons with whom they are fused. By neglecting their own needs and taking care of another person, or practicing diffuse intimacy conception, persons are engaging themselves in fusion. As a result, this partner may be more willing to accept extradyadic relations because they are threatened by the loss of the relationship (Reiss, Anderson, & Sponaugle, 1980; Saunders & Edwards, 1984).

Fusion

Fusion, part of differentiation, refers to one's amount of emotional involvement with people. It indicates the degree to which one organizes one's life around a person or relationship (Bowen, 1978). Other authors recognize fusion as occurring when one's "ego boundaries" between oneself and another are dissolved. Essentially, it is the inability to have an "I" when one is part of a "we," characterized by dependence on others (Anderson & Sabatelli, 1990). Fusion also appears to be related to infidelity when controlling for age of the respondent and duration of the relationship (Milewski-Hertlein, 2000). For women, those who are more fused are more likely to engage in infidelity. This reaction to what is occurring in the relationship and reaction to infidelity are both characteristics of individuals and the manner in which they handle their interaction with others.

Types of Infidelity

Infidelity has been categorized into several types, based on the reasons for infidelity (Brown, 1991; 1999; Kaslow, 1993; Lusterman, 1998; Pittman, 1989; 1993). Pittman (1989; 1993; Pittman & Wagers, 1995) divides types of infidelity into four categories:

1) Accidental infidelity
2) Philandering
3) Romantic affair
4) Marital arrangements

Accidental infidelity contains sex acts that "just happen". Philandering is defined as a habitual behavior where the philanderer is obsessed with gender and gender-based stereotypes, having a constant flow of partners. Romantic affairs occur when the infidel is in love with someone other than his partner. Finally, marital arrangements are characterized by one person's desire to increase distance in the relationship (Pittman, 1989; Pittman & Wagers, 1995).

Similar to Pittman, Brown (1991,1999) divides the types of affairs into five:

1) Conflict Avoidance
2) Intimacy Avoidance
3) Sexual Addiction
4) Empty Nest affairs
5) Out the Door affairs

Though the result is the same (engaging in extramarital coitus), Brown also bases her categorizations on the origins of the extradyadic behavior.

The Conflict-Avoidant affair may occur in couples with difficulty discussing their differences. Additionally, this one may occur in those relationships where partners were taught in their family of origin that anger is "bad." The Intimacy Avoidance type is the result of fear of becoming emotionally vulnerable. Brown (1991; 1999) characterized these relationships as those containing arguments to protect insecurities, and infidelity may become a weapon. The communication is frequent, but there are high emotional charges back and forth. Contact is through emotional conflict. The Sexual Addiction affair is self-explanatory, where partners engage in infidelity, likely at the knowledge of their partner, as a way to address this need. In the Empty Nest affairs, the marriage and individual feel empty. Brown (1999) asserted this type of affair occurs in middle-aged men. Finally, in Out the Door affairs, one may engage in an affair as they think about ending the marriage (Brown, 1999).

Computers and Internet Infidelity

Therapists struggle with the definition of Internet infidelity and cannot agree on its treatment (Nelson, 2000). Some couples have developed relationship understandings that accommodate multiple sexual/romantic partners. As Lieblum (1997) noted, the manner in which people use the Internet appears to be on a continuum – on one end are those who are merely curious, and another extreme are those who are obsessive, and many points in between the two. For the purposes of this study, Internet infidelity is defined as a secret romantic or sexual contact

facilitated by Internet use that is seen by at least one partner as an unacceptable breach of their marital contract. Concerning the present study, this breach is seen as sufficiently severe for the couple to enter therapy.

Computer Use

In 1997, nine million adults were accessing the web on a daily basis, and 20 million were accessing the web at least one time per week. In a similar 2001 study, 99% of college seniors reported using the Internet on a daily basis, with another 90% reporting that they use it to send and read email (Raff, 2001). Internet use in adults is also rising. In 1995, the Harris Poll reported nine percent of all adults were accessing the Internet from home, work, or another location. In 2001, this percentage increased to 64%. This represents approximately a 700% increase over the last six years, with only one percent of that increase in 2001.

Initial studies suggest that computer users are displaying more uninhibited behavior than in face-to-face communications (Cooper & Sportolari, 1997). One survey found that 75% of US adults report they use email to flirt with someone to whom they are attracted ("The Email Dating Game," 2001). There are also certain aspects of computer-mediated communication that can augment personal relationships (Cooper, McLoughlin, & Campbell, 2000). Communication over the Internet downplays physical attractiveness of the individuals and allows other connections between two people to develop, such as common interests and emotional intimacy.

Types of Cybersex Users

Online relationships and sexual behaviors are also characterized by secrecy (Cooper, Delmonico, & Burg, 2000a; 2000b). In a study examining online sexual behavior, the investigators found individuals who were not sexually compulsive were less likely to keep their online activities secret as opposed to those individuals who were sexually compulsive.

Cooper, Scherer, and Mathy (2001) found approximately 20% of all Internet users report engaging in some sexual activity online. Of those who pursue sexual interests online, 70% reported that they keep secret how much time they spend online from others (Cooper, Scherer, Boies, & Gordon, 1999). Cooper, Putnam, Planchon, and Boies (1999) surveyed nearly 10,000 Internet users. They found a discrepancy between the percentage of people engaging in sexual pursuits online: 43% of the respondents they surveyed indicated they spent less than 1 hour on the computer pursuing sexual interests, while a smaller percentage of 8% spent 11 hours or more online per week engaged in sexual pursuits. Typically, those who go online for sexual pursuits

use their home computers (78.8%), with almost 6% reporting that they used an office computer and another 12.7% reporting that use both office and home computers (Cooper, Scherer, Boies, & Gordon, 1999).

In a study exploring Internet use for sexual activities in Sweden, Cooper, Mansson, Daneback, Tikkanen, and Ross (2003) found 33% of women reported that they did not use the Internet for sexual activity as compared to 17% of men. They also found a gender difference in the types of activities in which people engage online. For example, men in Sweden were more likely to view erotic material than were women, where women more frequently participated in flirting online or communicating with a partner.

Cooper, Putnam, Planchon, and Boies (1999) developed a model describing three categories of individuals who use the Internet for sexual purposes. The three categories are recreational users, sexually compulsive users, and at-risk users. Recreational users refer to those users who seek out sexual material on the Internet for entertainment value. For example, a recreational user might be one who seeks out pornography sites, but does not have a problem or is not addicted to looking at these sites. Sexually compulsive users differ from recreational users in that sexually compulsive users use the Internet as a vehicle for expressing their sexual pursuits. At-risk users are those who would not have had a problem with sexually compulsive behavior unless there was an Internet (Cooper et al., 1999; Cooper, Griffin-Shelley, Delmonico, & Mathy, 2001).

As Internet sex is on the rise, there are also considerations in terms of an individual's physical health. Reitmeijer, Bull, and McFarlane (2001) reported that those seeking Internet sex had more partners than those who did not look for sex online. Further, 65% of those who were looking for sex online had sex with their Internet partner. Within these cases, however, only 44% reported using condoms during their last sexual encounter. Because those on the Internet have more partners than those who do not meet partners online, the risk of spreading sexually transmitted diseases is greater (Elford, Bolding, & Sherr, 2001; McFarlane, Bull, & Reitmeijer, 2000). For example, a recent syphilis outbreak in San Francisco in men who have sex with men appeared to be connected to the recruitment of partners online (Klausner, Wolf, Fischer-Ponce, Zolt, & Katz, 2000). Those who seek sex on the Internet are more likely to be male, homosexual, have a greater history of STDs, have more partners, and greater exposure to HIV (Toomey & Rothenberg, 2000).

Connected to this boom in Internet use for sexual purposes, online sexual problems also occur (Cooper, Mansson, Daneback, Tikkanen & Ross, 2003). Some of these problems include financial problems because of Internet use, greater risk of STDs, relational problems, Internet abuse problems, and employment related problems (Cooper, Morahan-Martin, Mathy, & Maheu, 2002; Morahan-Martin & Schumacher, 2000). People may find themselves addicted to the Internet, to cybersex, or other online dating concerns. As a result, therapists are seeing more and more clients who are presenting with Internet related concerns (Cooper, Scherer, Boies, & Gordon, 1999). One area in which therapists have been seeing more cases is that of Internet infidelity.

Infidelity and the Internet

There is little empirical data on the phenomenon of Internet infidelity (Hatala, Milewski, & Baack, 1999). Since the Internet has become a part of everyday life to most people, communicating online has made it easy for people to begin interpersonal relationships (Hatala, Milewski, & Baack, 1999). As many as 26.3% of Internet users stated they have established at least one romantic interpersonal relationship with someone online (Parks & Roberts, 1996). Cooper, McLoughlin, and Campbell (2000) report that Internet infidelity is becoming more common. They suggest that relationships that develop online to the exclusion of the primary partner may

> interfere with conflict resolution in [face to face] relationships or may lead to triangulation. Partners struggling with conflict in their [face to face] relationships may seek comfort, understanding, and sexual intimacy in online relationships instead of working out the conflict in the [face to face] relationship. (p. 523).

Further, some problems that individuals may experience in connection with Internet infidelity include shame, guilt, and other negative feelings. Experiencing these feelings might prevent partners from discussing the problems within their relationship and "coming clean" about the Internet infidelity (Cooper, McLoughlin, & Campbell, 2000).

Social norms may also affect the incidence and prevalence of Internet infidelity. Buunk and Bakker (1995) discussed the importance of injunctive and descriptive social norms on the likelihood of persons engaging in an affair. The more Internet use becomes a norm, and the more Internet infidelity becomes a norm, the higher the rates of incidence and prevalence.

Online romances are characterized by emotional components. Rather than judgments on physical attractiveness or physical sexuality, persons involved in online relationships are connected by a sense of how close they feel to someone based on self-description and communication (Cooper & Sportolari, 1997). Glass (2003) wrote, "Internet infidelity is the epitome of emotional involvement because it meets all three criteria that discriminate between a platonic friendship and an emotional affair." (p. 35). For example, the Internet provides an environment free from distractions and provides a forum in which people can say what they choose, thereby enhancing emotional intimacy. Secrecy, another critical component of infidelity, occurs when one partner does not disclose his or her activities to the other partner. Finally, sexual chemistry is developed with the content of the messages. Certainly, infidelity has found a medium through the Internet.

Henline and Lamke (2003) performed a study examining how respondents experienced sexual and emotional infidelity. Using a sample of college students, they asked students to complete a questionnaire about the nature and consequences of Internet infidelity. Specifically, they were asked to identify online behaviors that they would consider "unfaithful" if the individual was in a committed relationship. The researchers also asked participants to rate the probability that someone communicating online with someone other than their partner would lead to a face-to-face meeting. Results indicated that online infidelity was not only characterized by sexual components, but also by emotional components. Respondents reported that they would be more concerned about an emotional relationship leading to a face-to-face meeting, more so than an online sexual relationship leading to a face-to-face meeting. Like many other studies, however, this research uses a small sample of college students. This is problematic as younger individuals are less likely to be married, and less likely to be in cohabitating relationships (Whitty, 2003b).

Whitty (2003b) performed a similar study exploring men and women's attitudes on online infidelity. Similar to the Henline and Lamke (2003) study, Whitty asked the 1,117 respondents to rate behaviors on a five-point Likert scale assessing whether an activity could be considered "unfaithful" to one's partner. Respondents did view certain behaviors online as acts of betrayal, thus supporting the more recent ideas that betrayal in a relationship is not restricted to physical or sexual contact with anther person. In relation to gender, women viewed a wider range of behavior as infidelity as compared to men. Whitty (2003b) also reported that there were

three separate components of infidelity: sexual, emotional, and pornography. In considering age as a variable in one's assessment of infidelity, results of this study indicated that younger individuals rated more acts as fitting the criteria of betrayal than older adults, but women in the older age group (45-70) considered this to be the case more than younger women (ages 23-44).

Characteristics Related to Internet Infidelity

Cooper (2002) delineated three particular characteristics related to the Internet Infidelity. Cooper developed a "triple A" engine, three aspects that affect Internet infidelity as opposed to conventional infidelity. These three factors are accessibility, affordability, and anonymity. Accessibility refers to the access an individual has to the Internet. For example, if an individual has only minimal access to the Internet as opposed to an individual who has more access to the Internet, the person most likely to engage in infidelity is someone with access to the Internet.

Affordability refers to cost of engaging in Internet infidelity. Cooper (2002) asserts the principle of affordability works on the concept of supply and demand. For a very small price, a computer user can visit a multiple number of sites and meet multiple sexual needs. Additionally, people who might feel uncomfortable purchasing sexually charged material in stores could quickly download similar information in the privacy of their own home.

Finally, anonymity refers to the ability of promoting any identity on the Internet a person chooses (Cooper, 2002). In person, carrying on an affair means the other person gets to know who you are, can see you, and can potentially judge you. On the Internet, users can backspace, erase, and change what they say in order to promote a specific identity. For example, Cooper, Scherer, Boies, and Gordon (1999) reported that over half of the respondents in their survey (61%) admitted to pretend to be a different age either occasionally or often. As Maheu and Subotnik (2001) describe it,

> The Internet allows you to control your message, and, at the same time, prevent the intrusion of reality. Bad breath, dirty fingernails, or an irritating tendency to interrupt are irrelevant in email and chat rooms. Lovers are not distracted by physical attributes, allowing them to listen with their inner selves – their souls. (p. 27).

In addition to Cooper's (2002) "triple A engine" of accessibility, affordability, and anonymity, Leiblum and Döring (2002) proposed a "triple C engine" which focuses on the interactive component of the Internet. Communication refers to the messages sent back and forth between respondents. Collaboration refers to the interaction between two respondents online.

Finally, communities online also provide another forum for interaction. Lieblum and Döring (2002) emphasize the importance of also considering these relational and interactive components affecting Internet infidelity.

Impact of Internet Infidelity on Couples and Families

Though most who participate in online sexual activities report that their activities do not have a negative impact on their lives, there are still cases in which these sexual pursuits can affect families and relationships (Cooper, Morahan-Martin, Mathy, & Maheu, 2002). Internet infidelity, for example, can have significant impact on couples and families. Barak and Fisher (2002) report that cybersex relations "will become a major factor in deteriorating marital relations and, therefore, a cause of relationship distress and divorce." (p. 270). Schneider (2000) interviewed 91 women and 3 men who had experienced cybersex in their couple relationships and inquired as to how cybersex affected their marriages and families. Schneider (2000) explored the effects of a spouse's online sexual behaviors on the emotions, co-dependent behaviors, and sexual relationship with their spouse. Schneider (2000) found 22% of the respondents had separated or divorced as a result of the compulsive cybersex. Additionally, two-thirds of the couples reported that they lost interest in sex with their spouse.

Infidelity Treatment

Primary Frameworks Used to Study Treatment of Infidelity

Currently, there are several types of infidelity treatment. These treatments are based on several theoretical models. One of the most commonly cited theories for infidelity treatment models is the theory guiding Functional Family Therapy.

Infidelity creates emotional distance between two partners (Barton & Alexander, 1981; Moultrup 1990; Pittman, 1989; Pittman & Wagers, 1995; Strean, 1976) and calls attention to communication problems in the relationship, forcing the couple to communicate (Moultrup, 1990; Taibbi, 1983). The marital relationship, for example, is a dyad that symbolically represents a union. In the psychoanalytic perspective, spouses who share everything and are dependent on one another may seek each other out for affirmation. To be intimate with one another and to share an emotional connection may be threatening. Partners may instead engage in infidelity as a way to connect with someone, yet still avoids the intimacy with their partner (Strean, 1976).

One of the main family therapy theories addressing the role of distance regulation is functional family therapy. Functional family therapy focuses on the assumption that persons

create and respond to their environments through maintaining patterns of distance and closeness (Alexander & Parsons, unpublished manuscript; Barton & Alexander, 1981). Every behavior in a system provides a function. This behavior is then classified into one of three patterns: distance patterns, closeness, and midpointing or regulating. Symptoms are considered a sign of the function occurring in the family, however ineffective they may be: these symptoms are still providing a function for the person carrying them out.

Through the lens of functional family therapy, a classic symptom in a relationship dyad according to Barton and Alexander (1981) is infidelity. Barton and Alexander (1981) stated infidelity provides a distancing function between partners. Relationships where there exists infidelity by one partner or both are characterized by creating distance to avoid communication bringing two in a partnership closer together. This is reminiscent of Brown's "intimacy avoidant" affairs.

Functional family therapy is not the only framework used to understand, study, and treat infidelity. Primary frameworks to study infidelity and its treatment have been influenced by postmodern theories (specifically social constructionist theory and narrative theories) (e.g., Atwood & Seifer, 1997), and cognitive-behavioral theories (such as equity theory) (e.g., Walster, Traupmann, Walster, 1978).

Postmodern theories have served to broaden the definition of infidelity. Rather than considering infidelity from a narrow perspective as strictly physical coitus, postmodernism has challenged the definition. As a result, the definition of infidelity now includes emotional aspects, and includes emotional infidelity as a separate category. The broadened definition opens the door for Internet infidelity to be a legitimate presenting problem. Another result of the postmodern movement related to treatment of infidelity is the context of infidelity as a narrative. Reissman (1989) and Atwood and Seifer (1997) have used the narrative as a powerful tool in working through infidelity with couples.

Social equity theories used in studies (Shackelford, 1997; Treas & Giesen, 2000; Walster, Traupmann, & Walster, 1978) bring researchers to consider balance in relationships, from a combined social and behavioral standpoint. Infidelity, according to these theories, is the result of a power equity imbalance. Implications for treatment in these cases are to balance equity in the relationship. Social equity theories have influenced the body of knowledge by contributing

information about all systems - the equity between the couple, between the "third" person, and forced infidelity researchers to consider infidelity from a systemic perspective.

Conventional Infidelity Treatment

Glass (2002) noted: "The extramarital literature has failed to provide a coherent conceptual framework or consistent treatment approach." With the approaches that are published, several have overlap, but again there is not a consistent model. Elbaum (1981) identified several techniques for therapists treating extramarital sex relationships. Elbaum (1981) suggested each partner be seen individually for the first few sessions. The therapist should ask the involved spouse to break off the extramarital relationship while therapy is continuing. Then the therapist should work with the hurt and anger generated from the revelation of the affair. The therapist should then shift the focus to the unfaithful partner and encourage him or her to take responsibility for his or her actions (Elbaum, 1981).

Westfall (1989) has also produced a list of several areas for the therapist to consider when treating extramarital sex cases. One task is to assess the extent of the infidelity. This assessment includes several areas – the degree of secrecy around the affair, the degree of involvement with the other person, the permissiveness values of the couple, etc. Another task for the therapist is to make certain s/he is reacting to the crisis of the infidelity, connecting the infidelity to the larger processes of the couple's interaction. The therapist then moves to assist the couple with rebuilding their relationship (Westfall, 1989).

As far as specific models of treatment infidelity, one of the areas with a great deal of publishing is the self-help section, including Brown (1999), Lusterman (1998), Pittman (1989), and Spring (1996). Some basic models for the treatment of conventional infidelity include Pittman and Wagers (1995), Spring (1996), Lusterman (1998), Gordon and Baucom (1999), and Glass (2001; 2002).

The Pittman and Wagers (1995) model is composed of eight steps. In the first step, the therapist must determine the affair type. Determine if the infidelity was a one-time event, or if the spouse engaging in the infidelity has been engaging in infidelity throughout the marriage, or if there is a romantic relationship involved. Then the clinician must work to deal with the responses after the affair has been revealed. Typically, this might involve normalizing feelings. The therapist must then work to bring everyone together. Next, the therapist must work with the couple to define the problem. How has this affected the couple relationship? Does the couple

have a problem not being able to trust one another? Do they have difficulties communicating? The therapist also needs to manage anxieties in the room by providing a safe environment and reducing the chaos. After understanding what the issues are between the couple and being able to manage the anxiety and emotional reactivity of the individuals involved, the therapist's task is to find a solution. Often, a proposed solution might be to negotiate any resistance encountered by the family with the proposed solutions. Finally, once the therapist has worked through resistance to solutions and have implemented the solutions, the couple can terminate sessions.

Spring (1996) developed three related stages. Normalizing feelings is the first job of the therapist. Then the therapist should work with the couple to determine if they want to stay in the relationship or to quit the relationship. If the couple decides they want to recommit to the relationship, then the therapist works with the couple to rebuild the relationship.

Lusterman (1998) identifies three phases in recovery of infidelity. The first phase is characterized by two steps, which include building trust and honesty into the relationship. Once these are established, the couple can begin to build on trust by engaging in honesty. Phase two involves moving from the relationship components of trust and honesty to focusing on specifically reviewing the marriage. Then couple must then determine ground rules for their marriage, work on conflict resolution, and determine where things went wrong. Protecting the affair partner is also a component of this stage. Finally, in Phase three, the couple should determine if they would be happier remaining married or separating. Some couples determine after infidelity that they do not want to continue in the relationship with their partner and others want to commit again to the relationship. This is accomplished through assisting the couple understand and acknowledge their options, and to move toward a "good divorce" if they choose not to recommit to the relationship.

Gordon and Baucom (1999) have three phases in their treatment model as well. The therapist must first deal with the impact of the affair on all partners, explore the context of the relationship, and then build on the relationship. In the impact phase, the therapist should work to assess and set boundaries for the couple. It is also important for the therapist in this phase to implement self-care guidelines, allow the couple time out to vent, talk about the impact of the affair, and help them cope with flashbacks.

The second phase in the Gordon and Baucom's (1999) model is exploration of context. In this stage, therapist and couple explore factors that are related to infidelity. Problem solving is

the next step, followed by cognitive restructuring. The last phase is moving on, accomplished by understanding the story of the affair. It is important in this stage that the couple has a conversation about what it would take to forgive. Finally, the therapist helps the couple to explore commitment in relationships and factors related to commitment.

Glass (2001; 2002) presents a model of infidelity treatment akin to PTSD treatment, specifically with the components of flashbacks and obsessive rumination. In this model, the therapist can provide crisis intervention strategies. For example, therapy may be required twice per week until the clients feel safe. Glass (2002) noted weekly and bi-weekly sessions might be necessary to help the individuals deal with the PTSD symptoms. The therapist should also be helpful in assisting the couple in navigating times in which there will be flashbacks and other reminders of infidelity. The therapist should establish safety and hope, foster care and good will, and be able to manage affect as well as post-traumatic symptoms. The therapist then instructs the couple to tell the story of the affair. Then the therapist moves to understand vulnerabilities in the context of the affair, and to provide meaning to the couple in order to terminate.

As aforementioned, the treatment provided is prevalent in the self-help section. However, there is not much in the way of clinical literature. Glass (2002) found only a few books have been written on infidelity treatment (see, for example, Moultrup, 1990) and that only 11% of clinicians she surveyed have read about the treatment of infidelity in either books or journal articles.

The literature on conventional infidelity treatment may provide a basis from which clinicians can draw to treat Internet infidelity (Henline & Lamke, 2003; Schnarch & Morehouse, 2002). One such example is the treatment ideology for Internet infidelity described by Atwood and Schwartz (2002). The treatment model they provided is generated from some of the literature on conventional infidelity. However, conventional infidelity differs from Internet infidelity in important ways.

> Internet infidelity is different from traditional infidelities because it appears to be anonymous and relatively safe. It can be pursued in the privacy of one's own home or office. One's identity can be completely obscured or misrepresented. It can also be pursued any time, day or night with not much effort, seemingly not interfering with the individual's day-to-day living. (Atwood & Schwartz, 2002, p. 38).

In other words, conventional infidelity treatment, though it provides a base for intervention in Internet infidelity cases, may not address some of the factors that are related to Internet infidelity, such as anonymity, access, and affordability (Cooper, 2002).

Internet Infidelity Treatment

Internet infidelity, due to its complex factors related to it, can be treated through a variety of approaches and models. Delmonico, Griffin, and Carnes (2002) noted:

> Mental health professionals serve their clients best when they acknowledge that there are varieties of approaches in the treatment of cybersex behavior. In fact, treatment is most effective when clinicians consider utilizing a multifaceted approach that includes various modalities (e.g., individual, group, family, support groups, medication, etc.), and various theoretical orientations (e.g., cognitive-behavioral, reality therapy, psychodynamic, etc.). (p. 151).

Delmonico, Griffin, and Carnes (2002) present treatment for cybersex cases as proceeding through two phases: First- and second-order change.

First-order change**.** First-order change strategies refer to those employed as crisis intervention (Delmonico, Griffin, & Carnes, 2002). These strategies are to reduce Internet access, and then reduce awareness. Reducing Internet access involves the physical moving of the computer or Internet access to different location less accessible to the client. Another way to create first-order change is to restrict the problematic sites or web pages for an individual. Raising awareness is when the clinicians work to raise awareness of cybersex as a problem in the computer user's life (Delmonico, Griffin, & Carnes, 2002).

Second-order change. The components of second-order change include interrupting the ritual (called "attacking the appeal") including psychiatric evaluations, the family, social isolation, addressing of collateral issues (such as grief, stress, etc.), promoting sexual health, and supporting exploration of spirituality (Delmonico, Griffin, & Carnes, 2002).

Though the multifaceted approach described here is in relation to cybersex treatment, the same consideration should be involved when treating Internet infidelity cases. Each model described below contains integrative treatment strategies.

Treatment Models

One treatment model presenting factors influencing Internet infidelity is the Shaw (1997) model. Shaw's (1997) model is based on reducing vulnerability factors for Internet infidelity. Examples of vulnerability factors include a lack of connection with partners or a lack of ability to discuss problems with one's partners, resulting in searching for something else. Another example of a vulnerability factor is the readiness of an individual to be in an emotional relationship with someone, and the fear of being oneself. In an Internet relationship, people can be whomever they present themselves to others (Shaw, 1997). Shaw (1997) proposed therapists examine secrets between the partners in a relationship, emphasize a maturing processes, and build integrity and trust between the partners.

Young, Griffin-Shelley, Cooper, O'Mara, and Buchanan (2000) described similar steps to Internet infidelity treatment. In examining the factors leading to cybersex addiction (anonymity, convenience, and escape), the article provides a context for understanding the phenomenon of Internet infidelity and develops a rationale for the interventions they provided. The treatment model includes improving communication between the spouses, rebuilding trust, and addressing underlying issues within the marriage.

Maheu and Subotnik (2001) also provided strategies for dealing with Internet affairs in their book on Internet infidelity. The factors influencing Internet infidelity are based on Cooper's (2000; 2002) "triple-A engine" – anonymity, accessibility, and affordability. The interventions include both common couple interventions, followed by interventions with elements of transgenerational theory. Coping with emotions is the beginning of the process, followed by searching for understanding, and moving toward reconstructing the relationship. Therapists then guide the couple to examining family of origin issues. Expressing empathy is also part of the recovery process, as well as accepting responsibility and rebuilding trust between partners. Reducing co-dependency and reestablishing a courtship are the next steps to recovery, followed by finding closure and apologizing. In the last steps, treatment revolves around finding meaning, tolerating setbacks, and recognizing loss, specifically in regard to experiencing setbacks.

Atwood and Schwartz (2002) also provided readers with some guidelines on how to conduct therapy in Internet infidelity cases. Factors associated with an individual engaging in Internet infidelity include projection, differentiation of self, anonymity, intimacy issues, and communication difficulties, mid-life crisis, and Internet addiction. The treatment considerations presented are logical and flexible. They are based on dealing with underlying processes, and emphasized communication. The steps Atwood and Schwartz (2002) present for treating Internet infidelity begin with evaluation. Evaluation refers to assessing the Internet user's accessibility to the Internet as well as the activities in which the user is engaged when online. Social networks are also explored. Crisis intervention is the next step, where the therapist provides a safe environment. Once the environment is safe, the therapist can help the couple address underlying issues. Building communication is the next step, and once communication is established between the partners, they can rebuild marital trust. Finally, new stories are constructed and a ritual is determined by the couple to symbolize a new start.

Finally, there is one other model in the community. One website, NetAddiction.com, provides information and treatment assistance for those struggling with Internet Addiction. Its assistance is designed for those who are afflicted by cybersex, online gambling, and other addictions online.

Nelson (2000), in examining clinician's agreement on the treatment of Internet infidelity cases, reported: "…there are few critical issues, interventions, and gender differences in cases of extramarital infidelity upon which expert therapists can agree and find consensus." (p. 137). In his modified Delphi-study, therapists were asked to determine treatment for three vignettes of Internet infidelity cases. Among other things, the experts in the panel were divided on how to handle secrets, the extent to which a clinician should focus on individual or relational treatment, and how feminist family therapy has influenced their work. Given that these panel members were unable to come to consensus, there may be an opening for biases to potentially influence clinicians' assessment and treatment when Internet infidelity is the presenting problem.

Postmodernism

Postmodernism involves being skeptical about the idea of rationality and progress. It is a reaction to modernism, a philosophical position asserting individuals are inherently rational, and rejects the modernist position (Doherty, 1999). Modernism asserts there are accurate descriptions

to be made of the world (McNamee, 1992). Postmodernism moves from understanding broad knowledge and emphasized the creation of knowledge (Doherty, 1999).

Postmoderism is a reaction to the assumption that there is only one objective reality. Postmodernists believe that it is not always possible to completely understand another individual's experience (Doherty, 1995). Postmodern thinking focuses on narratives and texts (Lax, 1992). It emphasizes self-disclosure and pays attention to process (Lax, 1992). The individual is considered within his/her context. Postmodernists share beliefs and knowledge about how the world works as opposed to understanding only one objective position (Lax, 1992).

Postmodern Impact on Sex Research

Current philosophical and theoretical movements have significantly defined sex research. One such movement that has affected sex research is the movement from modernism to postmodernism. Up until the 1970s, modernist thought was influencing American policy, which dictated research (Lindenbaum, 1995). Since the 1970s, however, sex researchers have seen postmodernism differently, resulting in a restructuring of definitions and research agenda: "The loss of the 'authoritative voice' of an earlier period has been replaced by a more cautious and more precise examination of behaviors and ideologies in specific social and historical contexts." (Lindenbaum, 1995, p. 274).

The constructionist framework influenced sex research in couple of ways. First, the object of study moved from just subject matter to individuals in context (Gagnon & Parker, 1995). Some examples include studying such topics as orgasm, ejaculation, and how orgasm difficulties occur within the context of a couple's relationship (Gagnon & Parker, 1995).

Secondly, sexuality itself was seen as something that was not only mechanical and based on biological drives, but also influenced by history and context (Gagnon & Parker, 1995). Previously, internal drives were the focus of sex research, whereas the postmodern movement brought about exploration of the internal drives with external forces affecting their drives.

Postmodernism, Pathology, and the Definition of Infidelity

Postmodern thought challenges meanings. It deconstructs what we know to be true and believe to be lasting and works to provide new meaning and understanding of phenomenon (Doherty, 1999; Lax, 1992; Parry, 1991). Deconstruction helps individuals to take a new look at what they see before them as well as helping them understand how these new reflections fit into the larger culture (Parry, 1991).

The field of sexuality has not escaped this challenge. One of the ways in which sexuality has been deconstructed is in the meaning of pathology. Sexual behavior previously viewed as pathological is now seen in context of norms of society. For example, homosexuality was seen as pathological and considered a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM). In 1973, homosexuality was removed from the DSM and is currently not viewed as a diagnosable illness (APA, 2002).

Meanings of sexuality in general have been challenged and deconstructed by technology. For example, technology has introduced a variety of ways to conceive a child. Stem cell research, in vitro fertilization, and other reproductive technologies have influenced the meaning of definition of parenthood and family (Imber-Black, 2000).

The definition of infidelity, both Internet and otherwise, has been a topic of discussion in the research literature for at least 20 years. Researchers, such as Thompson (1984) and Brown (1991), originally defined infidelity as exclusively sexual, referring to physical contact/coitus with an individual other than one's partner. Thompson (1984) initially defined an affair as "genital sexual involvement outside the marriage without the express knowledge or consent of one's partner" (p. 36). Brown (1991), however, does acknowledge the duality of the term infidelity and remarks about its potential to become something more than just restricted to sexual affairs when she notes: "affairs of the heart, which do not involve a sexual relationship, are not truly affairs – yet." (p. 19).

The crux for several other researchers is the notion of the *secret* nature of infidelity (Laumann, 1998). For them, this is considered crucial to the definition (Glass, personal communication). Pittman (1989), for example, defines an affair in very general terms, as "a breach of trust, a betrayal of a relationship, a breaking of an agreement" (p. 20). Spring (1996) provides a solid definition of infidelity, stating infidelity occurs when any agreement set up between two partners is broken, emotional or physical.

Maheu and Subotnik (2001) defined Internet infidelity as occurring "when a partner in a committed relationship uses the computer or the Internet to violate promises, vows, or agreements concerning his or her sexual exclusivity" (p. 100). This, however, does not take into account the emotional nature of affairs. Other affairs not restricted to purely sexual intercourse are referred to as emotional affairs (Collins, 1999; Drigotas, Safstrom, & Gentilia, 1999; Hite, 1987; Shackelford, 1997; Sprey, 1972; Spring, 1996; Thompson, 1982; 1984). Aspects of

emotional intimacy may include sharing, understanding, companionship, and self-esteem (Glass & Wright, 1992).

Since the Internet has become a part of everyday life to most people, communicating on-line has made it very easy for people to begin interpersonal relationships (Hatala, Milewski, & Baack, 1999). Parks and Roberts (1996) report, for example, 26.3% of Internet users who state they have established at least one interpersonal relationship with someone on-line indicate a romantic relationship with someone online. Online romances are characterized by emotional components: rather than judgments on physical attractiveness or physical sexuality, those individuals involved in online relationships are connected by a sense of how close they feel to someone based on self-description and communication (Cooper & Sportolari, 1997).

Similar to other sexuality definitions, technology has also deconstructed the definition of infidelity. A definition for Internet infidelity needs to be broad enough to take into account the vast nature of the connection with the other individual – whether that connection is through the sharing of a sexual connection or an emotional, romantic connection. Internet infidelity, therefore, is defined as a secret romantic *or* sexual contact facilitated by Internet use that is seen by at least one partner as an unacceptable breach of their marital contract.

Feminism

Feminism attempts to understand the female experience through a consciousness-raising effort (Mander & Rush, 1974). It is an integrative position, moving to integrate subjective, objective, and other aspects of life seemingly in opposition to one another (Mander & Rush, 1974). Feminism encourages women to equally participate in all areas of life and society (Reiker & Carmen, 1984).

Reiker and Carmen (1984) stated: "American society is one of structured social inequality in which there is an unequal distribution of rewards based on gender, race, class differences, among others" (p. 18). Feminism explores the ways in which women have been oppressed, dominated, and have not had their own voice. It explores women's experiences and encourages women to be social agents in change (Baber & Allen, 1992).

There are several effects of inequality on women. Women are rewarded for developing a set of characteristics (Reiker & Carmen, 1984). For example, women are rewarded for being submissive, helpless, and compliant. Girls and women are encouraged to develop passive and

indirect strategies for dealing with conflict. Women might then be viewed as manipulative or controlling (Reiker & Carmen, 1984).

Feminism and Sexuality Research

The influence of feminism on sex research occurred in several ways. Feminists explored the actual manner in which the studies were being conducted. For example, men were doing more research than women in this field (Gagnon & Parker, 1995). Additionally, feminists examined the definition of pathology and normalcy in sexual behavior (Gagnon & Parker, 1995). Specifically, men's sexual behavior is typically regarded as the norm. This leaves women's sexual behavior potentially regarded as pathological.

Another criticism launched by feminists toward sexuality research was that of the role of gender development in regard to sexuality as well as the maintaining of unequal gender roles by sexuality researchers (Gagnon & Parker, 1995). Essentially, sexual practices of men and women are determined by inequalities in power, according to the feminist critique, resulting in oppressed and underrepresented women in sexuality research.

Mander and Rush (1974) also questioned sexuality research from a feminist perspective and critiqued sexuality research as being limited to looking at sexual physical behavior between men and women. "There is no way to isolate sex for scientific purposes and come up with any meaningful data." (p. 24). Mander and Rush (1974) outlined several problems with sexuality research:

- There is no goal to sex, nor criteria to be met
- Sex is a very important and central part of human lives
- Sex takes place in many more settings than just the bedroom
- Sex can be expressed and not expressed in a variety of ways
- Sex should not be demoralized.

In other words, sex researchers need to consider the variety of definitions related to sex, what sex means to women, to an individual, to a couple, and to society.

Feminist Critique of Family Therapy

Just as feminists were launching critiques of sexuality research, feminism was also influencing family therapy. Several authors turned their feminist critique toward family therapy in the late 1970s and early 1980s (i.e., Avis, 1985; Goldner, 1985; Hare-Mustin, 1978). These authors stated that gender was ignored in family therapy literature and that issues of power were

unrecognized by family therapy theorists. Three other types of feminism were apparent in the critique of family therapy by feminists (Avis, 1987; Goldner, 1985):

- Liberal feminism works to remove barriers and constraints, legal and otherwise, to work towards equality for men and women.
- Socialist feminism refers to feminism that analyzes why women are subordinate to men in society, specifically calling for the removal of patriarchy and capitalism to be abolished if women are going to be "liberated."
- Radical feminism states that women are oppressed everywhere – from country to country, class to class, culture to culture. In other words, what is happening personally for a woman is an example of what is happening with them in the larger society.

For example, Hare-Mustin (1978) criticized structural family therapy in the power structural family therapists give themselves over the family, and the gender of the person whom structural family therapists put in power positions. According to Hare-Mustin (1978): "[Minuchin] sees himself as modeling the male executive function, forming alliances, most typically with the father and…demanding that the father resume control of the family." (p. 184). As a result, she is criticizing two aspects of hierarchy: 1) that there is a hierarchical position of the therapist over the clients, and 2) the gender of the person in power should be male. This is termed a beta bias (Hare-Mustin, 1978).

Another way in which feminists see structural family therapy is as a disempowerment of mothers and/or women in the family. Women are socialized to be nurturing individuals in the family, yet this is labeled "enmeshment" by structural family therapists and considered that which maintains problematic behavior. Goldner (1985) noted, "Insofar as a woman's identity is wrapped up in her ability to nurture, she will do almost anything to 'fix things,' including the often disempowering, unnerving tasks suggested by family therapists." (p. 41).

In the aforementioned example, feminists have sought to equalize the imbalance between gender and power in therapy. Feminists have been attuned to the way in which women are viewed in therapy and are proactive in working to reduce beta biases in family therapy.

In general, feminists are concerned that women in therapy are treated differently than men, and that behavior of men is regarded as the norm whereas women's behavior should meet the norm. In regard to sexuality and family therapy, men's sexual behavior should not be

considered the norm without exploring the context in which the couple's circumstances and lives are embedded.

Therapist Conceptualization Processes

Therapist conceptualization refers to the manner in which a therapist thinks about, interprets a case, and intervenes based on that conceptualization. How a therapist conceptualizes a case influences the manner in which a therapist treats a case. For example, a structural family therapist tends to conceptualize cases in terms of hierarchy, whereas a transgenerational therapist would tend to see the same case in terms of intergenerational movement.

Models of therapy are not the only factors affecting the conceptualization of a therapist's cases. Conceptualizations of cases are also affected by therapist social background characteristics, as well as the social background characteristics of the client. These social background characteristics include gender, religion, or similar factors. In this sense, when social background characteristics of the therapist and/or client affect how a therapist conceptualizes a case, biases may result.

In cases of Internet infidelity and the therapist's conceptualization process, the extent to which the therapist identifies the client's behavior as compulsive may influence the differences in treatment. In this manner, therapists may tend to treat cases in an individual rather than a relational manner. Schneider (2002) encourages therapists to, rather than solely focusing on the time spent on the computer, to also focus on the sexual activities of the person using the computer, including taking an adequate sexual history and of the couple's sexual relationship.

Biases in Psychotherapy

Although therapists may strive to base their therapy on scientific research, the human element is also at work when making assessment and treatment decisions. According to Aponte (1985), "Therapy is shaped by the interaction of the personal values of therapists with the values of societal institutions…" (p. 324). Values direct our actions and allow us to interpret and judge social phenomenon, but also affect the therapeutic process (Aponte, 1985). In fact, it is the value system of the clinician that may define the problem in treatment, as well as the course of treatment. Aponte (1985) also stated, "Although therapists are often unconscious of these aspects of human functioning in their assessments, they nevertheless operate through them in the biases inherent in the therapies they use…" (p. 326). In other words, biases come through in clinical work because therapists are shaped by society and family background.

Biases in therapy can affect cases negatively. First, when emotional and mental health is defined in a narrow manner as a result of biases, therapists limit their effectiveness (Bernal & Castro, 1994). Then, once therapists misdiagnose clients, they may be at risk for also mistreating clients. Misdiagnosing and mistreating cases is not ethical care. In order to correct how biases impact diagnosing and treating presenting problems, "Efforts need to be made to train therapists who are prepared not to discriminate against people due to their background, especially race, color, culture, gender, religion, or social class." (Guanipa & Woolley, 2000, p. 189).

Gender Biases

Gender biases "refer to biases associated with complex characteristics in biological, cultural, social, and political categories" (Guanipa & Woolley, 2000, p. 183). It is an unconscious factor in how therapists see and make interpretations about the world (Fisher, 1989). In other words, the therapist can be impacted by many social background characteristics, some of which s/he might be aware and others which s/he may not.

According to Wakefield (1987), sex bias occurs when "overpathologizing results from a sex-linked inequity in the way that a diagnostic criterion is formulated." (p. 465). Therapists who have different standards of pathology for men and women are essentially creating sex bias. There is not one factor impacting the potential of bias in therapist conceptualization of cases and intervention strategies. As a result of several factors influencing bias, the unconscious nature of bias, and the different diagnostic criteria for different genders, therapists put themselves at risk for misdiagnosing and mistreating clients.

Gender biases are often discussed in the context of mental health. Reiker and Carmen (1984) suggested there is a double standard in mental health based on the sex role differences ascribed to sex role stereotyping and how one is adjusted to one environment. Broverman, Vogel, Broverman, Clarkson, and Rosenkrantz (1972) found that the picture of a healthy woman, according to mental health practitioners, was different from the picture of a healthy man or a healthy adult. Healthy women were considered more submissive, less adventurous, more suggestive, less competitive, less illogical, and less objective. The implications of this study might be that men and women get different treatment because there is a different picture of what an appropriate outcome would look like for both men and women.

Reiker and Carmen (1984) supported this finding when they state: "…anger in women is often labeled as pathological rather than understood as a consequence of a devalued position" (p.

29). Psychologists might use different words for men and women to describe the same behavior. In contrast, Zygmond and Denton (1988) mailed questionnaires to members of AAMFT and found that gender itself did not have a significant impact on the way clinicians chose to treat their clients.

Guanipa and Woolley (2000) believed that gender issues are critical in many marriage and family therapy training programs. They examined how therapists perceived gender in client presenting problems. In a qualitative study (Guanipa & Woolley, 2000), student marriage and family therapists were asked to watch the first 20 minutes of an intake interview and then to identify what issues the couples brought to therapy. The students who had been trained in gender issues were more likely to see gender issues in the couple's issues than those students who were not trained in gender issues. Additionally, the student therapists were also vulnerable to culture biases in their interpretations. The implications of this research are that training programs and supervisors need to help student therapists be more aware of their biases and how they interpret cases.

Seem and Johnson (1998) examined how counseling trainees conceptualize their cases and how gender biases play a role in that conceptualization. Counseling trainees were given packets containing a case description, dependent measures, and a sheet requesting personal information from the participants. Seem and Johnson (1998) found that therapists responded to clients who did not act in a stereotypical gender manner more negatively than clients who did did.

Sherman (1980; 1982) found therapists' sex role values are operating during therapy. Therapists rated those individuals who are sex role discrepant as more maladjusted. The implication of this study is that if a client does not act in a manner consistent with his/her gender roles, therapists view that individual as more pathological. McCollum and Russell (1992), however, found different results in a study about mother-blaming. Overly concerned parents were viewed as more pathological than the uninvolved parent role, regardless of the gender of the concerned parents. This research certainly brings into question values about bias in therapy treatment.

In a study examining client gender and perceived therapeutic resistance, Korner and Goldberg (1996) conducted a study in which 91 therapists responded to three vignettes of difficult male and female clients. Afterward, the therapists completed the Therapist Capacity

Questionnaire. This questionnaire is composed of items that assess the therapist's capacity to help the client, be supportive and encouraging, and to tolerate personal feelings. The results indicated that male therapists had a tendency to be more cognitive-behavioral in their approaches where women tended to be more psychodynamic. In terms of gender of the client, both male and female therapists were able to be supportive, understanding, and tolerant with their female clients more so than their male clients.

The present study is examining how clinicians respond to treating Internet infidelity cases when demographic variables, such as gender of the persons engaged in the affair, are manipulated. Gender was formerly considered the most consistent predictor of infidelity (Greeley, 1994; Johnson, 1970). Men were viewed as more likely to engage in extradyadic behavior (Seal, Agonstinelli, & Hannett, 1994), primarily due to opportunity. That is, since men typically worked outside of the home and women stayed home, men may have had more opportunity to find extradyadic partners (Greeley, 1994). Other scholars disagree, asserting women may engage in extradyadic relationships just as much as men their age (Norment, 1998).

Gender biases also refer to the gender of the therapist in clinical treatment. Jones and Zoppel (1982) found that female therapists rated themselves as having more success, particularly with female clients. This result was confirmed by interviews with clients about their therapists, specifically that females join more effectively with clients.

Sexuality Biases

Differential treatment is an area of concern in the clinical setting (Stabb, Cox, & Harber, 1997). Biases have the potential to affect assessment and treatment strategies in several presenting problems. Several studies have shown clinicians treat sexual problems differently depending on the gender of the clinician (i.e., Liss-Levinson, 1979; Schover, 1981; Schwartz & Strom, 1978). Schover (1981) examined therapist's responses to sexual material introduced by clients. Therapists were given case descriptions, photos, and audiotape of a client discussing a vague sexual symptom. Therapists received one of two vignettes – one in which the client was a male, and the other in which the client is a female. Female therapists appeared to be more comfortable with sexual material than male therapists are, where male therapists over- or underemphasized the sexual content.

Clinicians with high religiosity rated clients in vignettes regarding sexual behavior as more pathological than clinicians with lower levels of religiosity (Hecker, Trepper, Wetchler, &

Fontaine, 1995). Additionally, clinicians viewed single persons engaging in intercourse with multiple partners more pathological than those engaging in sex with the same frequency who were married.

Infidelity treatment and person-of-the-therapist

In infidelity cases, several authors have discussed the importance of therapists working with infidelity cases to be clear on their values. Moultrup (1990), for example, indicated that therapists should remain as neutral as possible in the treatment of infidelity cases. However, just as therapist may need to remain neutral during the sessions, it is also important they are aware of any countertransference issues that may be occurring during treatment. The therapist should be aware of his/her own limitations and be clear about their values when working with infidelity cases (Hurlbert, 1992; Taibbi, 1983). Some of the reactions that therapists need to be aware of include projections, reaction formation, and overidentifying with one of the partners to the point where therapy becomes non-productive. Taibbi (1983) suggests the way to reduce the likelihood of these effects is to seek supervision for such cases.

CHAPTER III: METHODOLOGY

"The object of collecting data is to provide a basis for making a decision and taking action."

- W. Edwards Deming

Present Methodology Gaps in Infidelity Research

There are several methodological gaps in present infidelity research. Infidelity treatment is not commonly measured in outcome studies. For the most part, treatment protocols are described in articles and supported by case examples (e.g., Atwood & Seifer, 1997). The research in infidelity typically centers on the following: incidence, prevalence, justification for, attitudes toward, and social background factors influencing likelihood to engage in infidelity. Testing treatment considerations seem secondary to the purpose of most treatment articles. This may result in the lack of coherent treatment approaches in the literature.

There are several problems in infidelity research, whether it is research on treatment or predicting infidelity. These include *reliability and validity concerns, overstated inference, the use of analogue studies,* and *sampling problems* such as lack of generalizability and non-probability sampling. Finally, several studies have used college students or analogue studies, not looking at infidelity when it is occurring (Atkins, Baucom, & Jacobson, 2001).

Reliability and Validity Concerns

Like many studies in sexuality, one of the methodological gaps in the literature on infidelity is the lack of reliability in testing measures as well as validity concerns. Similar to other studies about sex, the individual studies in the area of infidelity are plagued with volunteerism and social desirability problems. Participants in infidelity studies might not reveal whether they have had an affair or engaged in infidelity to appear as they act in a socially desirable manner. Social desirability might affect incidence, which changes from study to study, sample to sample, and population to population. For example, the percentage of persons engaging in infidelity has been estimated between as low as 11% and as high as 70% (Hite, 1987; Johnson, 1972; Kinsey et al, 1948; Kinsey, et al, 1953; Laumann, Gagnon, Michael, & Michaels, 1994; Wyatt, Peters, & Guthrie, 1988a; 1988b).

Another reliability and validity concern is the lack of tested treatment options. Treatment options are typically not tested in infidelity research. Case studies are typically supplied, but that does not necessarily mean that the specific treatment presented will work all of the time and in

the same manner for every individual. Published treatment models (e.g., Glass, 2001; Moultrup, 1990; Spring, 1996) describe treatment but do not provide tests for the treatment models they propose. The lack of tested treatment options is a validity concern because, without tested treatment, therapists and researchers have little proof that what they are doing to treat infidelity is effective.

Another methodological gap is the lack of identification of a qualitative method. As aforementioned, treatment articles focus on presenting a clinical mode for treatment and using a case summary to describe the model. It is unclear at times whether the case summary generated the model or whether the case summary was an example of the model. Treatment strategies could be enhanced if they adhered to a qualitative methodology. Qualitative methods lend themselves well to process research: they are congruent with marriage and family therapy in our work with systems and validate discovery-oriented therapy (Sprenkle & Moon, 1996), which is what infidelity treatment strategies are based on – discoveries and successes in clinical work with these couples.

Over-Stated Inference

Over-stated inference refers to the several jumps made in the literature to explain infidelity. Several studies have used attitude measurement of infidelity to determine whether an individual would engage in infidelity (see, for example, Seal, Agostinelli, & Hannett, 1994). It is not always appropriate, however, to infer behavior from attitudinal inventories. As Glass (2002) wrote: "Research which includes college students and unmarried persons cannot assume an association between extramarital attitudes and potential behavior because attitudes evolve as marital and social context changes."

Use of Analogue Studies

Several studies have made use of analogues in order to determine the probability of infidelity. For example, Neubeck and Schletzer (1962) gave couples situations and vignettes from which to project the likelihood of one engaging in infidelity. In a more recent study, Seal, Agostinelli, and Hannett (1994) used a hypothetical situation to show willingness to engage in infidelity. Certainly, one can question the reliability and validity of analogue studies; specifically since one is not exactly measuring what one intends to measure. Emmelkamp, Mersch, and Vissia (1985) noted that laboratory research might be very different from analogue studies in

several ways, specifically around treatment procedures. People may behave very differently when the situation is happening to them than what they would report they would do.

Sampling Problems

Like much of the research in published journals, college students were likely candidates for studies on infidelity (Roscoe, Cavanaugh, & Kennedy, 1988; Shackelford, 1997; Sheppard, Nelson, & Andreoli-Mathie, 1995; Weis & Slosernick, 1981). Samples of college students might significantly affect this research because those who go to college may be more liberal than others, and therefore would think of infidelity differently than a more conservative population.

Building a Body of Knowledge in Infidelity Treatment

Infidelity is a fitting arena for researchers to move toward methodological pluralism. With several different research questions in the area of infidelity, from prevalence to predictors to treatment options, researchers have many methods for responding to these questions in a reasonably sound manner, as well as generating new questions. The focus for the field of sexuality and infidelity complements the goals Sprenkle and Moon (1996) set aside for the movement of research in marriage and family therapy. The foci demonstrate the advantages of being multimethodological, bridging the researcher-clinician gap, and the field of marriage and family therapy will learn more about the methods themselves.

One major focus for researchers in the field of infidelity is the testing of proposed treatment models. Each model possesses some value, and has probably been effective for the clinician writing the articles. Testing treatment interventions would add to the body of knowledge in several ways. First, we would be able to sort through the sea of published treatment interventions and be able to focus on the "tried and true" as opposed to picking a method of treatment and working from there. Testing treatment models would inform practice by making practice more standardized and promoting effective treatment strategies. It would also address research gaps because testing these models in controlled settings would reduce the need for analogue studies, reduce the need for participation of college students, result in greater reliability and validity as well as generalizability for those who have experienced infidelity. The present study addresses this focus through exploring the current treatment options for infidelity that are used by practitioners and determining to what extent the treatments are influenced by social background characteristics of clinicians and clients.

Development of a qualitative component for treatment of infidelity, such as process research (in-depth interviewing procedure) and cluster analyses, would be helpful in infidelity research and also meet the goal of methodological pluralism. Themes would be identified as well as creating structural synthesis and model building. Atwater (1979) used grounded theory methodology to determine women's experiences related to infidelity, but this study was one of the only studies using specific qualitative methodology. Developing some strong qualitative components to build the research in this area would benefit the body of knowledge in that it would identify appropriate treatment strategies and common themes rather than best guesses, and influence infidelity research overall. Additionally, development of strong qualitative components would provide another plank for bridging the researcher-clinician gap and move the field of infidelity treatment research toward pluralism.

Developing strong qualitative components to the research would enhance the results of efficacy studies, finding out what works for those individuals involved in infidelity treatment, and be able to build better models to answer more questions about factors involved in infidelity. Additionally, it would enhance Internet infidelity treatment models through providing specific treatment strategies specific to Internet infidelity. The present study addresses this component in that it provides a qualitative forum in which clinicians can discuss why they treated the couple in they way that they did.

Research Design: An Internet Survey

Using the Internet as way to conduct research has several advantages over more traditional means. It is accessible to many, is cost effective, and provides a form of interaction that does not exist with telephone or mail surveys.

Smith and Leigh (1997) presented several advantages to performing Internet research. Computer networks have several important characteristics that lend themselves well to research. First, computer networks allow information to be passed from one user to another in a rapid format. Second, computers can assist in data collection and data analysis. Third, using the computer also does not restrict the researcher to a sample of convenience – typically university students. Researchers can better get in touch with the population of interest and will not be as limited in sampling selection as they once were (Smith & Leigh, 1997). Furthermore, Internet surveys are not restricted to participants who are geographically close to the researchers. Finally,

Internet research also provides anonymity and reduces demand characteristics (Smith & Leigh, 1997).

Swoboda, Muhlberger, Weitkunat, and Schneeweib (1997) also provided their own ideas about the benefit of the Internet for collecting data. Swoboda et al. (1997) sent a questionnaire to 8,859 people in one day. The researchers received 1,713 in return. One of the advantages was the speed of administering questionnaires as well as the speed of response. Swoboda et al. (1997) also indicated that they researchers can select a certain group of participants, should that be necessary to the research.

Dillman, Tortora, and Bowker (1999) have identified 11 principles for constructing web surveys. Specifically, the authors have developed ways in which to tailor web surveys to the expected computer knowledge of the audience as well as information about how to construct the web page survey for easy use (Bowker & Dillman, 2000; Dillman, et al., 1999). The present study follows the rigorous criteria identified by Dillman et al. to produce valid results. Based on previous Internet studies (i.e., Dodini, 2000), the response rate should approximate an average of 20%, if it approximates previous Internet studies.

Phase One Methodology

Participants

There were two phases in this research. In Phase One, I solicited 2,687 clinical members of the American Association for Marriage and Family Therapy (AAMFT). Of the 2,327 that potentially reached their intendees, 508 responded to the survey. Their names were randomly selected from a list of 15,000 names listed on TherapistLocater.net. The steps in the selection of participants was as follows:

- Log into AAMFT's site and go to TherapistLocater.Net
- Chose "select all" for states, and have practitioners listed in all 50 states.
- Viewed the practitioners listed on TherapistLocater.Net and collected therapist email addresses.

There were no restrictions as far as age, ethnicity, or any other factors.

Procedures

The AAMFT clinical member participants completed an inventory with vignettes and Likert-scale items. The investigator emailed potential participants a letter requesting their participation (Appendix B). In this letter, the investigator requested that they read an informed

consent form (Appendix A) and respond to a short demographic questionnaire (Appendix C). The potential participants were then instructed to go to a websites, read each of three Internet infidelity involvement vignettes, and respond to Likert-type statements immediately following each vignette (see Appendices D and E). Appendix D reflects the contents of Website 1, where clients engaging in Internet infidelity are male in all three Vignettes. Appendix E reflects the contents of Website 2. The vignettes in Website 2 are the same as in Website 1, except that the clients engaging in Internet infidelity are female. Half of the respondents were randomly assigned to Website 1; half assigned to Website 2.

These three basic vignettes were similar to the ones Nelson (2000) provided in his Internet infidelity treatment study. They represent three of the most common Internet infidelity situations: 1) one partner engaging in flirtatious email, 2) one partner meeting an individual online and starting a physical relationship, and 3) one partner downloading pornography. The vignettes were also consistent with those identified by Whitty (2003), who found that people consider that there are three types of Internet infidelity situations – sexual, emotional, and pornography. For complete vignettes, see Appendices D and E.

Six-point Likert statements, adapted from Hecker et al. (1995) and Pais, Piercy, and Miller (1998) were used to assess how the practitioners perceive and treat these cases. These items are also contained in Appendices D and E, immediately following their respective vignettes.

The assessment and treatment questions in Appendices D and E are based on previous literature. The assessment and treatment items represent several of the major factors and concepts in case assessment and treatment. The assessment and treatment items include:

- How serious is the presenting problem?
- To what degree is the presenting problem normal?
- How damaging is the problem to the relationship?
- To what degree is the identified client a sex addict?
- What is the prognosis for the marital relationship?
- How many sessions would you estimate successful therapy to take?
- What course of treatment would you take?

An operational definition of therapist assessment and treatment strategies are often found as part of an intake form at many agencies and from clinicians in private practice. Several items

included on an intake form are the number of sessions, an indication of severity of the problem, prognosis, and treatment plan. These items were asked in regard to the vignettes and used as an operational assessment. Treatment strategies were identified in the last items, which asked respondents to identify how likely they would be to focus on individual issues, environmental issues, relational issues, etc. The qualitative component is described in Phase Two of this research.

The questions that were asked on the demographics page represent items that may influence how a therapist conceptualizes and subsequently treats a particular case. As Guanipa and Woolley (2000) indicated, gender biases stem from several social background characteristics – cultural, biological, social, and political standards. It is these factors that were assessed on the part of the clinician in order to measure and/or control for the social background factors which may affect therapist assessment and treatment strategies.

Gender of the therapist[2] might affect how therapists conceptualize and view cases. Male therapists, for example, may view female clients engaging in Internet infidelity as more pathological than female therapists; likewise, female therapists may view male clients engaging in Internet infidelity as more pathological than female clients. In order to control for what differences may arise, gathering data about gender of the therapist is critical (see Item 1 in Appendix C).

Similarly, marital status of the therapist might also affect the severity of how therapists view infidelity cases. Married therapists may view infidelity differently than those who are divorced, particularly if the divorce for the therapist was related to infidelity in the therapist's own life. Therefore, assessment of the therapists' marital status is included in the demographics questionnaire (see Item 3 in Appendix C).

Therapist conceptualizations are also determined by the clinician's orientation. Clinical orientation provides a manner in which a clinician tends to view their cases. For example, those coming from a postmodern standpoint might be more likely to view Internet infidelity as less pathological than therapists shaped by modernism. Since clinical orientation may influence how

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[2] I was interested in examining gender of the clinician as opposed to sex. Sex refers to the biological mechanisms, where gender refers to the features and characteristics that a person identifies with a particular sex. This research is not interested in how biologically the therapists relate to cases, but is interested in the gender with which the respondent most identifies, as they will be responding to the items through this lens.

a therapist conceptualizes a case, this item was also included on the demographics page (see Item 5 in Appendix C).

Another factor related to how therapists view infidelity is likely shaped by their religious values. In a study by Hecker, Trepper, Wetchler, and Fontaine (1995), clinicians who rated themselves as being very religious viewed sexual behavior as more pathological than clinicians with lower levels of religiosity viewing the same sexual behavior. Since the level of religious involvement appears to be an important factor in how a therapist views a case with a presenting problem which is sexual in nature, an item assessing degree of religious involvement of the therapist is asked on the demographics questionnaire (see Item 9 in Appendix C).

Another social background factor with some bearing on how clinicians assess and treat infidelity is the impact of infidelity on their own personal lives. Clinicians may be reading vignettes they have personally experienced. This might affect how a clinician decides to treat a case. For example, if a therapist reads a vignette about a couple where one spouse has engaged in Internet infidelity, and this has occurred in the therapist's own life, the therapist may respond to the assessment and treatment items from his/her own experience as opposed to the case description. Therefore, in order to control for this event, one item on the demographics page assessed whether the therapist has been personally affected by infidelity (see Item 10 in Appendix C).

Experience is another factor that relates to case conceptualization and treatment. Several studies have explored the level of therapist training and how cases are conceptualized. The results of these studies is contradictory in regard to identifying if there are differences in biases and case conceptualization between novice and seasoned therapists. For example, Seem and Johnson (1998) discovered that counseling students in training were likely to have gender biases in their assessment of cases, while Ettenson, Shanteau, and Krogstad (1987) found no difference in expert versus novice assessments in cases. Due to the inconsistencies in the literature on this topic, it is important to assess the level of therapist experience (see Items 13, 14, and 15 in Appendix C).

The remaining items on the demographics page are standard items to assess the sample and to ascertain whether the sample is representative of AAMFT membership. These items inquire about the ethnicity of the therapist, income, field of highest degree, location of residence,

and age. Finally, respondents were asked if they wanted to participate in Phase Two of the study and asked to provide contact information.

Data Analyses

Results for the Likert-scale items were statistically analyzed through t-tests, MANOVA, and regression. The dependent variables were the assessment decisions of the therapists (e.g., prognosis estimates, the perceived seriousness of the problem), while the primary independent variables included the gender of the client and the gender, age, and religiosity of participants. The Bonferroni test was used to minimize the possibility of alpha error.

Phase Two Methodology

Dodini (2000), in his thesis on therapists' assessment of hope and justification in cases of Internet infidelity, wrote, "Future research on therapists' biases and beliefs in treating extramarital involvement will need to include a qualitative component that will enrich the understanding of the quantitative data." (p. 82). The present study contains a qualitative component to do just that.

Participants

Participants are eight clinical members of the American Association for Marriage and Family Therapy (AAMFT) (practicing clinicians). I performed a stratified random sample of the participants who had already completed the initial survey to participate (five men and five women) participate. The participant already completed Phase One of this study (a survey) and volunteered to take part in Phase Two, the interview phase. The participants already provided to the researcher their contact information during Phase One. There were no restrictions as far as age, ethnicity, or any other factors other than gender, as previously mentioned.

Participants involved in the research benefited in several ways. First, clinicians were able to share with other clinicians some information about treatment and assessment decisions. For example, the results of this study will be presented at conferences. Another benefit of this research is the potential development of a treatment framework for Internet infidelity cases. The outcome of this research will provide themes for how therapists assess and treat Internet infidelity cases. As a result, the findings can be compiled into a framework for treating Internet infidelity cases.

Procedures

AAMFT is a national association. As such, participants who have agreed to take part in Phase Two lived all over the country. Because of the variety of geographic location of the participants, semi-

structured interviews were conducted over the phone. The researcher first contacted the participant to arrange a time for the interview. I conducted the interviews at a time convenient for the clinician. Each interview lasted approximately 30 to 45 minutes. Only one interview was conducted of each participant. The interview protocol can be found in Appendix F.

I asked participants to elaborate on their thinking related to their assessment, perceptions, and treatment decisions in Internet infidelity cases. The interview protocol can be found in Appendix F, and the informed consent in Appendix B. These methods were selected because they are reflective and consistent with the theoretical framework of postmodernism and the literature review. The methods allowed the researcher to ask broad questions, allowing the participants to elaborate on their selected treatment strategies.

Data Analysis

The interview data also allowed me to provide rich illustrations of the participants' thinking behind various treatment decisions and perceptions of client behavior. The results for the interviews were analyzed qualitatively through analytic induction and constant comparison (Strauss & Corbin, 1990). I audiotaped the interviews with the participants. The audiotapes were transcribed. After transcription, I read the data and looked for themes in the statements by the clinicians that emerged from the data. Once themes were identified, I looked for categories across the themes.

Timeline

This research began this project in March of 2003. Potential volunteers were selected from the AAMFT membership list and asked to provide contact information in the event that they wanted to participate in the qualitative portion. The conducting of interviews lasted from May 2003 through August 2003. The transcription took place from September through October of 2003. Coding and development of themes and categories occurred through November. Cross-coding and comparative analyses were conducted in December of 2003. Results were written up between December of 2003 and February of 2004.

Dissemination

Findings will be disseminated at both local and national conferences. The findings will be collected and used as building blocks in developing a framework for treating Internet infidelity cases.

Achieving Rigor

There are a variety of ways that I have achieved rigor within the current project. *Credibility* is achieved through triangulation and member checks (Anfara, Brown, & Mangione, 2002). Triangulation is achieved through the comparison of interview responses to previously completed survey responses. Member checks also ensure credibility in that the participants will have the opportunity to make sure the results are consistent with the participants' responses (Merriam, 1998). *Transferability* is achieved through the rich, thick description and presentation of findings. *Dependability* is achieved through peer examination (having a committee examine the findings) and triangulation. *Confirmability* is achieved through including reflexivity in the findings, meaning that the researcher will assess how the findings will affect those who are studied, the researcher, and those receiving the findings.

Roles, Beliefs, and Assumptions

There are several beliefs and assumptions I have made about this research. First, I am working from the assumption that clinicians are invested in better understanding how they assess and treat Internet infidelity cases. Another assumption is that therapists will be able to articulate some of the strategies that they use to treat these cases to an outside party.

One belief that I have regarding this project is that Internet infidelity is an important and timely concept in contemporary society. I believe that therapists who are not clear on what goes into their treatment strategies are vulnerable to practicing through their values and biases. This does not necessarily result in the best practice for clients.

There are several aspects to my role in the current project. First, I am presently as student member of the same professional organization (AAMFT) from which the sample was drawn. This is a strength because I can relate to the participants in terms of a common language and understanding the content of their responses. This is also a weakness, however, in I may have been too limiting in the scope of my questioning. I might have a tendency to assume that I understands and/or fills in gaps when they occur, and I may be incorrect in those assumptions, potentially leading to inaccurate findings.

Another aspect that is part of the role of the researcher is one's personal belief about Internet infidelity. As a researcher, does one have the right to decide or make a judgment on the value of Internet infidelity? As a wife, I certainly have my own personal idea about what this might entail. Finally, as a therapist, I believe that whatever the couple decides is a breach of their

marital relationship. Between these three roles, it is difficult for one to determine how much weight each one has. At this time, I am still attempting to decide where to stand because of the complexity of this issue.

CHAPTER IV: RESULTS

"If we value the pursuit of knowledge, we must be free to follow wherever that search may lead us. The free mind is not a barking dog, to be tethered on a ten-foot chain."

- Adlai Stevenson

"The great tragedy of Science – the slaying of a beautiful hypothesis by an ugly fact."

- Thomas H. Huxley

Demographics

A total of 2,687 requests for participation were emailed to potential respondents. Of this number, 727 assessments in which a woman was the identified client (i.e., the partner engaging in sexual behavior via the computer) were sent to female clinicians (27.1%), with another 674 female assessments distributed to male clinicians (25.1%). Of the male assessments (vignettes featuring a man as the identified client), 705 were distributed to female clinicians (26.23%), and another 581(21.62%) were distributed to male clinicians. Of the total 2,687 questionnaires emailed, a total of 360 (13.4%) were returned as a result of a bad email address (82 female assessments from female clinicians, 95 female assessments from male clinicians, 105 male assessments from female clinicians, and 78 male assessments from male clinicians).

Therefore, no more than 2,327 questionnaires had the potential of reaching their participants.[3] See Table 1 for a breakdown of the response rates of the male and female assessments. The return rate was 21.83 % of those who potentially reached their intended receivers, or 508 questionnaires. Four of the returned questionnaires were deleted due to incomplete data. As a result, the remaining 504 questionnaires were utilized in the analysis, or 21.65 % of the potentially received questionnaires.

The analysis included a total of 241 (48.49 %) male therapists and 256 (51.61 %) female therapists, with seven participants not reporting their sex. Participant ages ranged from 20 to 78 years, with a mean age of 51.24 years.

Tables 1 through 9 display demographic information applying to all participants.

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[3] Though 2,327 reflects the number of emails that were not returned for a bad address, it is possible that some emails may not have been received and the sender receive no notification of such due to filters available within one's personal email box. Therefore, the response rate is a "worst case scenario" statistic and should be interpreted as such.

Table 1.

Sex of Respondents (N = 497).

Gender	Male Assessment		Female Assessment		Total
	n = 252	%	*n* = 245	%	
Male	123	48.6	118	48.1	241
Female	129	51.3	127	51.8	256

Of the total sample, 48.3% of the participant therapists were men and 51.6% were women. Six of the participants did not respond to this question.

Table 2.

Ethnicity of Respondents (N = 493).

Race	Male Assessment		Female Assessment	
	n= 251	%	*n*= 242	%
African American	6	2.4	5	1.6
Asian	2	0.8	0	0.0
Caucasian	235	93.6	226	93.4
Hispanic/Latin	4	1.6	2	0.8
Native American	2	0.8	3	1.2
Other	2	0.8	6	2.4

The largest proportion in the sample was Caucasian. The total sample was composed of 2.2% African American, 0.4% Asian, 93.5% Caucasian, 1.2% Hispanic, 1.0% Native American, and 1.6% who identified themselves as "Other." The "other" category was composed of: Arab-American, Asian-Caucasian, Biracial, White-Hispanic, and others.

Table 3.

Relationship Status (N = 500).

Relationship Status	Male Assessment		Female Assessment	
	n = 254	%	n = 246	%
Single, never married	9	3.56	7	2.84
Single, divorced/annulled	32	12.65	24	9.75
Married	166	65.35	155	63.0
Divorced, but remarried	40	15.81	43	17.48
Widowed	3	1.18	2	0.81
Widowed but remarried	2	0.79	4	1.63
Other Long Term Relationship	2	0.79	3	1.22
Separated	0	0.0	2	0.81
Domestic Partner	0	0.0	4	1.63
Other	0	0.0	2	0.81

Table 3 reflects the status of the relationship for participants. Most of the participants reported that they were married (n = 321, 64.2%). Overall, 3.2% (n = 16) of the sample reported they were single and never married. Another 11.22% (n = 56) reported that they were single after a divorce or annulment. Approximately 1.0% (n = 5) were widowed and 1.2% (n = 6) reported they were widowed but remarried. Another 1.0% were in other long term relationships (n = 5), 0.4% (n = 2) were separated, and 0.8% (n = 4) reported a domestic partnership.

Table 4.

Highest Degree Earned (N = 501).

Status	Male Assessment		Female Assessment	
	n = 253	%	n = 248	%
Bachelor's degree	1	0.3	1	0.42
Master's degree	150	59.52	143	57.66
Ph.D.	69	27.27	69	27.82
Ed.D.	10	3.96	10	4.03
Psy.D.	1	0.39	4	1.61
M.D.	0	0.0	2	0.81
D.Min.	9	3.57	13	5.24
Dual Master's	7	2.78	1	0.42
Post Master's Certificate	1	0.39	1	0.42
Other	5	1.98	4	1.61

Table 4 reflects the level of education of the participants. This was assessed in seven categories: bachelor's, master's, Ph.D., Ed.D., Psy.D., M.D., or "Other". Most respondents had completed their master's (58.6%, n = 293). Of all participants, 37% (n = 185) completed a doctoral degree; 27.5% (n = 138) completed at Ph.D; 4% (n = 20), 0.8% (n = 5), 0.4% (n = 2), 4.4% (n = 22) reported completion of an Ed.D., Psy.D, M.D., and D.Min respectively. "Other" was composed of Ed. S., Th.D., R.N., Advanced Degree in MFT, CAGS, and other. There were also two participants who indicated that they were doctoral candidates, and were collapsed into the Master's degree participant group.

Table 5.

Field of degree (N = 502).

Status	Male Assessment		Female Assessment	
	n = 254	%	n = 248	%
Marriage and Family Therapy	139	54.72	139	56.05
Social Work	18	7.11	14	5.65
Psychiatry	0	0.0	1	.403
Psychology	31	12.25	39	15.73
Divinity/Pastoral/Theology	15	5.93	12	4.84
Nursing	6	2.37	0	0.0
Family Studies	5	1.98	3	1.21
Counseling Education	23	9.09	24	9.68
Counseling/Couns. Psych/Rehab/general	9	3.56	5	2.02
MFT and another	3	1.19	4	1.61
Sociology	2	0.79	1	.403
Other	3	1.19	6	2.42

Table 5 presents in what field the respondents earned their degrees. Most participants in the study reported that they received their highest degree in the field of Marriage and Family Therapy (55.3%, n = 278). Approximately 14% (n = 70) of the respondents reported they received their degree in Psychology, and another 9.38% (n = 47) reported their highest degree was in Counseling Education. Respondents who had their highest degree in Social Work made up 6.39% (n = 32) of the sample. Those with their highest degree in Divinity/Pastoral/Theology made up 5.39% (n = 27), of the sample. A total of 2.79% (n = 14), 1.59% (n = 8), 1.39% (n = 7), 1.19% (n = 6), 0.59% (n = 3), 0.19% (n = 1), and 1.79% (n = 9), received their highest degree in Counseling/Counseling Psych/Rehabilitative, Family Studies, MFT and another area, Nursing, Sociology, Psychiatry, and Other, respectively. “Other” was made up of Sports Psychology, Education, Human Resources, Human Sexuality, Guidance and Public Administration, and Human Ecology.

Table 6.

Clinical Orientation (N = 508).

Orientation	Male Assessment		Female Assessment	
	n=250	%	*n=258*	%
Integrative	60	24.00%	40	38.85%
Solution-focused	42	16.80%	39	31.46%
Systemic (Milan, general)	30	12.00%	25	21.36%
Transgenerational	23	9.20%	22	17.48%
Experiential	19	7.60%	13	12.43%
Social Constructionist	14	5.60%	33	18.24%
Structural	12	4.80%	15	10.48%
Behavioral	11	4.40%	14	9.71%
Other	11	4.40%	6	6.61%
Cognitive/Cognitive-behavioral	9	3.60%	12	8.15%
Eclectic	9	3.60%	5	5.44%
Metaframeworks	8	3.20%	6	5.44%
Psychodynamic	8	3.20%	11	7.38%
Strategic	7	2.80%	9	6.21%
Emotionally Focused therapy	3	1.20%	0	1.17%

Table 6 reflects the clinical orientation of the participants in the present study. For this item, it was possible to have multiple responses. For example, some clinicians identified themselves as solution-focused and as behavioral. There were some categories that were collapsed into others. The category "Transgenerational," for example, was composed of clinicians indicating that they worked from a transgenerational orientation, a Bowenian orientation, and Contextual therapy. Social Constructionist was created from social constructionist and narrative. The category "Other" was composed of developmental, biopsychosocial, Adlerian, Gestalt, Ericksonian, Neurosemantic, Outcome-focused, faith-based, Rogerian therapy, Transactional analysis, Body therapy, and Multimodal. Metaframeworks was composed of those identifying themselves as using Metaframeworks and/or Internal Family Systems. Psychodynamic was composed of those identifying themselves as psychodynamic, psychoanalytic, object relations, and imago therapy.

Overall, 20% of the clinicians indicated that they used an integrative stance, followed by 16% who reported that they used a solution-focused perspective. Another 11% of the total

respondents indicated they used systemic therapies, followed by 6.2% who stated they used experiential therapies. Approximately 9.25% reported they used social constructionist; 5.3% used structural; 4.9% used behavioral; 3.34% used a variety of other modalities; 4.133% used cognitive and/or cognitive behavioral; 2.76 reported they were eclectic, with the same amount reporting they used metaframeworks; 3.74% identified themselves as psychodynamic; 3.15% reported they were strategic; and 0.59% reported they were influenced primarily by EFT.

Table 7.

Religious affiliation of participants (N = 499).

Status	Male Assessment		Female Assessment	
	n = 252	%	n= 247	%
Protestant	150	59.52	132	53.4
Catholic	25	9.96	29	11.74
Jewish	20	7.96	27	10.93
Islam	0	0.0	2	0.81
Other	23	9.16	22	8.91
No Religion Practiced	34	13.55	35	14.17

The different religious affiliations of the respondents are reflected in Table 7. The category Protestant was composed of Baptists, Christians, Episcopalians, Latter Day Saints, Lutherans, Non-Denominational, Presbyterian, Quaker, Seventh Day Adventist, Unitarian, United Methodist, and other Protestants. Another category, "No Religion Practiced" was also assessed, and made up 13.85% (n = 69) of the sample. Approximately 56.5% of the total sample (n = 282) reported they were Protestant; 10.84% (n = 54) reported they were Catholic; 9.44% (n = 47) reported they were Jewish; 0.4% (n = 2) reported they were Islamic; 9.04% (n = 45) reported they were Other.

Table 8.

Religiosity of participants (N = 497).

Level of religiosity	Male Assessment		Female Assessment	
	n =251	%	*n* =246	%
Very religious	114	45.2	101	41.06
Somewhat religious	105	42	97	39.43
Not at all religious	32	12.8	48	19.51

Participants also reported their level of religiosity (see Table 8). Approximately 43.3% of the total number of participants (n = 215) reported that they were very religious; 40.73% (n = 202) reported they were somewhat religious, and the remaining 16.13% (n = 80) reported that they were not at all religious. The level of religion of the therapists may also be different than that of their clients. For example, therapists in AAMFT might be either more religious than their clients in general, or vice versa.

Table 9.

Impact of infidelity on participants (N = 501).

Infidelity impacted therapist	Male Assessment		Female Assessment	
	n =253	%	*n* = 248	%
No	151	59.52	140	56.45
Yes	102	40.48	108	43.52

Table 9 reports the impact of infidelity on the lives of the family therapist participants in the current study. Over half of the participants (58.1%, n = 291) indicated that infidelity did not impact them personally.

Descriptive Statistics

Reported in Table 10 are the means, standard deviations, and other descriptive information for assessment and treatment items 1-5 and 7-11 in Vignette 1 for both the Male and Female Assessment inventories. Table 11 reflects the means, standard deviations, and other descriptive information for assessment and treatment items 1-5 and 7-11 for Vignette 2 for both the Male and Female Assessment inventories. For Vignette 3, Table 12 depicts means, standard deviations, and other descriptive information for assessment and treatment items 1-5 and 7-11 for both the Male and Female Assessment inventories.

Table 10.

Descriptive information for Vignette 1.

Assessment and Treatment Items – Vignette 1	Male Assessment			Female Assessment		
	n	*M*	*sd*	*n*	*M*	*sd*
1a. How serious is the presenting problem?	254	5.06	.85	248	4.92	.90
2a. To what degree is this typical?	251	3.32	1.45	246	3.09	1.33
3a. How damaging is this problem to the relationship?	254	4.91	.90	246	4.76	.93
4a. To what degree is the identified client a sex addict?	248	2.35	1.21	238	1.71	.95
5a. What is the prognosis for the marital relationship?	247	3.68	.98	243	3.88	1.02
6a. How many sessions will treatment take?	251	57.12	202.2	240	46.48	177.4
7a. How much should treatment focus on individual issues?	251	3.51	1.26	242	3.14	1.28
8a. How much should treatment focus on relational issues?	254	5.13	.88	242	5.19	.85
9a. How much should treatment focus on environmental issues?	252	2.60	1.40	242	2.35	1.33
10a. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	252	5.42	.78	244	5.32	.95
11a. How much should treatment focus on managing crisis?	253	3.86	1.34	245	3.63	1.28

Table 11.

Descriptive information for Vignette 2.

Assessment and Treatment Items – Vignette 2	Male Assessment			Female Assessment		
	n	*M*	*sd*	*n*	*M*	*sd*
1b. How serious is the presenting problem?	252	5.83	.44	246	5.79	.65
2b.To what degree is this typical?	249	3.49	1.31	244	3.45	1.38
3b. How damaging is this problem to the relationship?	251	5.71	.57	246	5.70	.59
4b. To what degree is the identified client a sex addict?	245	2.55	1.3	237	2.06	1.14
5b. What is the prognosis for the marital relationship?	247	2.91	1.14	242	2.97	1.13
6b. How many sessions will treatment take?	235	20.62	14.28	230	36.04	262.76[4]
7b. How much should treatment focus on individual issues?	250	4.03	1.35	243	3.78	1.47
8b. How much should treatment focus on relational issues?	251	5.25	.84	244	5.39	.83
9b. How much should treatment focus on environmental issues?	250	2.86	1.5	243	2.57	1.49
10b. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	249	5.41	.79	243	5.43	.82
11b. How much should treatment focus on managing crisis?	248	4.52	.132	243	4.52	1.34

[4] Though this standard deviation appears incorrect, I have checked it with the original data and it is, indeed, correct.

Table 12.

Descriptive information for Vignette 3.

Assessment and Treatment Items – Vignette 3	Male Assessment			Female Assessment		
	n	*M*	*sd*	*n*	*M*	*sd*
1c. How serious is the presenting problem?	251	4.43	1.16	246	4.22	1.18
2c. To what degree is this typical?	248	3.26	1.52	245	3.72	1.54
3c. How damaging is this problem to the relationship?	251	4.38	1.16	244	4.14	1.14
4c. To what degree is the identified client a sex addict?	245	3.34	1.51	240	2.90	1.46
5c. What is the prognosis for the marital relationship?	246	4.02	1.07	239	4.14	1.06
6c. How many sessions will treatment take?	248	67.05	222.04	238	43.78	67.14
7c. How much should treatment focus on individual issues?	249	4.38	1.36	241	4.04	1.43
8c. How much should treatment focus on relational issues?	250	4.89	1.00	244	4.96	.96
9c. How much should treatment focus on environmental issues?	250	3.42	1.64	244	3.10	1.59
10c. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	246	5.00	1.06	244	5.01	1.11
11c. How much should treatment focus on managing crisis?	251	3.99	1.42	244	3.89	1.42

Research Question #1

Do marriage and family therapists' assessment and treatment decisions in cases of infidelity change depending on the gender of the identified client?

Relevant to the reporting of the t-tests is the determination of the p-value for the analysis. The Bonferroni procedure was used which adjusts the overall α level for the number of comparisons that are performed. Because there were 11 assessment and treatment items, .05 was divided by 11 for a resulting *p*-value of .0045. Rounded up, the *p*-value used in this study was .005.

Vignette 1 Results

In the first vignette, one is communicating online with someone but has not met with them, and this is a problem for their partner. Using the 11 assessment and treatment items (see Appendix D), an independent samples t-test was produced to identify differences, if any, in how clinicians responded to these items depending on the sex of the identified client. Corresponding *n*, means, and standard deviations can be found in Table 10.

Of the 11 assessment and treatment items, two were shown to have significance in the Levine's test for equality of variances. These two items were:

- To what degree is this typical?
- To what degree is the identified client a sex addict?

As a result, the t-values reported will be those indicating that equal variances are not assumed for these two items, and for all others, will be reported indicating that equal variances are assumed. T values, *p*-values, mean difference scores and standard error difference scores are displayed in Table 13.

Results indicated that clinicians differentiate between men and women chatting with someone online in five areas: the prognosis, how they view the client as a sex addict, how much treatment should focus on individual issues, how much treatment should focus on environmental issues, and how much treatment should focus on managing crisis.

In exploring how clinicians assess these cases, results indicated a significant difference in the rating of a client as a sex addict, $t = 6.485$, $p = .000$. Men communicating with women were rated as having a significantly greater degree of sex addiction than women who were communicating with men online ($M_{men} = 2.35$, $M_{women} = 1.71$). In terms of treatment, clinicians

rated that they would be more likely to focus on individual sessions for men engaging in this behavior than for women ($M_{men} = 3.51$, $M_{women} = 3.14$), $t = 3.306$, $p = .001$.

Table 13.

T-test results for Vignette 1.

Assessment and Treatment Items	t-test information			
	t	*df*	Sig	M diff
1a. How serious is the presenting problem?	1.791	500	.074	.14
2a. To what degree is this typical?	1.838	493	.067	.23
3a. How damaging is this problem to the relationship?	1.823	498	.069	.15
4a. To what degree is the identified client a sex addict?	6.485*	466	.000	.64
5a. What is the prognosis for the marital relationship?	-2.162	486	.031	-.20
6a. How many sessions will treatment take?	.619	489	.536	10.64
7a. How much should treatment focus on individual issues?	3.306*	491	.001	.38
8a. How much should treatment focus on relational issues?	-.775	494	.439	-.006
9a. How much should treatment focus on environmental issues?	2.051	492	.041	.11
10a. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	1.245	494	.214	-.078
11a. How much should treatment focus on managing crisis?	1.987	496	.047	.12

* = significant at $p < .005$

Vignette 2 Results

In the second vignette, one individual is online communicating with someone, and meets with this person and has intercourse with this individual. Using the 11 assessment and treatment items (see Appendix D), an independent samples t-test was produced to identify differences, if any, in how clinicians responded to these items depending on the sex of the identified client. Corresponding n, means, and standard deviations can be found in Table 11.

Of the 11 assessment and treatment items, two were shown to have significance in the Levine's test for equality of variances. These two items were:

- To what degree is the identified client a sex addict?
- How much should treatment focus on individual issues?

As a result, the *t*-values reported will be those indicating that equal variances are not assumed for these two items. For all others, the values reported will be those assuming equal variances. *T* values, *p*-values, mean difference scores and standard error difference scores are displayed in Table 14.

Results indicated that there was a significant difference in the rating of a client as a sex addict, $t = 4.360$, $p = .000$. Men engaging in intercourse with a woman they met online were rated as having a significantly greater degree of sex addiction than women engaging in the same behavior ($M_{men} = 2.55$, $M_{women} = 2.06$).

Table 14.

T-test results for Vignette 2.

Assessment and Treatment Items	t-test information			
	t	*df*	Sig	M diff
1b. How serious is the presenting problem?	.825	496	.410	.041
2b. To what degree is this typical?	.289	489	.773	.035
3b. How damaging is this problem to the relationship?	.115	495	.908	.006
4b. To what degree is the identified client a sex addict?	4.360*	480	.000	.48
5b. What is the prognosis for the marital relationship?	-.586	487	.558	-.06
6b. How many sessions will treatment take?	-.898	463	.369	-15.4
7b. How much should treatment focus on individual issues?	1.933	491	.054	.25
8b. How much should treatment focus on relational issues?	1.935	493	.083	-.13
9b. How much should treatment focus on environmental issues?	2.167	491	.031	.29
10b. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	-.308	490	.758	-.023
11b. How much should treatment focus on managing crisis?	.014	489	.989	.016

* = significant at $p < .005$

Vignette 3 Results

In the third vignette, one individual is viewing pornography online and this is a problem to their partner. Using the 11 assessment and treatment items (see Appendix D), an independent samples t-test was produced to identify differences, if any, in how clinicians responded to these items depending on the sex of the identified client. Corresponding n, means, and standard deviations can be found in Table 11.

Of the 11 assessment and treatment items, one was shown to have significance in the Levine's test for equality of variances: how many sessions will treatment take? As a result, the t-value reported for this item will be those where equal variances are not assumed. For the remaining 10 items, *t*-values reported assume equal variances. T values, *p*-values, mean difference scores, and standard error difference scores are displayed in Table 15.

Within the pornography vignette, results indicated differences in therapists' assessments based on the gender of the identified client. Clinicians reported that women who viewed pornography online were significantly more atypical than men engaging in the same behavior ($M_{men} = 3.26$, $M_{women} = 3.72$), $t = -3.349$, $p = .001$. Clinicians also viewed men to more likely be sex addicted when using pornography online than women ($M_{men} = 3.34$, $M_{women} = 2.90$), $t = 3.248$, $p = .001$.

In treatment, there was a trend toward significance in the area of focusing treatment on individual issues when men were the identified client ($M_{men} = 4.38$, $M_{women} = 4.04$), $t = 2.705$, $p = .007$. This number is close to the α cutoff suggested by the Bonferroni procedure, and may warrant further attention in subsequent analyses (Wainer & Robinson, 2003).

Table 15

T-test results for Vignette 3.

Assessment and Treatment Items	t-test information			
	t	*df*	*Sig.*	M diff
1c. How serious is the presenting problem?	2.011	495	.045	.21
2c. To what degree is this typical?	-3.349*	491	.001	-.46
3c. How damaging is this problem to the relationship?	2.305	493	.022	.24
4c. To what degree is the identified client a sex addict?	3.248*	483	.001	.44
5c. What is the prognosis for the marital relationship?	-1.217	483	.224	-.12
6c. How many sessions will treatment take?	1.316	460	.191	23.28
7c. How much should treatment focus on individual issues?	2.705	488	.007	.34
8c. How much should treatment focus on relational issues?	-.804	492	.422	-.071
9c. How much should treatment focus on environmental issues?	2.239	492	.026	.33
10c. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	-.125	488	.901	.098
11c. How much should treatment focus on managing crisis?	.774	493	.439	.13

* = significant at $p < .005$

Research Question #2

Do the assessment and treatment decisions made in cases of Internet infidelity vary when examined in terms of therapist social background variables, such as age, gender, religion, marital status, and whether they report they have been impacted by infidelity in their lives?

To answer this question, a MANOVA was performed using the general linear model function via SPSS 11.5, considering the social background characteristics as covariates in the model (age, sex, religiosity, marital status, and impact of infidelity) and the 33 assessment and treatment items (see Appendix D) as the dependent variables. Within this model, age, sex, and religiosity of clinician were significant (p = .001, p = .009, and p = .000, respectively). Marital status of the clinician and the impact of infidelity on a clinician's life did not appear to significantly add to the model (p = .255, p = .784, respectively).

Before reviewing the results in this section, it is important to understand the nature of the variables that were used in the analysis. Age was kept as a continuous variable, with a range of 0 to 78. Gender remained dichotomous (male or female). Due to the large number of married individuals in the sample (n = 320), this variable was made dichotomous – cases were divided into those respondents who were married and those who were not (n = 188). Impact of infidelity was also a dichotomous variable; respondents either answered that this had impacted them in some way or had not. Finally, religion was in three ordered groups: not at all religious, somewhat religious, and very religious.

Similar to the procedure followed in the first section of this dissertation, a Bonferroni correction was implemented as a way to control for Type I error. The significance level used is .05 divided by 11, or .0045, rounded to .005.

<u>The Impact of Responding Clinician's Age on Assessment and Treatment Variables</u>

There were two variables across the three Internet infidelity vignettes in which age of the clinician appeared to be related to the assessment and treatment variables (see Table 16). While holding all other variables constant, age was significantly related to how many sessions were prescribed in Vignette 1, F = 8.206, p = .004, and the amount that treatment should focus on environmental issues in Vignette 2, F = 11.297, p = .001.

There were also some assessment and treatment items across the three vignettes that did not make the cut-off after the Bonferroni adjustment, but may be of interest for future research and other investigations. Some examples include how age is related to the amount that treatment

should focus on environmental issues in Vignettes 1 and 3 ($F = 6.859$, $p = .009$ and $F = 5.546$, $p = .019$, respectively), the number of sessions prescribed in Vignette 3 ($F = 6.815$, $p = .009$), and the amount treatment should focus on managing crisis in Vignette 3 ($F = 7.669$, $p = .006$).

Table 16.

Impact of Clinician Age Vignettes 1, 2, and 3.

Assessment and Treatment Items	p-values for Vignettes		
	1	*2*	*3*
1. How serious is the presenting problem?	.515	.201	.100
2. To what degree is this typical?	.942	.853	.490
3. How damaging is this problem to the relationship?	.943	.279	.328
4. To what degree is the identified client a sex addict?	.238	.671	.126
5. What is the prognosis for the marital relationship?	.576	.174	.026
6. How many sessions will treatment take?	.004*	.785	.009
7. How much should treatment focus on individual issues?	.045	.243	.636
8. How much should treatment focus on relational issues?	.849	.882	.883
9. How much should treatment focus on environmental issues?	.009	.001*	.019
10. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	.171	.508	.898
11. How much should treatment focus on managing crisis?	.012	.665	.006

* = significant at $p < .005$

After reviewing Table 16, it is evident that, though age influences the assessment and treatment variables in some capacity, the manner in which age influences these variables is unclear. In other words, age may have had an impact on how many sessions practitioners prescribed for the case, but it is uncertain at this time if the results mean that the older the clinician, the more sessions prescribed, or the younger the clinician, the more sessions prescribed. Therefore, the next step in this analysis is to perform a multiple regression analysis using the already-significant assessment and treatment items as the dependent variables and age (as well as other social background characteristics) as the independent variables. The order of the variables in the regression was not determined through any theory, but was a consistent order throughout the analyses.

For the number of sessions in Vignette 1 and with only age as the independent variable, Pearson's correlation was $r = .009$, and was therefore not significant, $p = .424$. Likewise, the regression equation in which age of the respondent was the sole predictor of number of sessions was not significant ($t = .192$, $p = .847$). These results may be due to, in part, a larger n. In the MANOVA, there were approximately 400 cases, depending on the item. Because we were just

recently looking at only age and not the other variables, there was no deletion of cases listwise, thus resulting in 78 more cases in the regression analysis.

Next, I ran an analysis in which age was one predictor, along with the other 4 social background variables, using the enter method for regression. In this analysis, the model was found to be significant, $p = .038$, though age itself did not significantly contribute to the model ($R^2 = .000$). Further results of the analysis are presented in Tables 17 and 18. Marital status, however, was shown to significantly add to the model for number of sessions in Vignette 1 (see Tables 17 and 18), $t = -1.959$, $p = .05$. In this case, clinicians who prescribed more sessions were those who were married.

Table 17.

Influence of Predictors for Number of Sessions in Vignette 1 (N = 478).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.071	.792	.000	-.002
Model 2: Age and Sex	.277	.758	.001	-.003
Model 3: Age, Sex, and Marital Status	2.289	.078	.014*	008
Model 4: Age, Sex, Marital Status, and Infidelity Impact	2.436	.046	.020	.012
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	2.374	.038	.025	.014

Dependent variable: Vignette 1 – How many sessions will treatment take? – Vignette 1

* = R^2 change is significant at .05

Table 18.

Regression Coefficients for Each Model for Number of Sessions in Vignette 1.

MODEL		B (unstandardized)	*t*	*Sig.*
1	(Constant)	40.680	.862	.389
	Age	.242	.266	.790
2	(Constant)	22.208	.410	.682
	Age	.241	.265	.791
	Sex	12.275	.695	.488
3	(Constant)	87.898	1.467	.143
	Age	-.179	-.195	.846
	Sex	3.442	.192	.848
	Marital status	-47.835	-2.512	.012
4	(Constant)	41.900	.638	.524
	Age	-.189	-.206	.837
	Sex	1.574	.088	.930
	Marital status	-39.943	-2.040	.042
	Impact of infidelity	31.049	1.688	.092
5	(Constant)	18.492	.274	.785
	Age	-.262	-.285	.776
	Sex	-1.625	-.090	.928
	Marital status	-38.537	-1.969	.050
	Impact of infidelity	31.180	1.697	.090
	Religiosity	17.837	1.451	.147

Dependent variable: How many sessions will treatment take? – Vignette 1

For Vignette 2, a clinician's age was related to how much the clinician would focus on environmental issues (see Table 16). Again, a separate regression equation was run to identify the manner in which age affected these results. Results indicated that, when considering the other social background characteristics, the younger the clinician, the more likely they would be to focus on environmental issues (t = -3.487, p = .001) Though significant, age only adds 3.1% or the variance explaining clinicians' decision to focus on environmental issues in Vignette 2 (see Figure 1). Tables 19 and 20 display results of the regression analyses including the five social background characteristics under investigation as they related to the focus that clinicians place on environmental factors in treatment.

Table 19.

Influence of Predictors on Environmental Focus in Vignette 2 (N = 479).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	15.02	.000	.031*	.028*
Model 2: Age and Sex	9.820	.000	.040*	.036*
Model 3: Age, Sex, and Marital Status	7.114	.000	.043	.037
Model 4: Age, Sex, Marital Status, and Infidelity Impact	5.387	.000	.043	.035
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	6.154	.000	.061*	.051*

Dependent variable: How much should treatment focus on environmental issues? – Vignette 2

* = R^2 change is significant at .05

Table 20.

Regression Coefficients for Environmental Focus in Vignette 2.

MODEL		B (unstandardized)	*t*	*Sig.*
1	(Constant)	7.087	11.367	.000
	Age	-.027	-3.876	.000
2	(Constant)	4.530	10.924	.000
	Age	-.027	-3.918	.000
	Sex	-.286	-2.123	.034
3	(Constant)	4.279	9.345	.000
	Age	-.0255	-3.639	.000
	Sex	.235	-1.845	.066
	Marital status	.188	1.294	.196
4	(Constant)	4.381	8.702	.000
	Age	-.0255	-3.632	.000
	Sex	-.249	-1.812	.071
	Marital status	.171	1.146	.253
	Impact of infidelity	-.0689	-.489	.625
5	(Constant)	4.745	9.230	.000
	Age	-.0243	-3.487	.001
	Sex	-.199	-1.449	.148
	Marital status	.146	.980	.327
	Impact of infidelity	-.0690	-.494	.622
	Religiosity	-.281	-2.977	.003

Dependent variable: How much should treatment focus on environmental issues? – Vignette 2

The Impact of Responding Clinician's Gender on Assessment and Treatment

Gender of the therapist did influence assessment and treatment in a few circumstances (see Table 21). Specifically, in Vignette 1, there were differences in between male and female clinicians in how much treatment should focus connecting the present problem to larger processes within the couple's interaction ($F = 8.254$, $p = .004$). In Vignette 3, the number of sessions prescribed also differed also based on clinician gender ($F = 9.346$, $p = .002$).

Table 21.

Impact of Clinician Gender for Vignettes 1, 2, and 3.

Assessment and Treatment Items	Vignette Significance		
	1	*2*	*3*
1. How serious is the presenting problem?	.209	.306	.081
2. To what degree is this typical?	.261	.240	.235
3. How damaging is this problem to the relationship?	.234	.036	.068
4. To what degree is the identified client a sex addict?	.702	.943	.050
5. What is the prognosis for the marital relationship?	.191	.782	.019
6. How many sessions will treatment take?	.140	.136	.002*
7. How much should treatment focus on individual issues?	.730	.972	.008
8. How much should treatment focus on relational issues?	.134	.127	.147
9. How much should treatment focus on environmental issues?	.909	.230	.615
10. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	.004*	.013	.604
11. How much should treatment focus on managing crisis?	.149	.659	.652

* = significant at $p < .005$

Again, separate regression analyses were performed to determine the manner in which gender of the clinician affected their treatment focus. Tables 22 through 25 provide the regression analyses for these assessment and treatment items. Results indicate that sex of the clinician is no longer significant in terms of explaining how a clinician was prescribe number of sessions (see Tables 22 through 23). This result may be due in part to the added 72 cases in the regression analysis.

Table 22.

Influence of Predictors on Number of Sessions in Vignette 3 (N = 472).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.316	.574	.001	-.001
Model 2: Age and Sex	.691	.502	.003	-.001
Model 3: Age, Sex, and Marital Status	1.280	.288	.008	.002
Model 4: Age, Sex, Marital Status, and Infidelity Impact	1.254	.287	.011	.002
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	.1405	.221	.015	.004

Dependent variable: How many sessions will treatment take? – Vignette 3

Table 23.

Regression Coefficients for Each Model for Number of Sessions in Vignette 3.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	26.763	.573	.567
	Age	.507	.562	.574
2	(Constant)	-.787	-.015	.988
	Age	.513	.569	.569
	Sex	17.990	1.033	.302
3	(Constant)	38.291	.645	.519
	Age	.274	.301	.764
	Sex	12.782	.721	.471
	Marital status	-29.177	-1.547	.122
4	(Constant)	8.303	.127	.899
	Age	.266	.292	.771
	Sex	11.631	.655	.512
	Marital status	-24.107	-1.243	.215
	Impact of infidelity	20.226	1.111	.267
5	(Constant)	-14.680	-.219	.827
	Age	.199	.218	.828
	Sex	8.710	.488	.626
	Marital status	-22.694	-1.170	.243
	Impact of infidelity	20.414	1.122	.262
	Religiosity	17.142	1.413	.158

Dependent variable: How many sessions will treatment take? – Vignette 3

Sex was still found to be a significant factor, however, on whether the clinician would connect the presenting problem to larger processes within the couple's relationship (see Tables 24 and 25). Above all, female clinicians are more likely to incorporate a couple's larger processes into treatment when the identified client is communicating with someone online than male clinicians, $t = 2.556$, $p = .011$. Similar to the results for age, however, sex of clinician, though significant, only accounted for 1.7% of variance in the model (see Table 24).

Table 24.

Influence of Predictors on Connection to Larger Processes in Vignette 1 ($N = 482$).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.165	.685	.000	-.002
Model 2: Age and Sex	4.173	.016	.017*	.013*
Model 3: Age, Sex, and Marital Status	2.971	.031	.018	.012
Model 4: Age, Sex, Marital Status, and Infidelity Impact	2.257	.062	.019	.010
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	1.918	.090	.020	.009

Dependent variable: How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction? – Vignette 1

Table 25.

Regression Coefficients for Each Model for Connection to Larger Processes in Vignette 1.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	5.458	26.433	.000
	Age	-.0016	-.406	.685
2	(Constant)	5.115	21.54	.000
	Age	-.0014	-.360	.719
	Sex	.221	2.860	.004
3	(Constant)	5.200	19.79	.000
	Age	-.0019	-.486	.628
	Sex	.209	2.657	.008
	Marital status	-.063	-.759	.448
4	(Constant)	5.244	18.127	.000
	Age	-.0019	-.483	.629
	Sex	.211	2.671	.008
	Marital status	-.071	-.823	.411
	Impact of infidelity	-.0293	-.362	.717
5	(Constant)	5.192	17.451	.000
	Age	-.002	-.530	.597
	Sex	.203	2.556	.011
	Marital status	-.067	-.783	.434
	Impact of infidelity	-.0293	-.362	.718
	Religiosity	.0412	.755	.450

Dependent variable: How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction? – Vignette 1

The Impact of Responding Clinician's Religiosity on Assessment and Treatment

How religious a clinician believed they were appeared to influence their assessment and treatment decisions. In Vignette 1, the degree of clinician religiosity affected how sex addicted they believed the client was ($F = 16.003$, $p = .000$), as well as how much focus should be placed on environmental issues ($F = 14.961$, $p = .000$) (see Table 26). In Vignette 3, a clinician's religiosity influenced his/her assessment of the client as a sex addict ($F = 20.811$, $p = .000$), but also the assessment of problem severity ($F = 16.307$, $p = .000$) and damage to the relationship ($F = 13.579$, $p = .000$, respectively). Religiosity affected the extent to which clinicians focused on

individual and environmental issues in treatment, such as removing the computer from the room ($F = 9.464$, $p = .002$, $F = 20.204$, $p = .000$, respectively) (see Table 26).

Table 26.

Impact of Clinician Religiosity for Vignettes 1, 2, and 3.

Assessment and Treatment Items	Vignettes		
	1	*2*	*3*
1. How serious is the presenting problem?	.845	.474	.000*
2. To what degree is this typical?	.325	.778	.556
3. How damaging is this problem to the relationship?	.143	.555	.000*
4. To what degree is the identified client a sex addict?	.000*	.046	.000*
5. What is the prognosis for the marital relationship?	.738	.306	.304
6. How many sessions will treatment take?	.328	.060	.698
7. How much should treatment focus on individual issues?	.168	.128	.002*
8. How much should treatment focus on relational issues?	.198	.057	.471
9. How much should treatment focus on environmental issues?	.000*	.012	.000*
10. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	.414	.237	.373
11. How much should treatment focus on managing crisis?	.145	.604	.070

- = significant at $p < .005$

Again, separate regression analyses were run to understand how a clinician's religiosity affected their assessment and treatment of Internet infidelity cases (see Table 26). Tables 27 through 39 provide the analysis for the regression equations for these assessment and treatment items as they relate to religiosity of the clinician.

Religiosity of clinician influenced how serious clinicians viewed the problem. Religiosity of the clinician explained 3.2% of the variance in the model (see Table 27). The more religious clinicians indicated they were, the more serious they rated the problem of one partner viewing pornography online, $t = -4.062$, $p = .000$ (see Table 28).

Also significant in this model, however, was the marital status of the clinician ($t = 2.326$, $p = .02$). This means that clinicians who were married were more likely to report the problem was more severe than clinicians who were not married. Though significant, it only added 1.3% to the full model (see Table 27).

Table 27.

Influence of Predictors on the Severity of the Problem in Vignette 3 (N = 483).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	3.603	.058	.007	.005
Model 2: Age and Sex	2.003	.136	.008	.004
Model 3: Age, Sex, and Marital Status	3.499	.016	.021*	.015*
Model 4: Age, Sex, Marital Status, and Infidelity Impact	2.630	.034	.022	.013
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	5.472	.000	.054*	.044*

Dependent variable: How serious is the presenting problem? – Vignette 3

* = R^2 change is significant at .05

Table 28.

Regression Coefficients for Each Model for Severity of the Problem in Vignette 3.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	3.819	13.531	.000
	Age	.010	1.898	.058
2	(Constant)	3.713	11.327	.000
	Age	.010	1.911	.057
	Sex	.0676	.638	.524
3	(Constant)	3.331	9.278	.000
	Age	.013	2.315	.021
	Sex	.119	1.109	.268
	Marital status	.289	2.539	.011
4	(Constant)	3.296	8.353	.000
	Age	.013	2.310	.021
	Sex	.118	1.093	.275
	Marital status	.295	2.516	.012
	Impact of infidelity	.0239	.217	.828
5	(Constant)	3.687	9.216	.000
	Age	.013	2.580	.010
	Sex	.169	1.587	.113
	Marital status	.268	2.326	.020
	Impact of infidelity	.0186	.172	.864
	Religiosity	-.295	-4.062	.000

Dependent variable: How serious is the presenting problem? – Vignette 3

In Tables 29 and 30, social background characteristics of the therapists and how they relate to the assessment of how damaging the problem is to the relationship is outlined. Religiosity of the clinician remained significant in clinicians' view of the damage of the problem to the relationship when controlling for other background variables, t = -3.797, p = .000. Consistent with the severity findings, clinicians who rated themselves as more religious determined that the situation described in Vignette 3 (frequent viewing of pornography online) was more damaging to the relationship than less religious clinicians. Religiosity also added 2.9% to the model.

Table 29.

Influence of Predictors on Damage of Problem to Relationship in Vignette 3 (N = 481).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	1.558	.213	.003	.001
Model 2: Age and Sex	1.111	.330	.005	.000
Model 3: Age, Sex, and Marital Status	3.147	.025	.019*	.013*
Model 4: Age, Sex, Marital Status, and Infidelity Impact	2.393	.050	.020	.011
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	4.851	.000	.049*	.039*

Dependent variable: How damaging is this problem to the relationship?

* = R^2 change is significant at .05

Table 30.

Regression Coefficients for Each Model for Damage of Problem to Relationship in Vignette 3.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	3.92	13.946	.000
	Age	.007	1.248	.213
2	(Constant)	3.79	11.607	.000
	Age	.007	1.264	.207
	Sex	.009	.815	.416
3	(Constant)	3.39	9.472	.000
	Age	.009	1.696	.091
	Sex	.140	1.313	.190
	Marital status	.304	2.681	.008
4	(Constant)	3.45	8.777	.000
	Age	.009	1.697	.090
	Sex	.143	1.334	.183
	Marital status	.294	2.512	.012
	Impact of infidelity	-.043	-.388	.698
5	(Constant)	3.81	9.547	.000
	Age	-.105	1.944	.052
	Sex	.191	1.790	.074
	Marital status	.272	2.356	.019
	Impact of infidelity	-.046	-.425	.671
	Religiosity	-.276	-3.797	.000

Dependent variable: How damaging is the problem to the relationship? – Vignette 3

Tables 31 through 34 display how the social background characteristics of clinicians influence their view of the identified client in Vignettes 1 and 3 as a sex addict. In Vignettes 1 and 3, religiosity is the only variable that significantly adds to the model (t = -4.354, p = .000 and t = -4.711, p = .000, respectively).

In the first vignette, religiosity explains 3.9% of the variance in how clinicians make assessments about sex addiction, and in the next vignette, 4.5%. In both vignettes (chatting online without intercourse, and viewing pornography online), clinicians who rated themselves as having a higher degree of religiosity identified those chatting online with someone of the opposite sex had a greater deal of sex addiction.

Table 31.

Influence of Predictors on Sex Addiction Assessment in Vignette 1 (N = 472).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	1.354	.245	.003	.001
Model 2: Age and Sex	.784	.457	.003	-.001
Model 3: Age, Sex, and Marital Status	.878	.452	.006	-.001
Model 4: Age, Sex, Marital Status, and Infidelity Impact	.748	.559	.006	-.002
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	4.413	.001	.045*	.035*

Dependent variable: To what degree is the identified client a sex addict?

* = R^2 change is significant at .05

Table 32.

Regression Coefficients for Each Model for Sex Addiction Assessment in Vignette 1.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	1.718	6.167	.000
	Age	.006	1.164	.245
2	(Constant)	1.791	5.587	.000
	Age	.006	1.163	.245
	Sex	-.0486	-.464	.643
3	(Constant)	1.953	5.475	.000
	Age	.0052	.960	.338
	Sex	-.071	-.659	.510
	Marital status	.118	-1.033	.302
4	(Constant)	2.05	5.232	.000
	Age	.005	.962	.336
	Sex	-.066	-.618	.537
	Marital status	-.134	-1.144	.253
	Impact of infidelity	-.066	-.602	.548
5	(Constant)	2.466	6.225	.000
	Age	.00649	1.209	.227
	Sex	-.011	-.105	.916
	Marital status	-.157	-1.363	.174
	Impact of infidelity	-.0698	-.647	.517
	Religiosity	-.314	-4.354	.000

Dependent variable: To what degree is the identified client a sex addict? – Vignette 1

Table 33.

Influence of Predictors on Sex Addiction Assessment in Vignette 3 (N = 472).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	1.759	.185	.004	.002
Model 2: Age and Sex	1.291	.276	.005	.001
Model 3: Age, Sex, and Marital Status	1.909	.127	.012	.006
Model 4: Age, Sex, Marital Status, and Infidelity Impact	1.699	.149	.014	.006
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	5.859	.000	.059*	.049*

Dependent variable: To what degree is the identified client a sex addict?

* = R^2 change is significant at .05

Table 34.

Regression Coefficients for Each Model for Sex Addiction Assessment in Vignette 3.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	2.642	7.126	.000
	Age	.0095	1.326	.185
2	(Constant)	2.449	5.733	.000
	Age	.0095	1.331	.184
	Sex	.126	.908	.365
3	(Constant)	2.090	4.427	.000
	Age	.0118	1.622	.106
	Sex	.174	1.229	.220
	Marital status	.266	1.770	.077
4	(Constant)	2.311	4.461	.000
	Age	.0118	1.629	.104
	Sex	.183	1.296	.196
	Marital status	.229	1.479	.140
	Impact of infidelity	-.150	-1.034	.301
5	(Constant)	2.906	5.565	.000
	Age	.014	1.921	.055
	Sex	.260	1.863	.063
	Marital status	.192	1.270	.205
	Impact of infidelity	-.156	-1.097	.273
	Religiosity	-.446	-4.711	.000

Dependent variable: To what degree is the identified client a sex addict? – Vignette 3

A clinician's decision to focus treatment on individual factors in pornography infidelity cases also appears to be related to how religious a clinician is (see Tables 35 and 36). Religiosity of a clinician adds 2.3% to the model of how likely a clinician is to focus on these individual factors, t = -3.384, p = .001. The more religious a clinician, the more likely they were to focus on individual issues.

In this model, however, sex of the clinician may also be of interest in further investigations. When sex is just added to age as a predictor, the alpha level of the change in the model is .065, near to the .05 cutoff. However, when all variables are considered, sex is considered a significant predictor within the equation, t = 2.399, p = .017 (see Table 36). This would seem to indicate that female clinicians are more likely to focus on individual issues in their treatment of these pornography cases.

Table 35.

Influence of Predictors on Individual Issues Focus in Vignette 3 (N = 477).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.269	.604	.001	-.002
Model 2: Age and Sex	1.839	.160	.008	.004
Model 3: Age, Sex, and Marital Status	1.629	.182	.010	.004
Model 4: Age, Sex, Marital Status, and Infidelity Impact	1.315	.263	.011	.003
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	3.366	.005	.034*	.024*

Dependent variable: How much should treatment focus on individual issues?

* = R^2 change is significant at .05

Table 36.

Regression Coefficients for Each Model for Individual Focus in Vignette 3.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	4.040	11.678	.000
	Age	.0035	.519	.604
2	(Constant)	3.670	9.196	.000
	Age	.0036	.548	.584
	Sex	.239	1.846	.065
3	(Constant)	3.468	7.893	.000
	Age	.0049	.723	.470
	Sex	.265	2.018	.044
	Marital status	.153	1.099	.273
4	(Constant)	3.344	6.924	.000
	Age	.0048	.714	.476
	Sex	.261	1.982	.048
	Marital status	.174	1.214	.226
	Impact of infidelity	.083	.616	.538
5	(Constant)	3.736	7.6	.000
	Age	.006	9.24	.356
	Sex	.315	2.399	.017
	Marital status	.150	1.055	.292
	Impact of infidelity	.0817	.610	.542
	Religiosity	-.304	-3.384	.001

Dependent variable: How much should treatment focus on individual issues? – Vignette 3

Clinicians who were more religious also indicated that treatment of the first vignette (in which there was chatting but no intercourse) would involve a heavier focus on environmental issues than other clinicians who were less religious, t = -3.723, p = .000 (see Table 38). Also significant within this model explaining what influenced clinicians' focus on environmental issues in their treatment of online chatting cases was age. Younger clinicians were more likely to focus on environmental factors in their treatment of such cases than older clinicians, t = -3.151, p = .002. Both age and religiosity of the responding clinician were significant in the model, with age explaining 2.8% of the variance and religiosity explaining 2.7%.

Table 37.

Influence of Predictors on Environmental Issues Focus in Vignette 1 (N = 481).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	13.662	.000	.028*	.026*
Model 2: Age and Sex	7.021	.001	.029	.024
Model 3: Age, Sex, and Marital Status	5.774	.001	.035	.029
Model 4: Age, Sex, Marital Status, and Infidelity Impact	4.322	.002	.035	.027
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	6.324	.000	.062*	.053*

Dependent variable: How much should treatment focus on environmental issues? – Vignette 1

* = R^2 change is significant at .05

Table 38.

Regression Coefficients for Each Model for Environmental Issues Focus in Vignette 1.

MODEL		B (unstandardized)	*t*	*Sig.*
1	(Constant)	3.682	11.123	.000
	Age	-.0235	-3.696	.000
2	(Constant)	3.803	9.933	.000
	Age	-.0236	-3.702	.000
	Sex	-.078	-.630	.529
3	(Constant)	3.483	8.261	.000
	Age	-.0216	-3.349	.001
	Sex	-.0353	-.281	.779
	Marital status	.239	1.793	.074
4	(Constant)	3.476	7.49	.000
	Age	-.0216	-3.345	.001
	Sex	-.0356	-.282	.778
	Marital status	.240	1.751	.081
	Impact of infidelity	.0051	.039	.969
5	(Constant)	3.882	8.247	.000
	Age	-.02	-3.151	.002
	Sex	.022	.176	.860
	Marital status	.213	1.567	.118
	Impact of infidelity	.00414	.032	.974
	Religiosity	-.320	-3.723	.000

Dependent variable: How much should treatment focus on environmental issues? – Vignette 1

In the third vignette (pornography), religiosity and age of the clinician were related to the degree to which they emphasize environmental factors in their treatment (see Tables 39 and 40). Age added 1.9% to the model and religiosity added 4.3%. Clinicians who were more religious were more likely to focus on environmental issues in their treatment in Vignette 3, t = -4.701, p = .000. Additionally, younger clinicians were also more likely to focus their treatment on environmental issues, t = -2.78, p = .014.

Table 39.

Influence of Predictors on Environmental Issues Focus in Vignette 3 (N = 480).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	9.419	.002	.019*	.017*
Model 2: Age and Sex	4.735	.009	.019	.015
Model 3: Age, Sex, and Marital Status	4.461	.004	.027*	.021*
Model 4: Age, Sex, Marital Status, and Infidelity Impact	3.399	.009	.028	.020
Model 5: Age, Sex, Marital Status, Infidelity Impact, and Religiosity	7.261	.000	.071*	.061*

Dependent variable: How much should treatment focus on environmental issues? – Vignette 3

* = R^2 change is significant at .05

Table 40.

Regression Coefficients for Each Model for Environmental Issues Focus in Vignette 3.

MODEL		B (unstandardized)	*t*	*Sig.*
1	(Constant)	4.463	11.347	.000
	Age	-.023	-3.069	.002
2	(Constant)	4.52	9.937	.000
	Age	-.023	-3.070	.002
	Sex	-.039	-.264	.792
3	(Constant)	4.10	8.164	.000
	Age	-.021	-2.678	.008
	Sex	.016	.106	.916
	Marital status	.312	1.964	.050
4	(Constant)	3.989	7.22	.000
	Age	-.021	-2.678	.008
	Sex	.0114	.076	.939
	Marital status	.331	2.021	.044
	Impact of infidelity	.074	.484	.629
5	(Constant)	4.624	8.297	.000
	Age	-.019	-2.78	.014
	Sex	.094	.635	.525
	Marital status	.289	1.799	.073
	Impact of infidelity	.067	.447	.655
	Religiosity	-.475	-4.701	.000

Dependent variable: How much should treatment focus on environmental issues? – Vignette 3

The Impact of Responding Clinician's Marital Status on Assessment and Treatment

Though there were no significant results for the influence of a clinician's martial status on the assessment and treatment items at $p < .005$ (see Table 41), it was this variable that was important in some of the other regression equations. These relationships were mentioned on throughout the earlier portions of this results section.

Table 41.

Impact of Clinician Marital Status for Vignettes 1, 2, and 3.

Assessment and Treatment Items	Vignette Significance		
	1	*2*	*3*
1. How serious is the presenting problem?	.484	.453	.018
2. To what degree is this typical?	.117	.345	.890
3. How damaging is this problem to the relationship?	.157	.754	.026
4. To what degree is the identified client a sex addict?	.114	.724	.229
5. What is the prognosis for the marital relationship?	.208	.639	.250
6. How many sessions will treatment take?	.813	.106	.076
7. How much should treatment focus on individual issues?	.599	.141	.074
8. How much should treatment focus on relational issues?	.019	.819	.368
9. How much should treatment focus on environmental issues?	.265	.262	.188
10. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	.887	.759	.958
11. How much should treatment focus on managing crisis?	.956	.254	.456

- = significant at $p < .005$.

The Impact of Infidelity of Responding Clinician on Assessment and Treatment

There were two assessment items over the three vignettes that appeared to be related to whether the responding clinician indicated that infidelity had affected them personally. In the first vignette, whether infidelity affected a clinician personally influenced the degree to which they believed the presenting problem was typical ($F = 5.048$, $p = .025$). In the third vignette, this experience impacted how many sessions the clinician believed treatment in viewing pornography online would take, $F = 3.939$, $p = .048$. Table 43 presents significance values for each of the assessment and treatment items for all three vignettes.

As an additional data check, there were correlations between the three personal infidelity variables. In other words, there were significant relationships between the impact of a clinician's parent's infidelity and the impact of their partner's infidelity, a clinician's parent's infidelity and their own infidelity, and a clinician's partner's infidelity and their own infidelity. See Table 42 for the corresponding correlation matrix.

Table 42.

Correlations of Personal Impact of Infidelity on Clinicians

Survey Items	Analyses	Survey Items		
		11	12	13
11. Has infidelity within your parents' relationship impacted you positively or negatively?	Pearson's r	1.000	-	-
	Sig. (2-tailed)	.	-	-
	N	114	-	-
12. Has infidelity from your partner impacted you positively or negatively?	Pearson's r	.544**	1.000	-
	Sig. (2-tailed)	.000	.	-
	N	39	111	-
13. Has your own infidelity impacted you positively or negatively?	Pearson 's r	.293	.501**	1.000
	Sig. (2-tailed)	.075	.000	.
	N	38	54	113

* = significant at $p < .05$

** = significant at $p < .01$

Table 43.

Impact of Clinician's Infidelity for Vignettes 1, 2, and 3.

Assessment and Treatment Items	Vignette Significance		
	1	*2*	*3*
1. How serious is the presenting problem?	.074	.246	.831
2. To what degree is this typical?	.055	.192	.153
3. How damaging is this problem to the relationship?	.436	.982	.526
4. To what degree is the identified client a sex addict?	.578	.264	.247
5. What is the prognosis for the marital relationship?	.999	.233	.538
6. How many sessions will treatment take?	.191	.176	.107
7. How much should treatment focus on individual issues?	.390	.280	.633
8. How much should treatment focus on relational issues?	.355	.701	.908
9. How much should treatment focus on environmental issues?	.991	.912	.746
10. How much should treatment focus on connecting the presenting problem to larger processes within the couple's interaction?	.852	.991	.693
11. How much should treatment focus on managing crisis?	.735	.704	.504

* = significant at $p < .005$

In addition to asking the respondents to indicate whether they had been impacted by infidelity in their lives, respondents were also asked to identify the type of impact this experience had for them on a Likert-type 6-point scale (see Appendix C). Correlational analysis found that clinicians whose parents' infidelity impacted them more negatively viewed Vignette 1 as more atypical than other clinicians ($r = .248$, $p = .008$). Clinicians who rated that their partner's infidelity was more negative correlated with a worse prognosis in Vignette 1 ($r = -.222$, $p = .020$) and with greater focus more on individual issues in Vignette 1 ($r = -.293$, $p = .002$) and Vignette 2 ($r = -.268$, $p = .005$). For Vignette 2, the therapists who rated their infidelity experience with their partner as having a negative impact correlated with considering the problem (chatting online leading to intercourse) as more serious ($r = .207$, $p = .030$). Finally, clinicians who reported a negative impact of their own infidelity correlated with rating the third vignette as more typical ($r = -.199$, $p = .037$).

Using the correlational analysis, regression analysis was performed. These results indicate that the degree of impact of a parent's infidelity was related to how typical clinicians view Vignette 1. Clinicians who rated the impact of their parents' infidelity as more negative saw

cases where one partner is chatting with someone else online as more atypical, $t = 2.529$, $p = .013$.

Table 44.

Influence of Predictors on Degree of How Typical in Vignette 1 (N = 112).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.199	.656	.002	-.007
Model 2: Age and Parent Infidelity	3.347	.039	.058*	.041*
Model 3: Age, Parent Infidelity, and Sex	2.212	.091	.058	.032
Model 4: Age, Parent Infidelity, Sex, and Marital Status	1.648	.168	.058	.023
Model 5: Age, Parent Infidelity, Sex, Marital Status, and Religiosity	1.440	.216	.064	.019

Dependent variable: To what degree is this typical? – Vignette 1

* = R^2 change is significant at .05

Table 45.

Regression Coefficients for Each Model for Degree of How Typical in Vignette 1.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	2.921	4.500	.00
	Age	.0057	.446	.65
2	(Constant)	1.797	2.326	.022
	Age	.00226	.178	.85
	Parent Infidelity	.301	2.547	.01
3	(Constant)	1.818	2.155	.03
	Age	.0024	.186	.85
	Parent Infidelity	.301	2.535	.01
	Sex	-.017	-.065	.948
4	(Constant)	1.858	2.060	.04
	Age	.0023	.175	.86
	Parent Infidelity	.302	2.526	.01
	Sex	-.0271	-.097	.923
	Marital Status	-.0354	.128	.89
5	(Constant)	1.601	1.669	.09
	Age	.0019	.152	.88
	Parent Infidelity	.303	2.529	.013
	Sex	-.0314	-.112	.911
	Marital status	-.011	-.040	.968
	Religiosity	.141	.793	.429

Dependent variable: To what degree is this typical? – Vignette 1

After the regression analysis for the prognosis estimates in Vignette 1, there were no indications that clinicians affected by a partner's infidelity differed from other clinicians without such experience in their prognosis estimates (see Tables 46 and 47).

Table 46.

Influence of Predictors on Prognosis Estimates in Vignette 1 (N = 106).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	2.069	.153	.020	.010
Model 2: Age and Partner Infidelity	1.170	.314	.022	.003
Model 3: Age, Partner Infidelity, and Sex	.963	.414	.028	-.001
Model 4: Age, Partner Infidelity, Sex, and Marital Status	.715	.583	.028	-.011
Model 5: Age, Partner Infidelity, Sex, Marital Status, and Religiosity	.618	.686	.030	-.019

Dependent variable: What is the prognosis for the marital relationship? – Vignette 1

* = R^2 change is significant at .05

Table 47.

Regression Coefficients for Each Model Prognosis in Vignette 1.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	1.972	2.829	.006
	Age	.0186	1.438	.153
2	(Constant)	1.724	2.123	.036
	Age	.020	1.513	.133
	Partner Infidelity	.035	.534	.594
3	(Constant)	1.442	1.576	.118
	Age	.020	1.572	.119
	Partner Infidelity	.0299	.455	.650
	Sex	.168	.747	.457
4	(Constant)	1.428	1.484	.141
	Age	.021	1.544	.126
	Partner Infidelity	.030	.455	.650
	Sex	.169	.744	.458
	Marital Status	.0118	.050	.960
5	(Constant)	1.270	1.251	.214
	Age	.021	.1532	.129
	Partner Infidelity	.0331	.495	.622
	Sex	.174	.762	.448
	Marital status	.024	.101	.920
	Religiosity	.0773	.501	.617

Dependent variable: What is the prognosis for the marital relationship? – Vignette 1

In this analysis, the impact of a clinician's partner engaging in infidelity explains 7.1 % of the variance in how much they would focus on individual issues in treatment of Vignette 1 (where online chatting led to intercourse) (see Table 47). Specifically, the more negative a clinician rated their experience was with their partner's infidelity, the less focus they would put on individual issues within treatment, t = -2.763, p = .007.

Table 48.

Influence of Predictors on Individual Issue Focus in Vignette 1 (N = 107).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.998	.320	.009	.000
Model 2: Age and Partner Infidelity	4.596	.012	.080*	.063*
Model 3: Age, Partner Infidelity, and Sex	3.035	.033	.080	.054
Model 4: Age, Partner Infidelity, Sex, and Marital Status	3.390	.012	.116*	.082*
Model 5: Age, Partner Infidelity, Sex, Marital Status, and Religiosity	3.171	.011	.135	.092

Dependent variable: How much should treatment focus on individual issues? – Vignette 1

* = R^2 change is significant at .05

Table 49.

Regression Coefficients for Each Model for Individual Issues Focus in Vignette 1.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	2.898	3.864	.000
	Age	.013	.999	.320
2	(Constant)	4.177	4.894	.000
	Age	.0057	.411	.682
	Partner Infidelity	-.193	-2.851	.005
3	(Constant)	4.185	4.390	.000
	Age	.0056	.406	.686
	Partner Infidelity	-.193	-2.821	.006
	Sex	-.0042	-.018	.986
4	(Constant)	3.590	3.652	.000
	Age	.0014	.815	.417
	Partner Infidelity	-.178	-2.628	.010
	Sex	.033	.142	.888
	Marital Status	.490	2.044	.044
5	(Constant)	4.058	3.945	.000
	Age	-.017	.841	.402
	Partner Infidelity	-.187	-2.763	.007
	Sex	.017	.075	940
	Marital status	.450	1.873	.064
	Religiosity	-.228	-1.464	.146

Dependent variable: How much should treatment focus on individual issues? – Vignette 1

In exploring the severity item through a regression analysis, the degree of impact a clinician experienced when their partner engaged in infidelity was not significant (see Tables 50 and 51).

Table 50.

Influence of Predictors on Severity in Vignette 2 (N = 107).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.765	.384	.007	-.002
Model 2: Age and Partner Infidelity	2.094	.128	.039	.020
Model 3: Age, Partner Infidelity, and Sex	1.837	.145	.051	.023
Model 4: Age, Partner Infidelity, Sex, and Marital Status	1.572	.188	.058	.021
Model 5: Age, Partner Infidelity, Sex, Marital Status, and Religiosity	1.566	.177	.072	.026

Dependent variable: How serious is the presenting problem? – Vignette 2

* = R^2 change is significant at .05

Table 51.

Regression Coefficients for Each Model for Severity in Vignette 2.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	6.125	16.498	.000
	Age	-.006	-.875	.384
2	(Constant)	.5707	13.236	.000
	Age	-.0033	-.479	.633
	Parent Infidelity	.0632	1.846	.068
3	(Constant)	5.465	11.395	.000
	Age	-.0026	-.371	.712
	Parent Infidelity	.059	1.721	.088
	Sex	.135	1.144	.255
4	(Constant)	5.335	10.629	.000
	Age	.0013	-.188	.851
	Parent Infidelity	.0625	1.805	.074
	Sex	.143	1.205	.231
	Marital Status	.109	.887	.377
5	(Constant)	5.537	10.510	.000
	Age	.0012	-.173	.863
	Parent Infidelity	.0587	1.694	.093
	Sex	.136	1.148	.254
	Marital status	.091	.743	.459
	Religiosity	-.098	-1.229	.222

Dependent variable: How serious is the presenting problem? – Vignette 2

For Vignette 2, the impact of a partner's infidelity influenced the degree of focus on individual issues (see Table 52). This explains 7.8% of the variance in a clinician's decision to focus on individual issues for treating these cases. As the negative impact of a partner's infidelity increases, the less likely they are to focus on individual issues in treating Vignette 2, $t = -2.873$, $p = .005$ (see Table 53).

Table 52.

Influence of Predictors on Individual Issue Focus in Vignette 2 ($N = 107$).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.157	.693	.001	-.008
Model 2: Age and Partner Infidelity	4.465	.014	.079*	.061*
Model 3: Age, Partner Infidelity, and Sex	2.951	.036	.079	.052
Model 4: Age, Partner Infidelity, Sex, and Marital Status	2.466	.050	.088	.052
Model 5: Age, Partner Infidelity, Sex, Marital Status, and Religiosity	2.107	.071	.094	.050

Dependent variable: How much should treatment focus on individual issues? – Vignette 2

* = R^2 change is significant at .05

Table 53.

Regression Coefficients for Each Model for Individual Issue Focus in Vignette 2.

MODEL		B (unstandardized)	t	Sig.
1	(Constant)	3.722	4.363	.000
	Age	.0063	.396	.693
2	(Constant)	5.225	5.402	.000
	Age	-.0034	-.217	.828
	Partner Infidelity	-.227	-2.960	.004
3	(Constant)	5.185	4.790	.000
	Age	-.0033	-.208	.836
	Partner Infidelity	-.228	-2.939	.004
	Sex	.0022	.082	.935
4	(Constant)	4.853	4.289	.000
	Age	-.0009	-.005	.996
	Partner Infidelity	-.219	-2.814	.006
	Sex	.042	.156	.876
	Marital Status	.277	1.005	.317
5	(Constant)	5.164	4.330	.000
	Age	.00009	.005	.996
	Partner Infidelity	-.225	-2.873	.005
	Sex	.031	.116	.908
	Marital status	.251	.902	.369
	Religiosity	-.151	-.837	.405

Dependent variable: How much should treatment focus on individual issues? – Vignette 2

Finally, a therapist's own infidelity and their level of religiosity added significantly to a model on how a therapist with conceptualize the pornography vignette, with the impact of one's own infidelity adding 4.3% to the model and 3.9%, with the entire model explaining 12.1% of the variance. The more a clinician viewed their own infidelity as having a negative impact, the more likely they were to report that the pornography vignette was more typical, t = -2.274, p = .025. Additionally, the more religious clinicians indicated they were, the more they rated the pornography vignette as typical, t = 2.14, p = .035.

Table 54.

Influence of Predictors on Degree of How Typical in Vignette 3 (N = 107).

Predictors				
	F	*Sig.*	R^2	*Adj.* R^2
Model 1: Age	.093	.761	.001	-.009
Model 2: Age and Own Infidelity	2.399	.096	.044*	.026*
Model 3: Age, Own Infidelity, and Sex	2.448	.068	.067	.039
Model 4: Age, Own Infidelity, Sex, and Marital Status	2.264	.067	.082	.046
Model 5: Age, Own Infidelity, Sex, Marital Status, and Religiosity	2.791	.021	.121*	.078*

Dependent variable: To what degree is this typical? – Vignette 3

* = R^2 change is significant at .05

Table 55.

Regression Coefficients for Each Model for Degree of How Typical in Vignette 2.

Model		B (unstandardized)	*t*	*Sig.*
1	(Constant)	3.119	3.431	.001
	Age	.00052	305	.761
2	(Constant)	3.849	4.031	.000
	Age	.006	.340	.734
	Own Infidelity	-.208	-2.168	.032
3	(Constant)	3.135	2.982	.004
	Age	.0052	.314	.754
	Own Infidelity	-.207	-2.181	.031
	Sex	.485	1.574	.118
4	(Constant)	3.747	3.257	.002
	Age	-.0001	-.007	.994
	Own Infidelity	-.231	-2.392	.019
	Sex	.466	1.517	.132
	Marital Status	-.416	-1.290	.200
5	(Constant)	2.819	2.328	.022
	Age	-.0019	-.111	.912
	Own Infidelity	-.216	-2.274	.025
	Sex	.546	1.794	.076
	Marital status	-.383	-1.208	.230
	Religiosity	.443	2.140	.035

Dependent variable: To what degree is this typical? – Vignette 3

Table 56.

The Results in a Nutshell.

Research Question	Description of findings	Corresponding statistics
1: Client Gender	Men were rated as having a higher degree of sex addiction than women	*Vig. 1: t* = 6.49, *p* =.000 *Vig. 2*: *t* = 4.36, *p* = .000 *Vig. 3: t* = 3.25, *p* = .001
	Therapists were more likely to focus on individual issues for men than women	*Vig. 3: t* = 3.306, *p* = .001
	Women looking at porn online were rated as less typical	*Vig. 3: t* = -3.349, *p* = .001
2a. Clinician Age	The younger the clinician, the more likely they would focus on environmental issues	*Vig. 2: t* = -3.487, *p* = .001, R^2 = .031
2b. Clinician Gender	Female clinicians were more likely to connect the presenting problem to larger processes within the couple's relationship	*Vig. 1*: *t* = -2.556, *p* = .011, R^2 = .017
2c. Clinician Religiosity	More religious rate clients in Internet infidelity cases as having a greater degree of sex addiction	*Vig. 1: t* = -4.4354, *p* = .000, R^2 = .039 *Vig. 3: t* = -4.711, *p* = .000, R^2 = .045
	More religious place greater focus on environmental issues	*Vig. 1: t* = -3.723, *p* = .000, R^2 = .027 *Vig. 3: t* = -4.701, *p* = .000, R^2 = .043
	More religious place greater focus on individual issues	*Vig. 3: t* = -3.384, *p* = .001, R^2 = .023
	More religious, the more serious and damaging they rated the pornography problem	*Vig. 3: t* = -4.062, *p* = .000, R^2 = .032 *Vig. 3: t* = 3.797, *p* = .000, R^2 = .029
2d. Personal experience with infidelity	Clinicians who reported their parent's infidelity as having a negative impact on them viewed Vignette 1 as less typical	*Vig. 1: t* = 2.529, *p* = .013, R^2 = .056
	The more negative a clinician rated their experience with their partner's infidelity, the less focus on individual issues	*Vig. 1: t* = -2.763, *p* = .007, R^2 = .071 *Vig. 2: t* = -2.873, *p* = .005, R^2 = .078
	The more negative a clinician's own infidelity affected them, the more likely they were to report that the pornography vignette was more typical	*Vig. 3: t* = -2.274, *p* = .025, R^2 = .043

Qualitative Findings

I conducted three pilot interviews and eight formal interviews. During the pilot interviews, I received information from my respondents about the questions, my questioning style, ideas for further probes, and ideas for other questions to assist in adequately measuring my construct. Findings from the pilot interviews were not included in the data analysis. The eight formal interviews were transcribed and included in the analysis.

First, I read each of the transcribed interviews. Next, I employed a bracketing procedure (Patton, 2002) to identify themes that emerged from the data. Themes from the participants' responses were analyzed through analytic induction and constant comparison (Glaser & Strauss, 1967). I re-read the data to determine if the themes supported my initial list, or if they needed to be modified. Then I reviewed, collapsed, and modified themes, generating a final distillation of themes. These themes were then placed under overarching categories. During this process, I also maintained a journal about my experiences so that my analysis and interpretation of the interviews would be understood in the context in which they were embedded.

I updated and compared the list of categories and their supporting themes. The categories and themes were revised as more data were analyzed. At this point, I also enlisted the assistance of a cross-coder for verification of themes. We reached agreement about which themes belonged under which categories through discussing any disagreements in the placement of themes and agreeing on a common placement. I also distributed the quotes for use in the Results section to another cross-coder for confirmation of themes. We reached agreement about the themes based on the quotes and came to agreement on a common placement. Once categories and themes were established, I reviewed the themes and categories and rechecked the fit with the data, resulting in the final coding categories. There were four main themes that were present in the interviews: how therapists conceptualize infidelity, what their treatment strategies are, under what circumstances their treatment changes, and characteristics of the Internet.

Characteristics of the Internet

Internet as a vehicle. Clinicians in the present study identified the Internet as being another means in which people can use to engage in infidelity. One interviewee described it in this way:

> I used to have clients who came and the issue was he or she has a friend of the opposite sex at the office. They're not having sex together but they're having lunch together. It used to be an emotional affair, not a physical affair. And this is another for now.

Places where people used to go to satisfy these needs might include strip clubs, purchasing pornographic material, etc. The advent of the Internet makes these other methods of sexual gratification just one more way to accomplish this.

Accessibility. Cooper (2002) developed a "triple A" engine, three aspects that affect Internet infidelity, and one of these includes accessibility. Accessibility refers to the access an individual has to the Internet. For example, if one has only minimal access to the Internet (as opposed to an individual who has more access to the Internet) one is most likely to engage in infidelity over the Internet. Additionally, people who might feel uncomfortable purchasing sexually charged material in stores could quickly download similar information in the privacy of their own home.

In the present investigation, accessibility was identified as a characteristic of the Internet that has contributed to the "quick evolution" of Internet infidelity. To engage in infidelity on the Internet was described by one clinician as "so easy" because of its accessibility. Another clinician exemplified this when he stated:

> I think that the Internet issue is…introducing things to couples sort of what I call the Pandora's Box syndrome, where now all of a sudden, things that were not possible are all of a sudden, readily accessible and able to get couples to get involved in and that they never had that opportunity before because society in a sense would create a buffer for them…its easier to get more involved much quicker, much deeper…Especially, for example…things that men would never even thought about seeing, you know,…wouldn't go to the seedy side of the city and sit and watch happen…its much broader in society…than what has been typically in the past.

Therapists' Conceptualizations of Internet Infidelity

Cooper and Sportolari (1997) reported that people involved in online relationships are attracted to others through how emotionally close they feel to someone as opposed to certain physical characteristics. In this way, it becomes difficult to understand when someone is engaging in infidelity. What was once clear-cut (engaging in intercourse with a person other than one's partner) is now muddied by the presence of the emotional connection that bonds people

who talk online. Interviewees in the present study described Internet infidelity as a betrayal (either emotional, sexual, or both) in which, as a result of unmet needs in the relationship, steps out of that relationship to have their needs met.

Betrayal. Betrayal was something that was central to the definitions of conventional and Internet infidelity. In part, betrayal was characterized by a breach of the marital contract. Though sexual contact with another was generally considered a breach of the marital contract, sexual contact with another person did not have to be in the picture in order for Internet behavior to be considered betrayal. One participant clarified this when he stated:

> So I think infidelity happens if someone feels betrayed in a relationship…I think that Internet infidelity is the same thing. And that…if one party in a partnership feels betrayed because of someone else's Internet activity, flirtatiousness or beyond, then that's infidelity for them.

Online relationships and sexual behaviors stemming within these relationships also contain an element of secrecy (Cooper, Delmonico, & Burg, 2000a; 2000b). Cooper, Delmonico, and Burg (2000a; 2000b) found that individuals who kept their online activity secret from others also displayed more sexually compulsive behavior. This element of secrecy maintained by one partner against another partner was also included the interviewees' conceptualizations of betrayal within Internet infidelity. For example, interviewees reported that people who engage in Internet infidelity were those "who are looking for emotional relationships online which often turn into sexual relationships, but talking to someone without their spouses knowledge…" or were maintaining

> a secret in that…only the two people involved know about it and it takes away from that which usually goes on between the person and his wife or husband or between two people not legally married in an emotionally committed relationship.

Not only were the online activities kept secret problematic for the clinicians in this study, but so was the "secretiveness of the relationship or the connections that one or both have…" Another participant used an example of one partner viewing porn to illustrate his point:

> It's the same saga as before when there is a problem with the wife when the husband views pornography – it is usually because she feels betrayed, that it is kept as a secret. As a matter of fact, I have seen cases where she can be absolutely abhorred…that he would

watch porno in private, but if they both wanted to watch it together as a marital aid, she would feel very comfortable with that.

Finally, betrayal involved in element of disrupting one's "couplehood." One participant exemplified this point when he stated:

> But, it's not so much the sexual contact that makes any difference. I think it's the secrecy and betrayal of trust and the splitting of something called emotional specialness between two couples, I mean two people of dyads...I think the betrayal of specialness is the pivotal point.

It is clear that the betrayal component includes some violation of what it means to be a couple and in some ways challenges a couple's identity.

Nature of infidelity. Infidelity has been characterized by having emotional components, physical components, and elements of both (Thompson, 1983). When research into the area of infidelity was first beginning, most of the research viewed infidelity under the strict lens of engaging in intercourse with another individual other than one's married partner. Through the decades, this definition has become more general, to include intercourse with another in dating relationships, any sexual contact with another while in a committed relationship with another. Further, infidelity can be seen in the emotional connections with another person through shared amount of time with one another, to any connection to the point where the primary relationship is starved of time, attention, and energy as a result of the extradyadic relationship. At its core, infidelity (Internet or any other type) is the breaking of trust (Lusterman, 1998).

Henline and Lamke (2003) explored the nature of Internet infidelity, focusing on individuals' descriptions of sexual and emotional infidelity. Their results indicate that Internet infidelity was multi-faceted. Respondents indicated that the emotional component of the infidelity was more disturbing and that they believed that the emotional connection with another was more likely to lead to a face-to-face meeting than having a relationship with someone online in a sexual manner.

The findings of the interview data indicate that clinicians define Internet infidelity as also that which can be physical, emotional, or have components of both. Several interviewees pointed to Internet infidelity as "striking" up a relationship or a conversation of an intimate nature with another individual via the means of the computer. As one clinician clarifies, "The intimate nature does not necessarily have to start off as sexual but certainly two people who find a certain

comradery – a certain connect[sic] with the other." Some clinicians who believed the Internet had characteristics of both described the manner in which they were interwoven in Internet infidelity cases. One participant's comments exemplified this process:

> Some people see [infidelity] as only sexual and some people see it as sexual and emotional and Internet infidelity is more of an – there's an emotional withdrawal that may translate into sexual conversations but there is something about the partner that one is committed to that is – one person withdraws some attention, both sexual and emotional, from that person.

The spectrum of Internet infidelity can include a wide variety of behaviors. On one end of the spectrum may be spending time on the computer rather than one's primary relationship. Behaviors in the middle of the continuum might include chatting with a specific person or people and developing an emotional relationship with someone at the cost of the primary relationship. Finally, at the other extreme may be the physical meeting and subsequent intercourse of two people who met online. One clinician described time away from the family in front of the computer as that which may be disloyal to one's family, if not infidelity. Another interviewee reported, "you don't have to be physically in the same place with someone to be intimate, I don't think. You can talk about things." In other cases, the therapists "let the couple define what infidelity is for them rather than put [their] own label on it." For example, some behaviors that are considered infidelity by one couple may not be considered infidelity or problematic by another couple. One clinician supported this:

> …one spouse may consider chatting in a chat room with anybody infidelity, where the other person may not have that script at all as infidelity. One partner, for example, may see presenting sexual play on the Internet as infidelity where the other one just considers it no different than buying a Playboy magazine…what have been the boundaries or understandings, either spoken or unspoken about…sexual context or content in the relationship?

Deficit model. Shaw's (1997) model for the treatment of Internet infidelity outlines several factors that make couples more vulnerable to the event of Internet infidelity. One of the vulnerabilities she identifies is a lack of connection with another partner or lack of ability to communicate about problems in the relationship. Additionally, Cooper, McLoughlin, and Campbell (2000) assert that an individual's use of cybersex can, in some cases, be a symptom of

a deeper relational problem, often relating to intimacy, dependency, and a feeling of abandonment.

The participants in the present study also consistently identified this vulnerability factor during the interviews. Overall, clinicians saw Internet infidelity as a symptom of a larger problem in the primary couple's relationship. For example, one clinician stated:

> an affair is usually a symptom of lack of trust and I would try to find out where that all stems from…I am of a belief that marriage should be made up of…two people who are open, [honest], and sharing with each other regardless of the risks and regardless of vulnerability. If that's not taking place and someone had to go elsewhere, it meant that the person felt they had to go underground. Like if I wanted to have an affair, the first person that would know about that other than myself would be my wife because it would tell her and me that something's wrong in the marriage.

The assessment by clinicians that Internet infidelity is a symptom of an underlying problem as opposed to an independent event is consistent with observations by other theorists and clinicians in the filed writing and talking about this issue. For example, Leiblum and Döring (2002) stated:

> The Internet should not be viewed as the *cause* [emphasis original] of cybersexual crises, however. Rather, crises involving cybersex signal the need for more comprehensive clinical assessment. A partner's online sexual activity may be a *symptom* rather than a *cause* [emphasis original]. It may signify preexisting problems in the individual…or in the relationship (e.g., lack of sexual communication. (p. 28-29).

Several other treatment models prevalent in the Internet infidelity literature seek to understand the underlying issues between partners in a couple. Some examples include the Young, Griffin-Shelley, Cooper, O'Mara, and Buchanan (2000) model, the Maheu and Subotnik (2001) model, and the Atwood and Schwartz (2002) model. Other areas of symptomology that clinicians referred to in the present study include a breakdown in communication, a breakdown in boundaries, and a breakdown in commitment. In understanding infidelity in this manner, clinicians often included a piece in their treatment that addressed what "led up" to the affair, or, as one interviewee termed, "gave rise to the affair in the first place."

Although there were several areas in a relationship that clinicians pointed to as potential triggers for the event of infidelity, clinicians overwhelmingly identified this "larger problem" as a deficit in the relationship in terms of needs. In other words, they viewed one individual in the

dyad as not having his/her needs fulfilled, thus resulting in the event of infidelity. One clinician describing his treatment of infidelity cases stated: "Then we work on boundaries, what was missing, what was needed, how to change their way of communication so that they can begin to look at what each other's needs are and try to meet them." Specific to Internet infidelity treatment, he later stated: "…we work on trying to figure out what need he felt…and if his wife can't meet it, so the Internet is trying to meet it." Another clinician, in discussing her treatment strategies, indicated that romance might be missing in the primary relationship: "Right, and then the other thing would be to explore with the wife what she was getting from those conversations that she wasn't getting from her everyday ordinary existence." Some of the needs identified as being unmet by clinicians were identified as communicative needs and sexual needs. For example, one clinician discussed pornography and the Internet in terms of the unmet needs:

> I think Internet infidelity is simply the same thing as reading porno magazines or the same thing as flirting with someone at the office. It's a symptom of an unfulfilled relational need. And when we didn't have the Internet we have other ways of doing that.

Unlike the actual action of engaging in a relationship with another individual, these unmet needs were typically not identified as the result of one person's actions, but instead of both people in the relationship. One clinician explained this by stating "Although they both share, you know, events leading up to the affair, one person made the decision to actually have a physical affair."

It also appeared that, in some ways, clinicians justify Internet infidelity behaviors. In explaining how they conceptualized Internet infidelity cases, clinicians viewed the occurrence of it as stemming from a deficit in the primary relationship. Clinicians repeatedly indicated that Internet infidelity was the result of one person attempting to get their needs met: when they were not able to do so from their partner, they would look to another person to meet these needs. For example, phrases such as "had to go elsewhere" and "his wife does not meet his needs" imply that those individuals who cannot be sexually gratified from their partner may be justified in seeking other options. Communication leading up to online sexual activity may be one more way that individuals can get their needs met.

"Stepping out of the relationship." Clinicians also identified the nature of Internet infidelity was one in which an individual "stepped out" of the relationship. This terminology was generated during many of the interviews. One clinician tied this to needs when he stated:

> [Stepping out of the marriage] was done once or even more than once, definitely more than once, it is a more pressing issue – that there is great trouble in the marriage, that the person stepping out may not want to be in that relationship anymore. It could be done for excitement, for titillation, but, again, I would want to know what's missing in the marriage.

Similar to the definition of betrayal and infidelity, "stepping out" could be emotional, physical, or a combination of both. Stepping out of the relationship emotionally might include building intimacy with another person at the expense of the primary partner. This may entail spending time with another person, and spending more time with this person than one spends with his/her partner, sharing intimate emotions and details about one's life while the primary relationship is suffering, etc. Physical stepping out of the relationship might include engaging in physical activity with another person – again, at the expense of one's primary partner. This typically refers to sexual intercourse with someone than one's primary partner, but can also include acts such as holding hands or kissing. The extent to which the "stepping out" of the relationship is a betrayal is determined by the contract established by the couple.

Therapists' Treatment Strategies for Internet Infidelity

Assessment. Several of the treatment approaches for conventional infidelity describe how they would assess in these cases. Elbaum (1981) for example, indicated that the therapist should ask the involved spouse to break off the extradyadic relationship for the duration of treatment. He then suggests that the therapist obtain an understanding of the hurt and anger felt by the uninvolved spouse. Westfall (1989) suggests that therapists identify the extent of the infidelity in terms of the extent of secrecy, the involvement with the other person. Pittman and Wagers (1995) suggest that the therapist determine what type of affair occurred (continuing or one-time). Gordon and Baucom (1999) suggest therapists should seek to understand the context of the primary relationship.

Weeks and Treat (2001) outline specific important considerations in the assessment of infidelity. These include exploring: a) the duration of the affair, b) number of sexual partners, c) gender of the third party, d) level of sexual activity, e) whether each partner was having an affair, f) degree of emotional involvement or attachment, g) each person's relationship to the third party, h) extent of lies and secrecy around the affair, i) degree to which the other person knew

about or consented about the affair, and j) the tolerance of the affair by the social network of the person or couple.

Therapists in the present study also identified information they believed important in the assessment of Internet infidelity cases. Many of the clinicians wanted to know what the goal was for the couple who was seeking therapy, as this would dictate the course of treatment. Some of the things that were included in goals were assessing the individual goals of each person in the dyad. As one clinician stated, it is important to identify "where each partner is, what their status is, whether they want to break up or continue…I just want to see what their kinds of goals were, what did they want to see happen…"

Related to this, therapists were also interested in assessing the couple's level of commitment to one another. Though this theme was prevalent throughout the interviews, it was especially pronounced when I asked the clinicians whether their treatment would be different if the couple presenting with Internet infidelity was not married. As one clinician explained, "…I would challenge them to look at whether they want to be committed in a relationship where a person has shown no commitment before they've even tried to commit."

Another main factor interviewees cited, consistent with the published models in conventional infidelity treatment (e.g., the Westfall [1989] and Pittman and Wagers [1995] models), includes taking an assessment of the affair event. For example, interviewees indicated that they would want to know if the affair has stopped, with one who stated: "I typically tell people that I won't treat them as a couple if I know the affair is continuing. That's a big first step."

Yet therapists understood Internet infidelity as a problem within a context as opposed to an individualized event. For many clinicians, taking a relationship history was critical to understanding the problem of infidelity for each couple. Some things that clinicians cited as important to take into account in the history of the relationship included exploring a couple's negotiation skills, the kind of marriage they had, what they did with each other when their marriage was in a happier place, how they feel about the relationship and how long they have been together. Clinicians may also choose, in addition to taking a complete relationship history, to identify the relationship history as it relates to infidelity. Another interviewee shared his ideas when he stated:

> I also usually like to know if there's some, any kind of history or patterns of…similar or same behaviors. In other words, just because they'll present for current infidelity doesn't mean that it's not happened multiple times in the past or in different forms or different circumstance.

One participant specifically was interested in if:

> …this was a pattern. I'd want to know…have they ever been in relationship before and had…this issue around the Internet infidelity. What their relationship with the computer is.

Finally, important to the clinicians was to determine the different ideas each partner might have about what constitutes infidelity in their relationship, and to work toward a common language. Before the Internet, couples were able to remain with their original contract throughout much of their marriage, as sex with another person was considered infidelity. With the advent of phones, the Internet, and other communicative devices, couples may have to revisit their original contracts, being more specific as to what they consider to be a betrayal of their commitment. Most couples do not revisit their original contract, until events occur which force them to do so. One clinician describing his treatment stated:

> It pretty much focuses on doing a couple things, one making sure we work with common definitions…for example, one partner may not consider what they're experiencing is infidelity…and so there's a process of establishing a common ground of whatever the breach of the relationship is and definition.

In other words, it may be important in therapy for the clinician to help the couple revisit their original contract and adapt the contract to include Internet relationships. Another clinician further exemplified this by stating:

> One spouse may consider chatting in a chat room with anybody infidelity, where the other person may not have that script at all as infidelity. One partner for example may see presenting sexual play on the Internet as infidelity where the other one just considers it no different than buying a Playboy magazine.

Theoretical frameworks. Published treatment strategies have included influences form several marriage and family therapy frameworks. For example, Glass's (2001; 2002) model of conventional infidelity treatment describes the role of the therapist as one that provides safety to the couple, reminiscent of Emotionally Focused therapy. In relation to Internet infidelity

treatment, Maheu and Subotnik (2001) provided interventions that were influenced by transgenerational theory, but also called for an expression of empathy from partners, consistent with an emotionally focused approach. Atwood and Schwartz (2002) also provided strategies that were influenced by differentiation-of-self issues.

Clinicians in the present study identified transgenerational theories and emotionally focused theories as those that influence their treatment strategies for Internet infidelity cases. Clinicians indicated that genogram work was important, with one stating one session would be devoted to the genogram. In addition to patterns of infidelity and addiction, clinicians also reported that they search for patterns of betrayal in one's family of origin.

Therapists also use Emotion-focused therapy (Johnson, 1996) to treat infidelity. One large piece of emotionally focused work is promoting safety and security in the therapy room. Glass (2002) structures her treatment as that which is akin to PTSD treatment. Within this framework, the therapist is encouraged to promote an environment of safety and hope for the couple. In this environment, the couple can come together and share their story.
Also related to this, the therapist can work with the couple to normalize feelings. Lusterman (1998) works to move couples to develop trust and honesty with one another as part of treatment. Elbaum (1981) also encourages couples to explore the hurt and feelings that each partner experienced within the affair event.

In the present study, this model helps the couple to express their hurt with one another and establishing safety within the relationship. Clinicians, such as this one, believed that it was important for uninvolved partner to be able to express their feelings:

> It's a matter of forgiveness, a matter of working with the, the one who's hurt and trying to, you know, figure out why it happened and let them have a voice and let the person that had the affair really try to understand how much they did hurt the other person.

In this way, clinicians are advocating that the couple move beyond the anger and begin to deal with primary emotions. Another clinician indicated that their treatment would include slowing down messages, as the process of recovery and expressing hurts to one another will take some time. Part of expressing primary emotions also involves expressing needs that each partner has in the relationship and to identify what each person needs to stop hurting. One clinician exemplified this by stating, "We'd work on what's needed to help the person feel safe and secure in the marriage." Another clinician described one aspect of treatment as examining

> …are [the partners] willing to look at what needs, things, need to change within the relationship…so that he doesn't have to look at the pornography or can they figure out a way for it to be OK with her, for him to look at the pornography? Can they look at it together? Is that a turn on for her?

In this way, the clinicians are looking at what the couples need in the moment, but are taking into account the larger picture. Therapists are also identifying ways to promote safety within the relationship through strategies that are specific to the Internet and the computer. One of the ways clinicians reported to accomplish this is to help the couple to rebuild trust, which many times results in reestablishing the boundaries for partners in a couple. According to one clinician, "…setting up physical boundaries becomes extremely important…they have to develop some mechanism so that she begins to feel a bit more secure in the relationship."

Therapists also use solution-focused as a theory base in infidelity work. For example, Pittman and Wagers (1995) seek to identify what couples need to move forward from the infidelity. They encourage therapists to address emotional reactivity and then to find and implement solutions. In the present investigation, solution-focused was also cited as a theoretical backdrop influencing clinicians' treatment strategies. This could include a variety of things, such as identifying what has been better for the couple from the time in which they placed the phone call for services. Another strategy included helping the couple in "setting up positive times together." One clinician discussed how she specifically employed the solution-focused approach in her treatment:

> I ask people whether they want to maintain their relationship, and what its going to take, and what they need in order to get past the trust, the trust issues, and…using the strengths of the relationship so its part of the relationship that worked for the both of them before and still do as a way of moving forward.

In these ways, therapists using the solution-focused approach provide treatment germane to each couple and client focused.

Common factors. There were several factors that appeared common across treatment approaches and strategies. One of these included a time for an apology or penance offered by the partner who engaged in the Internet infidelity to the uninvolved partner. This strategy was also cited in the literature as that which is important in achieving closure after the affair event. For example, Gordon and Baucom (1999) suggest that the therapist encourage the couple to identify

what it would take to forgive. The clinicians in the present study agreed that the apology can take a variety of forms, but should begin with the partner who engaged in the Internet infidelity taking responsibility for their actions:

> …if one or both partners consider that a betrayal…and/or wronged in the relationship…usually [the healing process] will involve some form of recognition of the wrong, some form of, and the description I usually use with people or we work through is a sort of healing model, that its a process, not an event, based on a concept of what they will understand as forgiveness.

In addition to an assumption of responsibility for the event by the unfaithful partner, clinicians also indicated that communication was central to the process of forgiveness: "I don't think they can ever deal with forgiveness and work this incident through unless they can communicate and connect with each other, especially on an intimate level."

Delmonico, Griffin, and Carnes (2002) identify both first- and second-order strategies as a way to treat cybersex addiction. Some of the examples of first-order change strategies include moving the computer to a less accessible location, place a restriction on the sites that are problematic, and work with the client to help them identify it as a problem. Therapists in the present study also believed that some of these first-order change strategies (e.g., adjusting environmental factors) were key to treating of Internet infidelity. Strategies under this theme include having couples struggling with this issue move the computer to another room, or investing in a "Net Nanny." One clinician stated she was interested in discovering

> …what's the status of the computer use for this person? You know, is he doing it, he or she, doing it at work? Um, is it something that is in a, you know, private space where he goes in the bedroom and locks the door? What's the situation with the computer? Where's the computer? Who uses it? When?

Cooper, Putnam, Planchon, and Boies (1999) also found that the amount of time on the computer was related to sexual pursuits online. Just over forty percent of the respondents they surveyed reported less than one hour of their time per week was spent pursuing online sexual interests, where a much smaller percentage (8%) spent considerably more time (11 hours or more) online per week engaged in sexual pursuits. The clinicians in the present survey suggested behavioral modification strategies.

> …can she shut it off and not get on at all? Then get rid of the computer. And I'm talking about whether the husband is using it frequently or the wife is using it frequently. That's the time that they are not playing with each other.

Clearly, there are implications for the relationship when the couple can set boundaries around the physical environment and computer use. The physical restructuring of where the computer is and new rules around the computer use (duration, frequency, etc) are ways that clinicians suggest to start building more in-depth things in the marriage.

Differential Treatment in Internet Infidelity Cases

There are several instances in which clinicians indicated that their treatment might differ from the abovementioned strategies. In other words, under what circumstances did clinicians decide to do something different from what they would normally do with these cases? How did they make these decisions?

Addiction. Clinicians identified that treatment in Internet infidelity cases would be different than if they viewed the Internet infidelity as an addiction problem. One clinician explained,

> Because…if it's a person that he's connected with, that he's repeatedly seeing, seeing online, then that's more like an affair. That's more like I would treat a couple where somebody's having an affair, whereas if its, if its just lots of people and different…places, then I would treat it more like an addiction, which would mean that I would want to be seeing him alone some of the time.

Clinicians were more likely to view individuals looking at pornography online as having a higher degree of addiction than those who chatted with someone online. One clinician described her treatment at this point as similar to treating an alcohol addiction, "in the sense of having his wife explain to him why it's a problem for her and what the consequences are of continued indulging in the addiction."

In part, this result may be explained by a therapist's identification of the problem is stemming from one's compulsive nature. For example, it may be stemming from either a computer compulsion or a sexual compulsion. In this way, the Internet is one easily accessible method to address the computer or sexual compulsions. In these cases, the compulsions lie within the individual and therefore may influence treatment to be individually or environmentally focused.

Needs. Treatment also changes based on clients' needs. Clinicians who participated in the interviews identified that each partner should be able to identify what they need from the other, and then identify ways to meet those needs. Needs identified were those that the uninvolved spouse identifies as necessary "in order to stay in the marriage," as those which are needed "to help the [uninvolved partner] feel safe and secure in the marriage," and those aspects that "need to change in the relationship."

Medical/physical health. One's physical health would also be something that would enter the course of treatment. Several clinicians who stated that their assessment and/or treatment would be somewhat different for older couples reported that they would explore more of the medical and physical issues affecting these couples:

> If the woman perhaps is menopausal, if the man has erectile problems or physical problems that stops sexuality for either one of them, that might be a factor that causes the other one to look for sexual byplay, albeit on the Internet.

Gender. Several studies have shown clinicians treat sexual problems differently depending on the gender of the clinician (i.e., Liss-Levinson, 1979; Schover, 1981; Schwartz & Strom, 1978). Therapists in the present study indicated that their strategies might differ in terms of the gender of the identified client. Some of the gender differences that clinicians reported influenced their treatment were things that related to demographic factors. For example, comments such as, "the homosexual males that I've worked with, their lifestyle tends to promote a lot of infidelity…Women seem to be different," and "if [infidelity] were to happen in the age, let's say, 70-75 and older, it would be the male who would be perpetrating the affair," demonstrate that clinicians ascribe several characteristics to who is more likely to engage in infidelity.

Several of the clinicians during the interview saw a difference in the use of pornography among women. When asked about their treatment for the vignette in which a client was viewing pornography, one clinician responded,

> So if you ask me if my treatment would be any different, I think I would be flabbergasted. If a couple came in and the husband said, "I am feeling, you know, terribly hurt. My wife is watching porn," I don't know what I would do. I think I would call the state and hand my license in.

Another area in which the clinicians determined that there might be a difference in their assessment of the Internet infidelity cases was how different partners might define betrayal. For example, the definition of whether the event was actually a betrayal might be assessed differently based on the gender of the players, as evidenced by the following statement: "two women together will often subscribe betrayal in behavior that, to me as a male, would not necessarily see as betrayal." Similarly, this difference in how men and women view a betrayal also affects how they understand their marital contract:

> it is more common for men to have multiple affairs and that certain men, whether personality or whatever, you know, just have the habit and propensity to have multiple affairs and…to address that issue and to see whether its something that the woman is going to accept for their marriage or not.

Because clinicians are conceptualizing and assessing these cases differently based on the gender of the client, there may also be changes in treatment. For example, one clinician described how he would alter treatment based on the gender of the client: "Men are the ones that I would be less concerned about…and I know this sounds like a double standard, but with a women I would treat it like an addiction and wonder if she can ease down."

Identifiable third person. The interviewees also there was a continuum of involvement on the Internet and treatment changed when there was an identifiable third party involved. Once an actual person was involved, clinicians referred to this as "stepping across the boundaries." For example, pornography does not involve a third person; therefore, clinicians perceived it as less serious and would change their treatment strategies. One clinician supported this when she stated,

> [Pornography] is a little bit different because its not another human being involved…there's not a third party…its just pictures or movies….I think I would [treat looking at pornography differently from chatting online] because there's not communication there. Its just purely…an individual, internal sort of thing going on…there isn't…a third party involved.

Clinicians also viewed the involvement of an identifiable third party as that which is more serious for the couple. This is evidenced by one interviewee stating, "I think stepping out of the marriage with a third party is a lot more serious than just watching a 15 or 17 inch screen, albeit frequently." Involving a third person could include chatting with an identifiable person online,

exchanging pictures, or speaking with a specific person as more serious. However, spending time talking to many others, where there was not one specific person, was viewed as less serious and different than those involving an identifiable person. One clinician exemplified this when he stated

> Well, I guess when, like I mentioned earlier, its whether I think…what's the word…hierarchy, or the extremeness of the infidelity on them, whether they're just flirting, if they're flirting with a bunch of people at once, you know, I see that as almost harmless compared to someone who engages in a more intensive flirting relationship with one person, and then if they're just flirting as opposed to having cybersex. It seems to make a difference in partly the treatment of the person as well as dealing with the spouse.

Because the involvement of a third person was viewed as a more intense experience, clinicians also indicated that the involvement of a third person would potentially require more forgiveness for the couple to move forward.

CHAPTER V: DISCUSSION

Given a choice between two theories, take the one which is funnier.

- Blore's Razor

The purpose of this study was to explore how demographic characteristics of clients and marriage and family therapists influenced their assessment and treatment of Internet infidelity cases. There were two phases in this study. In the first phase, approximately 500 members of the American Association for Marriage and Family Therapy responded to an online survey. This survey consisted of three vignettes from Nelson's (2000) Delphi study on Internet infidelity, with each vignette followed by 11 assessment and treatment items. These items were analyzed through MANOVA, with the implementation of a Bonferroni correction. Variables that were significant after the Bonferroni adjustment were further explored through regression analysis.

In the second phase, eight practicing clinicians participated in brief interviews about their assessment and treatment of Internet infidelity cases. These interviews provided in depth information to support the phase one quantitative responses. The interview data were transcribed and analyzed through constant comparative and analytic inductive means. Cross-coding of themes and of quotes was performed by two people independent to the project as a way to enhance credibility of findings.

The research questions under investigation in this research project are,

1) Do marriage and family therapists' assessment and treatment decisions in cases of infidelity change depending on the gender of the identified client?
2) Do the assessment and treatment decisions made in cases of Internet infidelity vary when examined in terms of therapist social background variables, such as age, gender, religion, marital status, and whether they report they have been impacted by infidelity in their lives?

The short answer is in some circumstances, therapists' assessment and treatment decisions in cases of Internet infidelity change depending on the gender of the identified client. Likewise, the assessment and treatment decisions made in cases of Internet infidelity vary under certain circumstances when examined in terms of therapist social background variables, such as age,

gender, religion, marital status, and whether they report they have been impacted by infidelity in their lives.

Though the discussion provided will include information about variables related to assessment and treatment in Internet infidelity at the .05 or .005 level, other information will be included in this discussion as it may be significant in further analyses or may function as key components in replication studies. Wainer and Robinson (2003) discuss the phenomenon of hypothesis testing and p-values and rally researchers to, rather than arbitrarily setting it at .05 and making "reject" or "fail to reject" dichotomous decisions based on that number, select a statistic appropriate for the question at hand. Once the cut-off value is determined, researchers should then consider the statistic in the context of the experiments. Wainer and Robinson (2003) reported that Fisher, when confronted with p-values of between .05 and .2, used these as opportunities to improve the design.

Within the present investigation, there were several relationships that may warrant further investigation or replication. For example, there were some relationships that did not make the cut off after the Bonferroni correction, but came close, and were close to significant across all three vignettes. These cases will also be discussed within this section.

Gender of the Identified Client

Feminists posit that women may be treated differently than men in therapy. Specifically, they indicate that men's behavior might be considered as the norm, where women have to change their behavior as a way to meet that norm or risk being considered abnormal. In terms of sexual behavior, several authors and researchers have found that there are, in some cases, differential treatment between men and women (see, for example, Hecker, Trepper, Wetchler, & Fontaine, 1995). Feminists challenge practitioners and sexuality researchers to avoid ascribing norms based on gender, and to rather understand where someone is based on the context in which the couple's circumstances and lives are embedded.

The results of this study indicate that, in some ways, the gender of the identified client in Internet infidelity cases sometimes makes a difference in how clinicians assess and treat these cases. Nearly true for all three vignettes, clinicians attributed a significantly higher degree of sex addiction to male clients. These findings were consistent with what respondents reported in the qualitative section, particularly around the use of pornography. In these cases, clinicians reported they would emphasize further individual sessions in the cases in which man was the identified

client, as well as a greater focus on environmental issues. In the pornography vignette, women viewing pornography online were considered more atypical then men engaging in the same behavior. This is consistent with the findings of Seem and Johnson (1998), who report that therapists responded to clients who did not act in a stereotypical gender manner more negatively than clients who did act in a stereotypical manner.

That being said, there were several instances in Vignette 1 (where someone was communicating with someone online but had not met with them) in which the p-values were close to $p < .05$ (within .024 either direction) but did not meet the $p \leq .005$ value determined by the Bonferroni correction. Some items that, if included in other studies may point at a difference between the gender of the client in other studies and replications, include a clinician's assessment of severity based on gender of client, degree of typicality of the problem, prognosis for the martial relationship, focus of treatment on environmental issues, and treatment's emphasis on managing crisis. In Vignette 2, future research may show differences between the gender of the client and a therapist's emphasis on individual issues, relational issues, and environmental issues in these cases. Again, in Vignette 3, some items that may be of further interest to future researchers are an assessment of the severity of the presenting problem, how damaging the problem is to the relationship, and focus on individual and environmental issues in treatment.

A couple items in the present study that were consistently not related to the gender of the client were a clinician's assessment of how many sessions treatment would take and how much treatment should be related to connecting the problem to the couple's larger interactions and processes. It is interesting to note that, although the number of sessions may not change depending on a client's sex, their approach in these sessions differs. For example, clinicians are more likely to allocate some as individual sessions where men are the identified clients. In terms of connecting the problem to larger processes in a couple's relationship, it appears that clinicians would tend to focus on this in cases, regardless of the gender of the client. Based on the mean, which ranged from 5 to 5.43 on the 6-point scale, this seems important for all clinicians to address regardless of gender of the client. This finding was supported in the qualitative interviews, as the clinicians, consistent with published observations and treatment models (e.g., Leiblum & Döring, 2003; Maheu & Subotnik, 2001; Young, Griffin-Shelley, Cooper, O'Mara, &

Buchanan, 2000) discussed the importance of understanding Internet infidelity as a symptom of underlying problems within the relationship.

Other results of the quantitative phase are not surprising, as many of the clinicians in the qualitative phase of this research echoed similar sentiments. Clinicians in the present study perceived potential differences in the definition of infidelity between men and women, differences in what would be considered a betrayal, and differences in norms of behavior. This is consistent with Dodini's (2000) research, as he found therapists rated the Internet infidelity behavior of women as more threatening to the primary relationship than the same behavrio of men. Maheu and Subotnik (2001) also discussed gender in terms of Internet infidelity. Rather than conceptualizing these behaviors or characteristics as those that are "male" or "female," they conceptualize the issue as on a continuum, with masculinity and femininity at each end. One of the areas in which men and women differ, for example, are their visited types of websites. Women, for example, visit sites that are about interactions and relationships, such as chatrooms, whereas men view websites that are more sexually explicit, such as newsgroups This is consistent with the Cooper, Mansson, Daneback, Tikkanen, and Ross (2003) investigation in which women in Sweden were more likely to use the Internet for communicative needs.

These results might also be explained by a therapist's epistemological stance or clinical orientation. One of the items in Phase One of the research assessed the therapist's clinical orientation. Because participants were from a wide variety of orientations and because a clinician's orientation was not part of the research questions, one's clinical orientation was not included in the analysis. However, it is possible the question of how a clinician assess and treat Internet infidelity cases based on the clients gender may be influenced by one's clinical orientation. One of the clinical influences and orientations that I did not include in the survey was whether the respondent was influenced by the principles of feminism. In fact, many of the clinicians may not have been trained in feminist ideals and principles. For example, on average, the mean age in which therapists indicated that they completed their training in MFT was approximately 37, whereas the mean age of respondents in the study was 51, meaning that, on average, the therapists in the study completed their MFT education 14 years ago. This difference in time may have been before the major implementation of feminism in MFT training programs and literature.

Gender of the Researcher

It is an interesting subject of inquiry as to whether the gender of the researcher had any influence on how the participants in the present study responded. Were men in the present study, when talking to the female researcher, more aware of their feminist parts, and therefore have a heightened awareness around this issue? In other words, men might pay more attention to how they were coming across to a woman, but if they were talking to a man, they would not necessarily have to experience that heightened awareness. Though this was an item that was not focused on in the present study, it may be worthwhile for researchers to study interactional components between the gender of the researchers and gender of the clinicians, particularly when exploring potential differential treatment between male and female clients.

Therapists' Social Background Variables and their Assessment and Treatment of Internet Infidelity

Age of the Clinician

A clinician's age appeared to have an effect, in some ways, on assessment and treatment decisions that they made in Internet infidelity cases. The younger the clinician, the more likely they were include an environmental focus in their treatment of Internet infidelity cases. This makes sense, as younger clinicians may be more knowledgeable about computers in general and, therefore, with be more familiar with strategies for removing the computer or limiting Internet access than older clinicians. This factor seemed to be important across all three vignettes, implying findings that are more generalizable.

Translating this to treatment, younger clinicians described their treatment as consistent with the treatment prescribed by Delmonico, Griffin, and Carnes (2002). Delmonico et al. (2002) suggested the adjustment of environmental factors as a first-order change technique for the treatment of Internet infidelity cases. These include reducing access to the Internet as a way to stop the problem, and raising awareness. In terms of reducing access to the Internet, younger clinicians may best be able to do this because they may be more familiar with computers than older clinicians and, therefore, have more strategies to assign to couples as ways to reduce access. Raising awareness include referring the client to cybersex support groups, taking a cybersex history, understanding the cycle of cybersex, and consequences of the behavior. Again, younger clinicians who are more familiar with computers might be more versed in computer

jargon, and be able to take a cybersexual history in detail than an older clinician who merely adapts a sex history. Other treatment considerations will be discussed in the Implications section.

One of the other interesting results is that age was significant in the regression when including martial status of the clinician. Yet, even with this result, the amount of variance explained is not a great deal. Subsequent analyses should focus on the potential interaction between age of therapists and their marital status, potentially considering age as a categorical factor rather than age as a continuous covariate and its interaction with marital status. Additionally, other analyses might have a greater sample of persons who are in long term relationships, widowed, or are otherwise unmarried, and therefore creating more categories. As it is, the present sample had inadequate sample size for these other marital forms, and was pooled into one large "unmarried" group.

Gender of the Clinician

In the present study, female clinicians were more likely to focus treatment on the couple's larger processes in cases where an individual is communicating online with someone but has not met them in person. There was, however, no difference between male and female therapists in their assignment of pathology to the problem. Also potentially important is the therapists' gender in their assessment of how damaging the problem is to the relationship. Though this was not statistically significant at the Bonferroni level in the present study, the *p*-values for Vignettes 2 and 3 were close to .05. These items may then be included in a replication of this study, as they may yield some other findings or be important in further revisions of this model.

Hecker, Trepper, Wetchler, and Fontaine (1995) found that therapists, in their assessment of sexual addiction cases, differed in their assessment of pathology in cases depending on gender. Male therapists had a tendency to pathologize clients more than female therapists. Several factors may explain these results. First, the vignettes used in the present study were those from Nelson's (2000) study, and therefore differed from the vignettes presented in the Hecker et al. study. The vignettes differed primarily in that that the Hecker et al study focused on sexual addiction, while Nelson's (2000) vignettes focused on Internet infidelity. Another explanation for the results might be the different number of participants. As observed in the results section in the present study, relationships between clinician gender and the assessment and treatment items that were significant in the first analysis at the .005 level were no longer significant after adding

approximately 70 cases in the regression analyses. The Hecker et al. study included 199 respondents, less than half of the respondents in the present study. Since adding 70 cases appeared to make a difference, there is a chance that with the same study and a greater number of respondents, the results may have been different.

Additionally, within the third vignette (pornography online), there were several factors that were close to the .05 value, but were above the .005 value as identified by the Bonferroni correction. Though this was not consistent across three vignettes, there was a pattern of potentially differential treatment based on client gender within this vignette. Specifically, there may be some relationship between the sex of the therapist and the severity of the problem, the extent of damage the situation caused to the relationship, the assessment of sex addiction for a client, prognosis estimates, number of sessions, and the extent to which treatment should focus on individual issues. Again, though these were not significant at the Bonferroni adjusted level, they did appear to be wholly different than reported relationships within the other two vignettes. The differences in the pornography vignette and the other two vignettes may be a focus of future research.

Religiosity of the Clinician

The factor that sheds the "brightest light" on how the social background characteristics of clinicians' influences their treatment was that of religiosity of the clinician. The more religious the clinician reported that they were, the more serious they rated the problem in Vignette 3 (where one partner viewing pornography online). Similarly, they described this problem as more damaging than less religious clinicians. Within this analysis, it was also revealed that, in terms of therapist marital status, those therapists who were married also reported that the pornography cases were more severe and more damaging to the couple than unmarried clinicians. Additionally, clinicians who rated themselves as more religious believed that married individuals who chat online with someone else have a greater degree of sex addiction.

When looking at the results as a whole, there are several patterns for examination. The first type of pattern of interest is that *across* vignettes. There were relatively low p-values across all three vignettes assessing whether clients were sex addicts. There were also low p-values across all three vignettes for measuring how much treatment should focus on environmental issues. The second pattern of interest is that *within* vignettes. There were several items within the pornography vignette that had relatively low *p*-values, including an assessment of severity,

damage to relationship, degree of sex addiction, and focus of treatment on environmental issues, individual issues, and managing crisis. Some of these low *p*-values were below the Bonferroni level established, and some were above; however, they may be of interest for future researchers or replication studies.

These findings make sense when considering how religion impacts moral values and judgments a person makes. One's religious faith is often constructed by one's environment and upbringing. Those who are religious may have experienced a stricter upbringing in comparison to growing up in less religious environments. Likewise, they may also be more likely to consider one's actions in terms of morality and appropriateness. When one uses pornography as a way to meet sexual desire needs, clinicians that are more religious may view this as more inappropriate.

In terms of treatment, clinicians who reported a greater degree of religiosity were more likely to focus on individual issues in their treatment of pornography cases. Within this analysis, female clinicians were also found to focus on individual issues. Similar to the individual issue focus, clinicians who were more religious reported that they would be more likely to focus on environmental issues in the treatment of Vignettes 1 and 3. These findings correspond with the previous assessment findings. If, for example, those chatting online are viewed as having a higher degree of sex addiction, it then makes sense that their treatment would reflect a heightened individual and environmental focus in their assessment and treatment.

Across all three vignettes, some items that were not related to religiosity of the clinician include the extent to which the problems were rated as typical, the prognosis for the marital relationship, and the degree of focus of treatment on connecting the presenting problem to the larger processes within the couple's interaction. In the assessment phase, although more religious therapists viewed some of these cases as more severe and more damaging in some circumstances, there was no difference in prognosis estimates or assessment of problem typicality. This means that although the clinicians felt the problems may have been more damaging to the relationship, they were able to treat the case and adjust their conceptualizations in a way that did not allow their biases to drive their treatment.

Yet there are also instances in which highly religious therapists are not exempt from engaging in infidelity themselves. Within the present study, six of the highly religious clinicians reported that their own infidelity had some impact on them. This implies that religiosity of a

therapist does not exclude them form engaging in this behavior, though their reported view may be different.

Marital Status of the Clinician

In and of itself, the consideration of one's marital status was not related to any of the assessment and treatment items at the Bonferroni level. Yet, when we examine patterns across and within the variables and move beyond the Bonferroni established *p*-values, marital status may be an important variable in future research in exploring assessment and treatment of Internet infidelity cases. For example, some items that had relatively low *p*-values related to marital status are a clinician's assessment of the severity of the presenting problem, the extent of damage to the relationship, the number of sessions that treatment would take, and the extent to which treatment focuses on individual issues. Because these variables were not run through a regression analysis to determine to directionality, it is unclear the manner of any such relationships at this time. It makes sense that these items are connected – how serious the problem should be connected a clinician's assessment of how damaging the problem is to the relationship. Further, if therapists determine that the problem is more severe and damaging, these assessments might be reflected in their prescription of number of sessions and their emphasis on types of treatment.

Despite the fact that there were not any significant relationships within the marital status analysis, this variable, when included in the regression for age, in the religiosity models, therapists who were married also reported that the pornography cases were more severe and more damaging to the couple than unmarried clinicians. This occurred after the regression analysis was conducted for the religiosity of the clinician. One reason for this may be the greater number of cases in the regression analysis. Again, as the regression analysis was conducted without listwise deletion of cases, approximately 20% more cases were added to the regression analysis, thus influencing the manner of the relationships significantly.

Another reason for these results may be the different types of unmarried clinicians. From the demographics information (see Table 3), there are 10 groups of marital status, nine of which were "unmarried." Because of the low *n* in each of the unmarried groups, were all combined into one large group. Differences, however, may exist in each of these separate groups. Further investigations should seek to solicit adequate numbers in each of these groups to determine if there are any differences in the unmarried groups.

Impact of a Clinician's Personal Infidelity Experience

Because there were several items measuring the personal infidelity experiences of clinicians, there were several tests to measure how these experiences influenced assessment and treatment decisions. Clinicians indicated the degree to which their parents' infidelity had affected them, the degree to which their partners' infidelity affected them, and the degree to which clinicians' own experiences with infidelity had affected them. Each of these potential influences will be discussed separately.

In exploring the influence of parents' infidelity on their children therapists, those therapists who were more negatively impacted by their parents' infidelity viewed cases in which one partner was online communicating with someone else as more typical than those who reported they were more positively influenced. Implications of this are that, though this was affecting the clinicians' assessment of typicality, this family event did not affect their therapy.

For those clinicians whose partners engaged in infidelity, the more negative the impact, the less they reported they were likely to focus on individual issues within their treatment for the second vignette (where one person communicates online with another and engages in intercourse with them). In contrast to the results of a parents' infidelity on the clinician, the negative impact of a clinician's partner's infidelity influences treatment. One explanation may lie in the correlational data about these items in the Results section. There are relationships between the impact of clinician's parents' infidelity, a clinician's partner's infidelity, and a clinician's own infidelity. Since these items are correlated, therapists 'parents' infidelity, though not overtly translating to treatment, may affect the manner in which a clinician's partner's infidelity is perceived.

Consider the following: therapist Bob's father (Ted) had an affair when Bob was a young child. When Bob's mother (Alice) discovered this, Ted and Alice divorced and Bob was allowed only sporadic contact with his father. Bob never processed these events.[5] Once an adult, Therapist Bob married Carol, only to discover 10 years into their marriage that she, too, had been unfaithful with someone she met online. Because of his experience with his parents, Bob was not able to recover from this hurt and he and Carol ultimately divorced. Therapist Bob may overtly

[5] Alice did not have the money to send Bob to a qualified MFT after the divorce, as divorce literature tells us that a woman's standard of living tends to decrease post divorce. She, of course, had Medicare, but in 2003, MFTs were denied coverage by Medicare. Poor Bob.

tie his treatment in infidelity cases based on his experience with Carol, but may believe his experience with Ted and Alice as something separate, when, in fact, it might have altered how he perceived Carol's Internet relationship

In such cases, one's parent's infidelity might ultimately end up affecting treatment in these cases, albeit indirectly. Likewise, it is also not clear the degree to which a parent's infidelity influences a therapist's own infidelity, and any subsequent treatment. Further analyses may want to explore these relationships via a path diagram or related analyses as a way to determine direct and indirect effects of such relationships.

So how will Therapist Bob respond to his Internet infidelity clients if he had been unfaithful to Carol? Clinicians whose own infidelity had a negative impact on them considered the pornography vignette as typical. Similar to infidelity by one's parents, the assessment of more typical did not translate to differences in treatment. Although clinicians felt that these problems were more typical, they were able to adjust their conceptualizations as they applied treatment.

These results support the recommendations by other therapists and writers who have discussed the importance of therapist's being clear about their own values when working with cases involving extramarital involvement (i.e., Hurlbert, 1992; Taibbi, 1983). Specifically, therapists who had some personal experience with infidelity viewed cases differently than other therapists without this same experience. As Taibbi suggests (1983), clinicians in this situation may benefit from continued consultation and/or supervision with regard to these cases. Therapist Bob, for example, may have been in a different situation if he was able to process this information with a supervisor or within his own therapy.

Another way in which therapists can work with reducing the influence that personal experiences have on their therapy is by attending to self-of-therapist issues. Edwards and Bess (1998) report that, though therapists may have a wealth of clinical knowledge, one's interventions are only helpful and effective when they are aware of their outside influences, beliefs systems, values, and personality traits. They believe that therapists should integrate their professional self with their technical self. To accomplish this, therapists should take an inventory of themselves, which includes a list of behaviors and personality traits that are as natural to them as "breathing" (p. 97). The therapist then is asked to develop self-knowledge, and accept that, as a therapist, you will not be able to be effective with every person and family. Some can use

experiential activities to develop self-of-therapist, as Deacon (1996) suggests, explore family-of-origin as a way to gain access to self-knowledge (Titleman, 1987), or can seek their own personal therapy as a way to address other self-of-therapist issues.

Qualitative Findings

The qualitative portion of this research sought to identify the treatment strategies that clinicians exercise in Internet infidelity cases. There were four main themes present in the interviews: how therapists conceptualize infidelity, what their treatment strategies are, under what circumstances their treatment changes, and characteristics of the Internet. Therapists characterized the Internet as a vehicle for engaging in sexual activity. They also saw the Internet as very accessible, and as a result, much easier to get involved with than other already existing forms of sexual entertainment.

It appears, according to clinicians, the Internet is just one way in a long line of different ways to achieve sexual gratification through means other than by one's partner. Some examples before the Internet might include engaging in writing letters to another person, visiting strip clubs against the wishes of one's partner, and viewing pornography via magazines, television, or other sources. Yet the Internet may be different from these other forms of sexual gratification in that it is easily accessible, affordable, and one can participate with a certain degree of anonymity (Cooper, 2002).

Therapists believed that Internet infidelity includes a betrayal or some breach of the relational contract. Part of this betrayal involves an element of secrecy – of both the online activities, but also of the relationship with a third party. The nature of the relationship with a third party online was that which, clinicians reported, could include a wide variety of behavior – from emotional to sexual to anything in between. In some way, shape, or form, one individual "steps out" of the relationship, emotionally or physically. Clinicians in the present study also viewed Internet infidelity as stemming from unmet needs in the primary relationship, and indicated that treatment should reflect this, through identifying unmet needs and helping the couples to find a way to meet those needs, thereby eliminating the need for the Internet infidelity symptom.

This finding ties in with the postmodern philosophy underlying this project. The spectrum of infidelity behavior includes a wide range of behaviors. For some clinicians and families, part of the definition of infidelity includes participation in sexual intercourse with a

person other than one's partner. Other couples may have a different idea of what infidelity would be for them. Some such behaviors that can constitute infidelity include cybersex, viewing pornography, varying degrees of physical intimacy, such as kissing and holding hands, and even developing emotional intimacy with another person to the detriment of the primary relationship. More importantly, clinicians are willing to work with the definition that the couple provides in treatment.

There are also several other theories that fit well for exploring this problem. Bowen family systems theory (Bowen 1978), for example, fits with the triangulation piece, as those who engage in Internet infidelity may be more likely to use to computer and the people on it to reduce their anxiety. Functional family therapy (Alexander & Parsons, 1978) fits with the clinicians' conceptualization that Internet infidelity was a result of something lacking in the relationship. In functional family therapy, behaviors are seen in the context of either creating distance between two people or decreasing space between two people. For example, an individual who cannot tolerate intimacy may be more likely to have an affair. Choosing to engage in a relationship with other than one's partner might be a way to create distance if there is a problem in the primary relationship, or might also be a way to gain the other partner's attention and to work toward closeness. In structural family therapy terms (Minuchin, 1974), Internet infidelity behavior may also be considered a symptom of a structure problem for the couple. Symbolic-experiential therapists and contextual family therapists may view the third party in Internet infidelity cases as a symbol, that which might be used by the person engaging in the infidelity as a way to understand him/herself.

Again, one of the parts in the findings indicated that therapists might feel there is some justification in some cases of using the Internet as a tool for sexual gratification. Dodini (2000) found that therapists who had personal experience with infidelity were more likely to rate it as justifiable than other therapists without such experience. Though the assessment of whether or not therapists justified this behavior was not a question under investigation in this research, it appeared as a byproduct in therapist comments about the nature of Internet infidelity, and this was not necessarily restricted to those therapists who had a personal experience with infidelity. Future research could explore the circumstances under which infidelity is justified in the view of clinicians, and the population at large. For example, if a spouse is unable to engage in sexual activity as a result of an illness or disability, is their partner more justified in seeking sexual

gratification through other means? At what point, when one partner is not getting his/her needs met, is a relationship with someone online justified? For instance, in the case of a medical illness or sudden disability, one partner may give the other partner "permission" to engage in infidelity as a way to help them meet their needs. In these cases, the infidelity may not necessarily constitute a secret, which is, according to Glass (personal communication) and some of the clinicians in the study, a critical component of infidelity. These cases might most resemble comarital relationships, where there is an understanding of sexual polygamy but also of mutual exclusivity.

Specific treatment strategies outlined by therapists include an assessment, which would seek to identify the goals of therapy, gauging the couple's commitment to one another, gathering information about the affair event, and understanding the couple's history with one another. Clinicians were also interested in the definitions of Internet infidelity, including the definitions of each individual member as well as that agreed upon by the couple, if any. These strategies are consistent with those presented in conventional infidelity literature. This means that clinicians are, in some ways, using conventional infidelity to inform their treatment of Internet infidelity cases. Other authors believe that cases of Internet infidelity should include special treatment considerations (Schnarch, 1997; Shaw, 1997).

Some of the theoretical frameworks that clinicians identified in treating Internet infidelity cases primarily included those based on transgenerational, emotion-focused therapies, and solution-focused interventions. Several strategies also emerged across frameworks as common factors in treatment. For example, many of the clinicians identified an apology or a course of forgiveness as part of their treatment strategies. Other ideas included adjustment of environmental strategies.

Clinicians were also able to identify circumstances in which they would alter their treatment. In cases of addiction, for example, clinicians would focus more on individual treatment than on couple's treatment. Further, clinicians also indicated that they would alter their treatment based on the needs of the couple, tailoring treatment to address problems specific to each couple. Health or medical concerns of the couple would also influence therapists in the present study to assess further as to the manner in which these health concerns affect the couple.

Gender of the client also appeared to influence how therapists assess and treat Internet infidelity cases, though clinicians typically answered that direct question as "no." Specifically,

clinicians believed that women were less likely to use pornography, and reported that they would be shocked if this situation presented itself in their office. When asked whether their treatment would differ based on gender, clinicians reported that it would not, but then made comments at other parts of the interviews opposing this view. For example, the participants had a tendency to use the pronoun "he" during the interview process when describing the involved partner. Further, clinicians added to this by describing infidelity as potentially occurring when a wife could not meet her husband's needs.

There may be a couple of reasons for the inconsistencies in what the clinicians reported they would do with men and women and what they actually described throughout the course of the interviews. Clinicians may have believed that the politically correct response was to report that their treatment did not change. Therefore, differences in treatment were not identified when participants were directly asked whether their treatment would change, but instead are understood within the context of the interviews. Another reason for the discrepancy in gender messages might be heightened awareness around discussing the topic with a female interviewer. In this way, therapists who would not want to be perceived as ignorant of feminist issues, particularly when talking with a woman.

Participants also responded that their treatment was different in the cases where there was an identifiable third party in the vignettes. Those interviewed believed that the involvement of a third party was more serious in that it violated a boundary that, for example, using pornography did not. As such, treatment in these cases would include more emphasis on forgiveness for the couple to more forward.

Discussion Synthesis

The Internet adds new dimension to the assessment and treatment of infidelity cases. The results of the present study illustrate that therapists who are more religious tended to view Internet infidelity as that which might require a greater individual focus. Age and gender of the clinicians also affected how therapists used treated cases, with younger clinicians more likely to alter environmental issues and female clinicians more likely to focus on couple processes in treatment. Because age and gender is an important finding, family therapy researchers may seek to find another understanding of how to moderate the focus on environmental issues. Further, clinicians also viewed men as more likely to be sex addicted, while women engaging in the same behavior were viewed as atypical for engaging in the same behavior. Clinicians also made

differential decisions in treatment based on client needs, client gender, client health, and their personal theoretical orientation.

Therapists' Biases in Assessment and Treatment of Internet Infidelity

As Stabb, Cox, and Harber (1997) report, differential treatment is an area of concern in clinical work, as biases can affect how one develops treatment strategies for the presenting problem. Of the areas in which there were differences in treatment for Internet infidelity cases, more often these differences were reflected in treatment as clinicians prescribed further emphasis on the individual rather than systemic factors. If not in pathologized in assessment (at least not as identified by the pathology assessment item within this study), clinicians still pathologized in the treatment section. Moreover, when they do so, they tend to recommend individual as opposed to systemic treatment.

Though Stabb, Cox, and Harber (1997) speak to the problem of differential treatment, they do not mention whether or not differential assessment should also be considered an issue. There were several instances in the present study where clinicians demonstrated differences in their assessment, but these differences in assessment did not translate to treatment. These findings indicate that even if a clinician's personal experiences or social background characteristics might influence their assessment; clinicians are able to prevent these from translating to treatment.

Another aspect that might be preventing biases in the assessment phase from reaching the treatment phase might be tied to AAMFT's recent focus on self-of-the-therapist. For example, the annual conference in 2004 carries the theme, "The Moral Imperative," and submissions are to reflect, in part, information related to the self-of-the-therapist. It is possible that therapists have a greater sense of awareness about how these factors can influence their therapy, and are attempting to separate these issues from their therapy.

Throughout this investigation, there have been times in which a therapist's social background characteristics influenced their assessment but not their treatment, influenced their treatment without influencing their assessment, or influenced their treatment and their assessment. This leads one to be curious about the circumstances in which assessment is not translated to treatment, and vice-versa. In reviewing these patterns within the present research, a potential pattern to answer this question emerged. In the cases where gender of client, of the therapist, and a therapist's age was a factor, there consistently were differences in treatment, but

not as much difference in the assessment items. In the case of religiosity and the impact of personal infidelity experience of a clinician, there tended to be more assessment differences, but this did not necessarily translate into treatment. Future research may seek to understand under what circumstances treatment is affected.

The Complexity of Internet Infidelity

Internet infidelity is a complex issue (Maheu & Subotnik, 2001). Some of the reasons that clinicians in the qualitative portion reported that people might engage in infidelity, Internet or any other kind, is that they were missing something from their relationship. Maheu and Subotnik (2001) report, "The Internet provides an escape to millions of people who otherwise cannot see a reasonable way to transform their difficult relationships." (p. 9). These issues, however, do not end with simply not being able to work on one's relationship. There may be other issues complicating Internet infidelity cases.

One such factor is what the nature of Internet infidelity. Cooper and Sportolari (1997) report that online romances are characterized by emotional components. As the couple communicates more often, they build an emotional intimacy with one another that sustains the relationship. These relationships, however, may also be about physical attractiveness to some degree. As Internet technology develops, it becomes easier for users to exchange movies, photos, and use tools such as video conferencing that enhance feelings of physical attractiveness. Some dating websites might also provide pictures of those in their dating pool as a screening tool for potential daters to use.

For example, age of the client may be a factor that complicates treatment of Internet infidelity cases. As clinicians described in Phase Two of the present investigation, physical health concerns of the client would influence their treatment of clients. Tepper and Owens (2002) reported older individuals and those with health concerns can use the Internet as a way to research treatment options and gain information about their conditions. Another such implication might be the client who is addicted to sex on the Internet. Though there were no vignettes in the present investigation that the client was overtly identified as a sex addict, yet clinicians reported that their treatment would be different for cases in which they assessed the client as a sex addict.

Further complicating the picture of Internet infidelity is the computer as a vehicle. Many clinicians in the present study reported that the computer, because of its accessibility and quick evolution, is something new for couples and families to work with. The reality is that some of

these same conversations that happen over the computer can happen over the phone, via mail, or in person. As a result, the computer is given more power in these relationships than other means of communicating.

The implications of the computer having this power are the strategies in the present study identified by clinicians may be inconsistent with what they reported the reason was for the infidelity. In this investigation, clinicians overwhelmingly reported that there was something lacking in the primary relationship, yet their treatment strategies, in part, reflect environmental changes. It appears that when the computer has this much power, it influences clinician strategies for treatment of Internet infidelity cases, forcing the strategies to be more environmental rather than stemming from the clinician conceptualizations. Further, the environmental strategies employed may not be altogether realistic. For example, some clinicians reported that the clinician should move the computer or take the computer out of the house. Because of the multiple uses of the computer for all members of the family, removal of the computer may not be a realistic strategy.

What might be the most complex about Internet infidelity is the lack of theoretical base in its treatment. Though clinicians in the present study were able to identify some strategies within already existing models and frameworks for their treatment, there was no model or framework as a whole that was used consistently from clinician to clinician. This finding corresponds with those of Nelson (2000), who reported that his panel experts did not agree on treatment for the vignettes. In Nelson's (2000) investigation, however, treatment appeared to be derived from cases of conventional infidelity, without considering the Internet variable. Rather, they were a collection of interventions for the treatment of conventional infidelity. This proves problematic for clinicians who work with Internet infidelity cases, as they have no map that incorporates the Internet variable for their treatment.

Hertlein and Piercy (in press) suggest that what might be behind some of the difference in treatment is that clinicians find it difficult to define what exactly Internet infidelity is. As found in the present investigation, some couple and family therapists consider sex a primary criterion in the definition, while others believe that emotional intimacy defines Internet infidelity. Secrecy may also be seen as a critical component. Likewise, many also consider a breach of trust part of the definition of Internet infidelity. These observations are consistent with those made by conventional infidelity authors, such as Lusterman (1998) and Thompson (1984). It appears that

Internet infidelity cases might best be served by a framework that integrates traditional infidelity treatment frameworks and strategies which are specific to the Internet, such as the stages provided by Delmonico, Griffin, and Carnes (2002) (reducing access and raising awareness of the cybersex problems within the relationship).

The Changing Definition of Infidelity

When first beginning this project, one of my former professors advised me that before I could do research on this topic, I had to also consider how I would define Internet infidelity. At that time, I had a clearer understanding of traditional infidelity, but was unsure what, over the Internet, would be considered infidelity. As I reach the end of this project, I believe I have a clearer understanding of how I would work with these couples and how I would resolve my own ambiguity in the matter. Like the clinicians in the present study, I am now more of the belief that each couple decides, based on their own relationship, what infidelity would be considered within their relationship. It can include viewing porn, online or offline; it can include sexual intercourse; it can include kissing; it can include cybersex; it can simply include spending time with another person other than your partner. The Internet has served to force therapists, couples, and families to reconsider their contracts and what they have used in the past to define betrayal.

The fact that the definition of infidelity is changing may be influenced by postmodernism. Consistent with postmodern ideas and philosophy, individuals are considered within their context (Lax, 1992), and as such, one cannot know another's experience (Doherty, 1995). In defining Internet infidelity, the clinicians in the present study believed that the couple's definition of infidelity was an important factor to consider in treatment. Certainly, what the therapist considers infidelity might not be what the couple considers infidelity. For example, in areas of the world where polygamy is a social norm, these couples will not define infidelity in the same manner as others for who this is not a social norm. Similarly, a couple that believes a betrayal has occurred may seek therapy, and if the therapist does not concur with the couple in their assessment and definition, treatment may be compromised. Therapists who are sensitive to the incorporation of the client's definition of infidelity and work within those parameters will serve their clients well.

The definition of infidelity can be viewed on a continuum. In the past, infidelity was typically viewed as when one person engaged in intercourse with another person other than their partner (Thompson, 1983; Johnson, 1972). The Internet has demonstrated that communication

can take many forms, some of which can violate the bounds of a couple's contract with one another. Part of this continuum might also include the involvement of an identifiable third party, which clinicians perceived as more severe. Internet infidelity can include a wide range of sexual and emotional behaviors, consistent with the definition and findings of Henline and Lamke (2003). Some of the characteristics that their respondents reported constituted infidelity behavior included cybersex, sexual chatting, online dating/plans to meet online/ emotional involvement with online contact, sexual interactions/flirting, betraying confidences of one's partner, and keeping secrets from one's partner.

Many of the therapists in the present study also believed that Internet infidelity combined many of these components. For example, the betrayal, the secrecy, and the sexual and emotional components are that which compose our common definition of infidelity. This research also indicates that the definitions of infidelity for those in comarital sexual relationships ("swingers") and those of traditional married couples are converging. Swinging refers to those who married couples who engage in agreed upon comarital sex (Constantine, Constantine, & Edelman, 1972; Jenks, 1998). Swingers, although they can be physically intimate with other people outside of the relationship, consider cheating to come into play when emotional intimacy is taking place between their partner and another (Collins, 1999; Sprey, 1972). This appears to be more the case in Internet infidelity cases – as one partner chats online with or otherwise becomes emotionally intimate with another, taking time away from spending time with their primary partner and depleting the primary dyad of energy, this may be considered infidelity.

Likewise, clinicians considered the definition of Internet infidelity to include any other relationship that depletes the primary dyad of energy and is facilitated by Internet use. This can include websites, online chat rooms, instant messengers, and other tools for sexual gratification accessed through computers and/or the Internet. Cooper and Griffin-Shelley (2002) define online sexual activities as

> any activity (including text, audio, and graphic files) that involves sexuality for purposes of recreation entertainment, exploration, support, education, commerce, efforts to attain or secure sexual or romantic partners, and so on. (p. 3).

These activities can include downloading material, purchasing sexual material, sexually explicit conversations, and others (Cooper, Morahan-Martin, Mathy, & Maheu, 2002). Cooper, Griffin-Shelley, Delmonico, and Mathy (2001) performed a study of online sexual activities and found

that most people who engage in online sexual activities do not have problems with their behavior. For those who did experience online sexual problems, they were more likely to be single and spent twice the time on the Internet as the sample. Further, those who were experiencing online sexual problems also reported less frequent sexual activities with their partner. Clearly, time on the Internet and reduced interaction with one's partner may be important variables in whether problems develop.

The results of the present study seem to imply that the definition of Internet infidelity is based on the couples' definition. One partner may feel their partner is too emotionally involved with someone online, to the point where it interferes with the primary relationship. But this is not to say that the connection that one feels with another over the computer is always infidelity. Clinicians in the present study described and emotional closeness, a "certain comradery," and a connection as being present in Internet infidelity cases. Though this may be a component in some Internet infidelity cases, it does not always mean Internet infidelity is occurring. Further implications for the wide definition of Internet infidelity are discussed in the next section.

Implications

Implications for Treatment

Consistent with Nelson's (2000) investigation, clinicians assembled strategies for treating Internet infidelity cases from the conventional infidelity literature base. For instance, the therapists in the current study reported that they employ both individual and relational foci in their treatment of Internet infidelity cases. This finding is in harmony with research conducted by Nelson (2000), where experts agreed that they could utilize individual and relational treatment strategies in these cases. Nelson (2000) also found that therapists were interested in identifying the goals of therapy (i.e., was this couple or divorce therapy) before prescribing an individual or relational focus.

Whether a clinician focuses on relational or individual factors is explained, to some degree, by the model to which s/he ascribes. In the present study, participating clinicians prescribed to a wide variety of clinical orientations. Examples of orientations with a relational focus included systemic, structural, and Emotionally Focused therapy; an example of an individualistic orientation was psychodynamic. These orientations may influence the direction a practitioner decides to take with a case and, of course, influence their responses to the present investigation.

Yet, as other authors and researchers note, it is critical to have a relational focus in infidelity cases. Elbaum (1981) describes the therapist's job is, in part, to work so that each member of the couple will resist from blaming one another and each take responsibility for his/her part in the relationship's problems. In this way, therapy focuses on the needs and issues lying within both partners and the relationship dynamics maintained by both. Pittman (1989) would tend to agree, as he indicated that connecting with and working with both partners is critical in cases of infidelity. Internet infidelity cases should be no exception, but in the present study, therapists' social background characteristics such as being more religious, were related to greater focus on the individual in treatment. Therefore, couple and family therapists should develop strategies that help them to maintain their relational focus in Internet infidelity cases.

The times when the treatment would appropriately be individualized or have a greater focus on environmental strategies may be those cases in which the therapist determines the problem to be the result of sexual compulsion. In these instances, relational strategies for this treatment would be those strategies, models, and techniques that support the identified client in working through their compulsion. In these cases, the therapist can incorporate both individual and relational treatment.

Therapists are also encouraged to meet their clients where they are, and part of this may understand better what role the computer plays in their lives. Cases that involve computers may create problems other than Internet infidelity. Such problems include a variety of addictions (such as to multiplayer online games), cybersex involvement, work-related problems, and others. As computers become more affordable, more advanced, and the Internet more accessible, these problems will only continue to increase. Therapists should perform a thorough assessment of the computer in the couple's life. Some questions might include (but are not limited to):

- When does the couple use the computer? Under what circumstances?
- Is there more than one computer in the house?
- Is there more than one computer with Internet access?
- Does the couple communicate using the computer, such as through email, instant messenger, or other communication forums?
- Are/were there any parameters around one partner's computer use or time spent on the computer?

- What attempts, if any, has the couple made in the past to limit access to the Internet or to the computer?
- How much time does each person spend on the computer?
- Are there any sites or web addresses that are off limits?

Through using these questions within assessment and other phases of therapy, the therapist can help understand the problematic structure and, with the couple, generate ideas for changes within the environment and couple dynamics.

Further implications for this study include continued emphasis on self-of-the-therapist and how one's values shape therapy. As Aponte (1985) emphasized, therapists' own biases and value might affect their definition of the problem, their assessment of the problem, and corresponding treatment. This finding was supported in the present investigation, as social background characteristics of clinicians appeared to influence how they sometimes viewed and/or treated Internet infidelity cases. It is imperative that therapists continue to examine their belief and value systems while in practice.

Utilizing the Internet for clients' benefit

The present study, in addition to understanding what clinicians are currently attempting to do to treat Internet infidelity, also provides some further strategies for treating these cases. Just as therapists recommended some environmental strategies for terminating the infidelity relationship, these same strategies can be used to enhance the primary couples relationship. Clinicians may also consider using these same strategies for enhancing the relationship of the primary dyad.

Cooper, Scherer, and Marcus (2002) describe certain interventions that can be used as ways to strengthen couple relationships. The Internet, for example, can be an aid in sex therapy treatment. The Internet is a place where partners can communicate with each other, but also look to for information about sexual concerns or other relevant educational materials (Cooper & McLoughlin, 2001). Therapists should consider if, given their assessment of a case and each couple's identity, whether the Internet could be used as a helpful tool in rebuilding their relationship. For example, in sex therapy, the Internet can be used with clients who feel weak to experience strength in some area. Cooper, Scherer, and Marcus (2002) identify several facets of the Internet that can be used as aids in therapy: websites, bulletin boards and newsgroups, email, and instant messenger/chatroom environments.

Such features can also be used in Internet infidelity treatment. For example, there are a number of websites devoted to providing information to couples on the recovery of Internet infidelity. Therapists can assign couples to look at these websites together, thus encouraging couples to be active in their treatment (Cooper, Scherer, & Marcus, 2002). Bulletin boards may be places for couples to gain support from others in similar situations or dealing with some of the same issues. For the couple themselves, therapy might include assigning the couple to communicate with each other, rather than communicating with third parties online. Even with two computers with Internet access in the same house, couples may connect through text messaging quick love notes to one another during a busy day. Therapists can also recommend that each member of a couple create a new screen name for such communications. Therapists can also prescribe couples to begin to rebuild their relationships using the computer. For example, one can learn to flirt on the Internet (Whitty, 2003a). Just as they can flirt, they can also flirt with their partner online, thus making the relationship better. Finally, therapists can also prescribe couples to participate in interactive or multiplayer games online as a way to build common interests and spend time together.

Implications for MFT Education

COAMTFE, the accrediting body for marriage and family therapy programs, delineates standards for master's, doctoral, and post-graduate degree programs in marriage and family therapy (COAMFTE, 2003). For master's degree programs, COAMFTE requires that students should have a broad range of exposure to theories and practice in MFT. Master's programs are to provide students with the basic didactic and clinical skills. Also included in master's curriculum should be some emphasis on professional socialization and development. The implications for this study are consistent with those outlined by COAMFTE.

Part of the "broad range" of theories to be taught, based on the findings of this study, should continue to include studying feminist literature and its impact on family therapy. In this investigation, women were typically more pathologized for their behavior on line than men. Yet in today's society, the Internet is accessible to anyone – man, woman, and child. Programs should continue to incorporate feminist ideology into their programs, but specifically into their supervision practices of therapist trainees.

Like the emphasis on feminism, another theory to continue to include in MFT training is postmodernism, specifically identifying how it has influenced therapy, families, and couples. In

the present study, postmodernism appears to influence the definition of infidelity to incorporate a wider range of behaviors as betrayals. Equally, supervisors and family therapy educators should be aware of the influence of postmodernism on diagnoses and intervention strategies, and provide opportunities for students to grapple with these issues.

In the area of professional development, education in marriage and couples counseling should also emphasize how one's values and biases influence their therapy. Supervisors should continually work with their supervisees to help them identify possible circumstances in which their values and beliefs influence their case conceptualization and subsequent treatment. Supervisors should continue to challenge therapists about the origin of their clinical decisions and encourage therapists to continuously evaluate potential influences in their assessment and treatment decisions.

Finally, clinicians who are working with Internet infidelity cases (or any case involving computer use) should be adequately familiar with computers and the Internet. In this way, therapists can perform a more comprehensive assessment about client's computer use. Cooper, Scherer, and Marcus (2002) encourage therapists to use the Internet not just as a resource for clients, but also for adding to their knowledge base. As a result, clinicians will be able to assign realistic and appropriate interventions for couples and families dealing with these concerns.

Implications for the Field of MFT

As a field, marriage and family therapy was founded on the idea that relational systems contribute to both problem formation and problem resolution. This is what makes us unique as a field. Yet the present study indicates that social background characteristics of the therapist sometimes alter whether the therapist maintains a systemic view in Internet infidelity cases. When this happens, therapists abandon the systems perspective, focus on the individual, and distance themselves from that which makes us unique as a field: Therapists who practice under the rubric of systems theory should continually assess in what way they are employing the systems perspective in their cases, particularly infidelity cases, and revisit the suitability of their treatment.

Strengths of the Study

Nelson (2000) reported that his Delphi study on Internet infidelity indicated that therapists did not believe that therapist's required special training in cases of Internet infidelity, and that their already existing treatment strategies for infidelity This study had several strengths.

First, it helped to clarify what role therapists' social background characteristics had, if any, in their assessment and treatment of Internet infidelity cases. The findings of this study indicate that therapists' treatment decision in Internet infidelity cases are based in part on the needs of the client, the gender of the client, and the gender, age and religiosity of the clinician. To date, this was the first study to fully examine how these factors influenced clinicians' assessment and treatment of Internet infidelity cases. It not only adds to the knowledge base of conventional and Internet infidelity treatment, but also adds to the knowledge of how therapists' characteristics influence the manner in which they conceptualize and treat cases.

Another strength of this study was the mixed methodology. The quantitative portion uncovered some interesting relationships between social background characteristics and assessment and treatment in Internet infidelity cases; the qualitative information provided support for these numbers, and participants were able to expand on their decision-making process in these cases, not restricted to boiling down their treatment strategies to Likert-type responses on a handful of items. In short, using both quantitative and qualitative methods gave more power to the findings, as each half can inform the other.

Limitations of the Study

Design

There were several limitations in the present study. Constructing an Internet survey that used a university's server was limiting in some ways. First, I did not maintain the system because it was part of the university's system and was housed on their servers. This limited control that I had over the instrument. As a result, there were several instances that would-be participants indicated that they could not access the website. One participant described her frustration with the structure:

> I tried to click on your link and was unable to. I am emailing you because I would like to give you feedback. Writing your site down and trying to go through that whole process is cumbersome. It is not user friendly so I did not pursue it. I wish you luck with your research, but encourage you to design a better structure.

Although I had the ability to thank them for their feedback, I had limited ability to maintain the server as it belonged to the University. Future researchers might benefit from establishing their own research website so that they have the ability to control the server on which the survey is host.

The present investigation, though it asked therapists to report about their personal experiences, if any, therapists had with infidelity, did not seek to understand therapists' experiences with computers, Internet infidelity, pornography, etc. This may have been important information to include, as clinicians views of the Internet and computers may have influenced their assessment and treatment of such cases, just as the extent of their religious beliefs have. Further questions might have included an assessment of the clinician's computer skills (other than knowing they had email to participate), assessing how much time clinicians spent online, etc.

Item Limitations

Another comment that many participants had, in responding to my initial email, was indicating that they did not see how the questions help someone determine the level of sex addiction. Although this single item on the survey was a red herring and not of real interest to the research question at hand, participants appeared to gravitate toward this item and made leaps as to what the hypothesis was in the project. Several participants commented that the "vignettes do not provide enough info to determine addiction." One participant stated:

> I was surprised that the questions focused on a woman's infidelity and you had questions concerning sex addiction with so little information. I would never make such snap judgments about how many sessions it would take to help a relationship…without knowing the couple personally.

As a result of these incorrect assumptions, therapists did not feel they could complete the survey, resulting in lost data. It seemed that people were interpreting what we were looking at "sex addiction," albeit incorrectly, and were making attributions about my intentions to this end.

Another item that may have been a limitation in the present investigation was the lack of assessment of a clinician's supervisory status. One of the questions that I did not as was whether the clinician was an AAMFT approved supervisor. This might have been important, because AAMFT approved supervisors have to go through a supervisory process that other clinicians do not. Does going through this process, then, change the way one thinks about cases? This is something that I could also have used to divide the groups of therapists and explore is their supervisory experience made a difference in the way they think about cases.

There were also limitations within the vignettes presented. First, the vignettes did not provide a great deal of detailed information about the couples. Emmelkamp, Mersch, and Vissia

(1985) purport that analogue studies may be limited in measuring what someone might actually do in a given situation. Applied to this study, therapists might prescribe different treatment when they are in the situation rather as opposed to what they prescribe when reading a vignette., Because of the nature of the questions, however, the vignettes appeared to be the most appropriate manner in which to complete the research. To actually view and rate clinicians assessment and treatment of these cases would be costly, time-consuming, and results may be hampered by the therapist-client relationship.

Sample

Another limitation was the access of the survey to people who are not very good with computers. Participants, in some cases, could not figure out what they were supposed to do. They are not as familiar with computers, and as a result had difficulty completing the survey.

As far as sample, because I could not access the full list of AAMFT members from which I could choose, the sample was restricted to those who listed themselves on TherapistLocator.net. As a result, my sample may be reflecting a specific cross-section of therapists who are computer savvy and potentially have greater access to the computer than others. Further, of the therapists on TherapistLocator.net, not all provided an email address for contact. Some therapists only listed their phone number and mailing address, and therefore were not contacted.

Directions for Future Research

Thorstein Veblen (1919), noted US economist and social philosopher, once was quoted as saying: "The outcome of any serious research can only be to make two questions grow where only one grew before." Based on the results of the present investigation, several questions grew from the two hypotheses at the inception of this project for consideration in future research. Several items had relatively low p-values and might be of interest for future researchers or replications of this project. These include:

- Examining any possible interactions between gender of client, gender of clinician, and other social background variables;
- Exploring the relationship of clinician age to treatment focus on environmental issues, number of sessions, and the extent of crisis management;
- Examining differences between gender of the identified client and a therapist's focus on individual issues, relational issues, and environmental issues in Internet infidelity cases;

- Examining differences between gender of a client using online pornography and a clinician's assessment of the severity of the presenting problem, how damaging the problem is to the relationship, and focus on individual and environmental issues in treatment;
- Identifying relationships, if any, in a therapist's marital status and one's assessment of the severity of the presenting problem, the extent of damage to the relationship, the number of sessions that treatment would take, and the extent to which treatment focuses on individual issues in Internet infidelity cases. Part of this should include a larger number of participants who are single, divorced, widowed, etc.

Further, researchers may want to further explore other circumstances in which assessment and treatment decisions are more vulnerable to social background characteristics. Social background characteristics that were biological in nature appeared to impact treatment, whereas those characteristics that were psychological in nature were more likely to influence the assessments. Though this is a tentative result based on the patterns from the present study, it may be an element of consideration for future researchers when exploring the impact of social background characteristics on treatment of infidelity cases.

As mentioned throughout the results and discussion sections, there were several instances where differences existed in assessment and treatment in the pornography vignettes than in the other two vignettes involving online communication. Another question for research might include the differences in the assessment and treatment of the pornography vignette versus the other two vignettes. Additionally, future research might seek to understand under what circumstances Internet infidelity might be justified in the view of clinicians and what impact this perception would have on treatment. Finally, future researchers might be interested in identifying the differences in how clinicians see individual and relational treatment, using this information to further treatment frameworks for Internet sex cases.

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APPENDICES

Appendix A

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Internet Extradyadic Involvement: An Examination of Family Therapist Assessment and Treatment Strategies.

Principal Investigators: Katherine M. Hertlein

Purpose of this Research/Project

The purpose of this project is to identify the assessment and treatment of Internet infidelity cases.

Procedures

The researchers will secure the email addresses of 500 clinical members of the American Association for Marriage and Family Therapy (AAMFT) and distribute questionnaires to each. The researcher will provide you with a link to a website and ask you to read the vignettes and respond to statements following each vignette. Demographic information will be requested of you as well. Six-point Likert statements will be used to assess how you might perceive and handle several cases.

Risks

If during or after the participation in this research you experience any psychological discomfort, you may contact the researcher at the number below. The researcher is able to answer any questions regarding the topic area. Should you have other concerns than those that you feel comfortable disclosing to the researcher, you can contact the Institutional Review Board with those concerns. Their contact information can be found on the second page of this consent.

Benefits

This research has several significant benefits. This research will seek to understand factors related to how therapists see and treat Internet infidelity. This research will add to the existing knowledge base about therapy and treatment decisions, especially in the area of Internet affairs. No benefits were used to encourage or coerce participation. You can contact the research team and request the results of the research.

Extent of Anonymity and Confidentiality

Your responses will be confidential. No response will be linked to an individual respondent. In some situations, it may be necessary for the investigators to break confidentiality. If child abuse is known or strongly suspected, investigators are required to notify the appropriate authorities. If you are believed to be a threat to yourself or others, the investigator should notify the appropriate authorities. These are the conditions in which confidentiality would be broken.

Compensation

There will be no compensation for the participants involved in this study.

Freedom to withdraw

You have the freedom to withdraw from the project at any time without being penalized in any capacity.

Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech, by the Department of Human Development.

4/4/02	4/4/03 (option for renewal)
IRB Approval Date	Approval Expiration Date

Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

Participant's Permission

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent. Submission of the inventory is evidence of my voluntary willingness to participate.

Should I have any pertinent questions about this research or its conduct, and research participants' rights, and whom to contact in the event of a research-related injury to the participant, I may contact:

Katherine Hertlein	khertlei@vt.edu
Investigator(s)	Telephone/e-mail
Scott Johnson, PhD Fred Piercy, PhD	540-231-7201
Faculty Advisor	Telephone/e-mail
_____	_____
Departmental Reviewer/Department head	Telephone/e-mail

David Moore
Chair, IRB
Office of Research Compliance
Research & Graduate Studies

David Moore
dmoore@vt.edu

This Informed Consent is valid from 4/4/2002 to 4/4/2003 with option for renewal.
IRB Approval Number: #02-207

(Note: Should you choose to participate in only the first phase of research, please print out a copy of this Informed Consent for your records. Should you choose to participate in both the first and second phases, you will be given a complete copy (or duplicate original) of the signed Informed Consent.)

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Internet Extradyadic Involvement: An Examination of Family Therapist Assessment and Treatment Strategies.

Principal Investigators: Katherine M. Hertlein

Purpose of this Research/Project

The purpose of this project is to identify the assessment and treatment of Internet infidelity cases.

Procedures

I will interview participants in relation to their assessment and treatment decisions in Internet infidelity cases.

Risks

If during or after the participation in this research you experience any psychological discomfort, you may contact the researcher at the number below. I am able to answer any questions regarding the topic area. Should you have other concerns than those that you feel comfortable disclosing to the researcher, you can contact the Institutional Review Board with those concerns. Their contact information can be found on the second page of this consent.

Benefits

This research has several significant benefits. This research will seek to understand factors related to how therapists see and treat Internet infidelity. It will add to the existing knowledge base about therapy and treatment decisions, especially in the area of Internet affairs. No benefits were used to encourage or coerce participation. You can contact the research team and request the results of the research.

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Compensation

There will be no compensation for the participants involved in this study.

Freedom to withdraw

You have the freedom to withdraw from the project at any time without being penalized in any capacity.

Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech, by the Department of Human Development.

_____2/4/03_____ _____2/4/04 (option for renewal)____

IRB Approval Date Approval Expiration Date

Participant's Responsibilities

I voluntarily agree to participate in this study.

Participant's Permission

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent. My signature below is evidence of my voluntary willingness to participate.

_____ _____

Signature of Participant Date

Should I have any pertinent questions about this research or its conduct, and research participants' rights, and whom to contact in the event of a research-related injury to the participant, I may contact:

Katherine Hertlein	khertlei@vt.edu
Investigator(s)	Telephone/e-mail
Scott Johnson, PhD Fred Piercy, PhD	540-231-7201
Faculty Advisor	Telephone/e-mail
_____	_____
Departmental Reviewer/Department head	Telephone/e-mail

David Moore
Chair, IRB
Office of Research Compliance
Research & Graduate Studies

David Moore
dmoore@vt.edu

This Informed Consent is valid from __2/4/2003_____ to _2/4/2004____ with option for renewal. IRB Approval Number: #03-064

Please return a SIGNED copy of the consent to:
Family Therapy Center
Attn: Kat Hertlein
840 University City Blvd, Suite 1
Blacksburg, VA 24060
Fax #: 540-231-7209

Dear AAMFT Clinician,

My name is Kat Hertlein and I really need your help! I am a doctoral candidate at Virginia Tech in the Marriage and Family Therapy program. I am doing my dissertation on how experienced couple and family therapists assess and treat infidelity cases. I know you are busy, but because of your interest in couples and relationship issues, I am hoping you would be interested in taking a quick survey!

Your responses to this survey will remain completely anonymous unless you choose to participate in the second phase (a phone interview).

To participate in this study please click on the Internet link below. The link will take you to the web site that houses the informed consent and the survey. It will only take about 10 to 15 minutes. PLEASE HELP!

To participate in this study, please click here:

<http://survey.vt.edu/survey/entry.jsp?id=1042947526000> or
<https://survey.vt.edu/survey/entry.jsp?id=1045887431952>

If that doesn't work, try cutting and pasting the address into the web browser.

Thank you in advance for your help on this project!

Sincerely,

Kat Hertlein, M. S.
Doctoral Candidate
Virginia Polytechnic Institute and State University

Dear AAMFT clinician,

Just a reminder to complete the assessment and treatment survey I emailed to you earlier if you haven't done so already. I really need your help!

To participate in this study please click here:

<http://survey.vt.edu/survey/entry.jsp?id=1042947526000> or
<https://survey.vt.edu/survey/entry.jsp?id=1045887431952>

It will only take about 10 to 15 minutes. PLEASE HELP!

Thank you in advance for your help on this project!

Sincerely,

Kat Hertlein, M. S.
Doctoral Candidate
Virginia Polytechnic Institute and State University

Demographic Items

1. Please indicate your gender.
    a. Male
    b. Female

2. Indicate the highest degree you have earned.
    a. Bachelor's degree
    b. Master's degree
    c. Ph.D.
    d. Ed.D
    e. Psy.D
    f. M.D.
    g. Other (please specify)

3. What is your marital status?
    a. single, never married
    b. single, divorced
    c. married
    d. divorced but remarried
    e. widowed, not remarried
    f. widowed, but remarried

4. In what field is your degree?
    a. Marriage and Family Therapy
    b. Social Work
    c. Psychiatry
    d. Psychology
    e. Divinity
    f. Nursing
    g. Family Studies
    h. Counseling Education
    i. Other (please specify)

5. Please choose the option which best describes your clinical orientation
    a. Behavioral
    b. Experiential
    c. Metaframeworks
    d. Strategic
    e. Structural
    f. Social Constructionist (Narrative, and Collaborative language)
    g. Solution-focused
    h. Systemic (Milan)
    i. Transgenerational
    j. Integrative
    k. Other (please specify)
    _____

6. At what age did you complete or do you plan to complete your training in Marriage and Family Therapy? _____

7. What is your ethnic identity?
    a. African American/Black
    b. Asian or Asian American
    c. Caucasian/White
    d. Hispanic
    e. Native American
    f. Other (please specify)_____

8. What, if any, religion do you practice?
    a. Protestant
        Which denomination? _____
    b. Catholic
    c. Jewish
    d. Islam
    e. Other
    f. No religion practiced

9. How religious do you think you are?

a. Very religious
b. Somewhat religious
c. Not at all religious

10. Has an extramarital relationship impacted you personally?

Yes No

11. Has infidelity on within your parent's relationship impacted you positively or negatively?

Positive impact Negative impact

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5---------- 6

12. Has infidelity from your partner impacted you positively or negatively?

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5---------- 6

13. Has your own infidelity impacted you positively or negatively?

Positive impact Negative impact

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5---------- 6

14. How old were you on your last birthday? _____

15. In which state do you live? _____

16. Are you licensed or certified to practice in your state?

a. Yes
b. No

17. How many years have you been conducting therapy since your highest earned degree?

_____

18. How many hours a week do you provide direct client contact hours? _____

19. How many couples do you see in your practice on a weekly basis?

20. How many cases involving Internet infidelity have you seen?

21. Which of the following categories comes closest to the place where you practice?
    a. In open country
    b. In a small city or town (under 50,000)
    c. In a medium-size city (50,000-250,000)
    d. In a suburb near a large city
    e. In a large city (250,000)

22. Would you be willing to be contacted via phone to pursue further questions about this interview?

    Yes No

    If so, what is your name and phone number?

_____

Name Phone Number with area code

VIGNETTE 1

A professional couple reports to you for marital therapy. The husband works from a computer out of their home where he became involved in a relationship with a woman. The wife knew nothing about the relationship and found out about it through an old e-mail he left in their garbage. His e-mail was flirtatious in nature, and is very uncharacteristic of how he behaves in their marriage. The wife is furious that her husband is communicating at this level of intimacy. The third party also lives in a neighboring state and the wife believes that they have been seeing each other. The husband explains that this was, "an outlet" for him and his wife does not have anything to worry about.

Instructions: Although the vignette you have just read is fairly brief, please circle the number that best corresponds to your answer related to that vignette.

1. How serious is the presenting problem? (1 not serious, 6 very serious)

   1 2 3 4 5 6

2. To what degree is this typical? (1 typical, 6 atypical)

   1 2 3 4 5 6

3. How damaging is this problem to the relationship? (1 not damaging, 6 very damaging)

   1 2 3 4 5 6

4. To what degree is the identified client a sex addict? (1 not a sex addict, 6 sex addict)

   1 2 3 4 5 6

5. What is the prognosis for the marital relationship? (1 poor, 6 excellent)

   1 2 3 4 5 6

6. How many sessions would you estimate it would take to meet the goals of therapy?

7. How much should treatment focus on individual issues? (1 not much, 6 a great deal of focus on the individual)

1 2 3 4 5 6

8. How much should treatment focus on relational issues? (1 not much, 6 a great deal of focus on the relational)

1 2 3 4 5 6

9. How much should treatment focus on environmental issues, such as removing the computer or limiting Internet access? (1 not much, 6 a great deal of focus on the environment)

1 2 3 4 5 6

10. How much should treatment focus on connecting the presenting problem to larger processes in the couples interaction? (1 not much, 6 a great deal of focus on the couples interaction)

1 2 3 4 5 6

11. How much should treatment focus on managing crisis? (1 not much, 6 a great deal of focus on crisis intervention)

1 2 3 4 5 6

VIGNETTE 2

A married couple of 8 years, with three young children comes to you for marital therapy. The wife is a frequent user of the Internet. She admits to you, in the presence of her husband, that she met another man in a chat room and they began a relationship over the phone and through e-mail. Reluctantly, the wife also confesses, in front of her husband, that she met with the third party on two separate occasions where they had sexual intercourse. The wife is scared, confused, and does not know if she wants to return to her marriage. The husband is extremely angry at the betrayal and is worried about the future of his family.

Instructions: Although the vignette you have just read is fairly brief, please circle the number that best corresponds to your answer related to that vignette.

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11. How much should treatment focus on managing crisis? (1 not much, 6 a great deal of focus on crisis intervention)

1 2 3 4 5 6

VIGNETTE 3

A couple comes to you for therapy after the husband is "caught" downloading pornographic material from various web sites. The wife is outraged and disgusted by his perversity and betrayal. She cannot understand why he "needs" to use pornography. The husband is embarrassed and ashamed about getting caught. The wife now does not trust his faithfulness to their marriage. The husband responds defensively and says, "It's no big deal. I was just curious."

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A couple comes to you for therapy after the wife is “caught” downloading pornographic material from various web sites. The husband is outraged and disgusted by her perversity and betrayal. He cannot understand why she “needs” to use pornography. The wife is embarrassed and ashamed about getting caught. The husband now does not trust her faithfulness to their marriage. The wife responds defensively and says, “It's no big deal. I was just curious.”

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1 2 3 4 5 6

Interview Protocol for the Female Assessment

General Interview Questions

- What is infidelity? What is Internet infidelity?
- How do you typically treat "conventional" infidelity cases? Do you treat conventional infidelity cases differ from Internet infidelity cases?
- What information do you typically need from a couple where the presenting problem is infidelity in order to provide effective treatment? Would there be any difference in cases of Internet infidelity?

First Vignette Interview questions

- In the first vignette, a wife became involved in a relationship with a man online but has not seen him. If this was a problem to the husband, what would you do with the couple in therapy? Why?
- Would you do something different if it was a man who was in the chatroom, and his wife didn't like it? If so, what would you do differently? Why? And is it more serious when a male client engaging in this behavior, or a female client?
- Would your treatment be different if the couple was two men? Two women?
- Would your treatment be different if the couple was not married?
- Would your treatment be different if the couple was older?

Second Vignette Interview questions

- In the second vignette, a wife became involved in a relationship with a man online and eventually engaged in intercourse with him. If this was a problem for her husband, What would you do? Why?
- How would your treatment be different from the first vignette?
- Would you do something different if it was a man instead of a woman? If so, what would you do differently? Why?
- Would your treatment be different if the couple was two men? Two women?
- Would your treatment be different if the couple was not married?
- Would your treatment be different if the couple was older?

Third Vignette Interview questions

- In the third vignette, a wife was a frequent user of pornography online, and this was a problem to the husband. Is this a problem you have seen in therapy? (if not, why not?) What would you do? Why?
- How would your treatment be different from the first vignette? (Remember, in the first vignette and this vignette, no actual intercourse is occurring? Would your treatment of this presenting problem (a spouse complaining about the other spouse's surfing for porn) be different than the second vignette (where actual intercourse was occurring)?
- Would you do something different if it was a wife complaining about a husband surfing for porn instead of a husband complaining about a wife? If so, what would you do differently? Why?
- Would your treatment be different if the couple was two men? Two women?
- Would your treatment be different if the couple was not married?
- Would your treatment be different if the couple was older?
- What else do you think it would be important for me to know about Internet infidelity treatment that I haven't asked you about?

Interview Protocol for the Male Assessment

General Interview Questions

- What is infidelity? What is Internet infidelity?
- How do you typically treat "conventional" infidelity cases? Do you treat conventional infidelity cases differ from Internet infidelity cases?
- What information do you typically need from a couple where the presenting problem is infidelity in order to provide effective treatment? Would there be any difference in cases of Internet infidelity?

First Vignette Interview questions

- In the first vignette, a husband became involved in a relationship with a man online but has not seen him. If this was a problem to the wife, what would you do with the couple in therapy? Why?
- Would you do something different if it was a woman who was in the chatroom, and her husband didn't like it? If so, what would you do differently? Why? And is it more serious when a male client engaging in this behavior, or a female client?
- Would your treatment be different if the couple was two men? Two women?
- Would your treatment be different if the couple was not married?
- Would your treatment be different if the couple was older?

Second Vignette Interview questions

- In the second vignette, a husband became involved in a relationship with a man online and eventually engaged in intercourse with him and the husband's wife complained. What would you do? Why?
- How would your treatment be different from the first vignette?
- Would you do something different if it was a husband complaining about a wife instead of a wife complaining about a husband's behavior? If so, what would you do differently? Why?
- Would your treatment be different if the couple was two men? Two women?
- Would your treatment be different if the couple was not married?
- Would your treatment be different if the couple was older?

Third Vignette Interview questions

- In the third vignette, a husband was a frequent user of pornography online and this was a problem to the wife. Is this a problem you have seen in therapy? (if not, why not?) What would you do? Why?
- How would your treatment be different from the first vignette? From the second? (Remember, in the first vignette and this vignette, no actual intercourse is occurring)? Would your treatment of this presenting problem (surfing for porn) be different than the second vignette (where actual intercourse was occurring)?
- Would you do something different if it was a wife complaining about a husband surfing for porn instead of a husband complaining about a wife? If so, what would you do differently? Why?
- Would your treatment be different if the couple was two men? Two women?
- Would your treatment be different if the couple was not married?
- Would your treatment be different if the couple was older?
- What else do you think it would be important for me to know about Internet infidelity treatment that I haven't asked you about?

CURRICULUM VITA

Katherine Milewski Hertlein, M.S.

2002 Lombardi Dr.
Blacksburg, VA 24060
540-951-8711 (Home)
540-250-0545 (Mobile phone)
Email: khertlei@vt.edu
Website: http://increment.cx/khertlein

Education

Virginia Polytechnic Institute and State University
Blacksburg, VA 24061
August 2001 – present
Doctoral candidate in Marriage and Family Therapy PhD Program

Purdue University Calumet
Hammond, IN 46323
August 1998 – December 2000
Graduated with M.S. in Marriage and Family Therapy
G.P.A.: 4.0/4.0

Truman State University
(formerly Northeast Missouri State University)
Kirksville, MO 63501
August 1993 – May 1997
Graduated with B.A. in Psychology
G.P.A.: 3.66/4.0

Positions Held

Virginia Polytechnic Institute and State University
Blacksburg, VA 24061

January 2003-present
Research Assistant
Worked with Dr. Karen Roberto in the Center for Gerontology managing data on several studies relating to nursing home retention, guardianship, and health care providers. Duties include adding variables to the data sets, coding data, running appropriate statistical analyses and providing summary of results.

August 2002- May 2003
Administrative Assistant
Worked with the Human Development Department Head and Assistant Department Head. Duties included maintaining the departmental newsletter and Other administrative tasks as assigned.

September 2001-May 2002
Research Assistant
Worked with Dr. Meszaros, Dr. Creamer, and Dr. Burger on a grant ($3500) received from the Center for Information Technology Impacts on Children, Youth, and Families to study women in technology. Duties included conducting interviews, coding data, and developing an abstract for submission to a conference.

August 2001 – May 2002
Graduate Teaching Assistant
Taught the Introduction to Human Sexuality class (up to 250 students). Prepared lectures, contacted and worked with guest lectures, prepared and administered exams and assignments.

Journal for Marriage and the Family
January 2002-present

Occasional reviewer
Participating in the Reviewer-In-Training program. Reviewed articles for the journal periodically.

Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice
Hammond, IN 46323
March 2000 – April 2002

Column Editor/Author
Seeks contributors for a website review column. Edited the work of contributors. Write columns reviewing mental health websites on an issue-to-issue basis. Additionally wrote columns fitting special journal issues focusing on specific websites.

Ad hoc reviewer
Performed reviewing duties for journal editor. Reviewed articles for possible submission into journal.

Solicitation of Ads
Contacted organizations and agencies about placing call for papers. Responsible for submitting calls to agencies, listservs, and other professional organizations.

Samaritan Counseling Center
8955 Columbia Ave.
Munster, IN 46321

Jan 2001-August 2001
Staff Therapist
Duties include setting appointments, maintaining a client load of 10-12 clients

weekly, maintaining paperwork, attending staff meetings and training meetings, on-call responsibilities. During the therapeutic process, tasks include setting goals and working to meet those goals.

Thornton Township Youth Committee
South Holland, IL 60473

February 2000 – August 2000
Contract worker/therapist
Worked with NYPUM and CCBYS program as a program facilitator and provided bilingual therapeutic services to clients. Duties included creating a study skills program and presenting program to youths, as well as providing therapeutic services to Spanish-speaking clients. Created posters and handouts for career and community fairs. Organized study skills binder for clinical use tailored to two distinct age groups: grade school and high school students.

Purdue University Calumet
Hammond, IN 46323

August 1999 – December 2000
Teacher's assistant (Research Methods)
Performed duties of teacher's assistant for research methods. Duties include recording/maintaining the grade book, lectures, grading homework and quizzes, creating an experiment for students to perform, and teaching statistical analyses on SPSS.

August 1998 – June 1999
Teacher's assistant (Introduction to Psychology)
Taught an introductory psychology class. Created all exams, assignments, and lectures. Responsibilities include lecturing; grading assignments and exams, administering tests, and helping students gain a greater understanding of psychology.

Illinois Masonic Children's Home
La Grange, IL 60452

August 1997-July 1998
Child Care Worker
Responsible for care of nine boys. Fostered loving environment for children. Attended school meetings and other meeting relevant to improving children's academic and social performance.

Preferred Family Health Care
Kirksville, MO 63501

Feb 1997 – August 1997
Psychosocial Rehabilitation Assistant
Facilitated group sessions focusing on integration into the community. Responsible for transportation of clients to and from daily activities. Solely responsible for facilitating and creating evening groups, additionally focused on

increasing social interaction and teaching skills for independent living.

Truman State University
Kirksville, MO 63501

Sept 1994-August 1997
Researcher in Psychology Department
Contributed to all aspects of the research process from design to manuscript. Presented research at national and local conferences. Participated in writing proposals and manuscripts for publication.

Internship Experience

Family Service of Roanoke Valley
360 Campbell Ave.
Roanoke, VA 24016

May 2003 –present
Therapist intern
Duties include setting appointments, maintaining a client load of 20 clients weekly, maintaining paperwork, attending staff meetings and training meetings. During the therapeutic process, tasks include setting goals and working to meet those goals.

Also participated in clinical outcome research study. Collected data using the ECBI for participants in the Children's Treatment Program, created a database for ongoing project management, analyzed data, and summed up findings in a funding report.

Virginia Polytechnic Institute and State University
Family Therapy Center
840 University City Blvd
Suite 1
Blacksburg, VA 24061

January 2002 - present
Therapist intern
Duties include setting appointments, maintaining a client load of 10-12 clients weekly, maintaining paperwork, attending staff meetings and training meetings. During the therapeutic process, tasks include setting goals and working to meet those goals.

Samaritan Counseling Center
8955 Columbia Ave.
Munster, IN 46321

December 1999-Dec 2000
Therapist intern
Duties include setting appointments, maintaining a client load of 10-12 clients

weekly, maintaining paperwork, attending staff meetings and training meetings. During the therapeutic process, tasks include setting goals and working to meet those goals.

Purdue University Calumet Marriage and Family Therapy Center
2415 169th St.
Hammond, IN 46323

January 1999-December 1999
Therapist intern
Duties include setting appointments, maintaining a client load of 3-5 clients weekly, maintaining paperwork, attending staff meetings and training meetings. During the therapeutic process, tasks include setting goals and working to meet those goals.

Thornton Township Youth Committee
333 E. 162nd St.
South Holland, IL 60473

January 1999-December 1999
Therapist intern
Duties include setting appointments, maintaining a client load of 8-10 clients weekly, maintaining paperwork, attending staff meetings and training meetings. During the therapeutic process, tasks include setting goals across five major areas (physical/medical, interpersonal, education, intrapersonal, and living at age appropriate standards), and working to meet those goals.

Edward Hospital
Naperville, IL 60406

May 1996-August 1996
Administrative intern
Created and conducted patient and staff satisfaction surveys. Worked closely with human resources to create and facilitate a team-building workshop. Served as a member of a team devoted to increasing the expediency of patient care. Worked closely with the hospital social worker to learn job duties.

Guest Lecture Opportunities

Virginia Polytechnic Institute and State University
Reproductive Technology
April 8, 2003

Virginia Polytechnic Institute and State University
The GTA as a Class Instructor
GTA workshop
August 19, 2002

Virginia Polytechnic Institute and State University

Marriage and Family Therapy: The Approach and the Results
April 10, 2002

Virginia Polytechnic Institute and State University
College dating behavior
October 15, 2001

Indiana University Northwest
Infidelity
June 14, 2001

Purdue University Calumet
Behavioral Marital Therapies
April 25, 2001

Publications

Journal Articles

In press

Hertlein, K. M., & Killmer J. M. (in press). Toward differentiated decision-making: Family systems theory with the homeless clinical population. *American Journal of Family Therapy.*

Hertlein, K. M. (in press). Feminist suggestions for the practice of medical family therapy: One therapist's personal framework. *Journal of Feminist Family Therapy.*

Hertlein, K. M., & Piercy, F. (in press). A theoretical framework for defining, understanding, and treating Internet infidelity. *Journal of Couple and Relationship Therapy.*

Hertlein, K. M., & Ricci, R. J. (in press). A systematic research synthesis of EMDR studies: Implementation of the Platinum Standard. *Trauma, Violence, and Abuse: A Review Journal.*

2003

Hertlein, K. M., Ray, R., Wetchler, J., & Killmer, J. M. (2003). The role of differentiation in extradyadic relationships. *Journal of Couple and Relationship Therapy, 2*(4), 33-50.

2002

Hertlein, K. M. (2002). Coming *into* the closet. *Journal of Clinical Activities, Assignments, and Homework in Psychotherapy Practice, 2*(2), 133-134.

Hertlein, K. M. (2002). Lose your marbles. *Journal of Clinical Activities, Assignments, and Homework in Psychotherapy Practice, 2*(2), 119-121.

Hertlein, K. M. (2002). Twenty ways to be creative in therapy. *Journal of Clinical Activities, Assignments, and Homework in Psychotherapy Practice, 2*(2) 131-132.

2001

Hope, L. B., Milewski-Hertlein, K. A., & Rodriguez, A. (2001). Removing the gag that binds: The effect of political correctness on family therapy. *Contemporary Family Therapy, 23*(1), 33-49.

Milewski-Hertlein, K. A. (2001). Hooray for Hollywood! *Journal of Clinical Activities, Assignments, and Homework in Psychotherapy Practice, 1*(4), 57-63.

2000

Milewski-Hertlein, K. A. (2000). The use of a socially constructed genogram in clinical practice. *American Journal of Family Therapy, 29*, 23-38.

1999

Hatala, M. N., Milewski, K. A., & Baack, D. W. (1999). Downloading love: A content analysis of Internet personal advertisements placed by college students. *College Student Journal, 33*(1), 124-129.

Submitted for publication/In preparation

Hertlein, K. M., Lambert-Shute, J., & Benson, K. (2003). Postmodern influence in family therapy research: Reflections of graduate students. Manuscript accepted with revisions. *The Qualitative Report.*

Hertlein, K. M., & Skaggs, G. (2003). Assessing the relationship between differentiation and infidelity: A structural equation model. Manuscript submitted for publication. *Journal of Couple and Relationship Therapy.*

Lambert-Shute, J., & Hertlein, K. M., & Piercy. F. P. (manuscript in preparation). Clinicians' views of family therapy journals: How are they stacking up?

Hertlein, K. M., & Lambert-Shute, J. L. (manuscript in preparation). Factors impacting students' choices of marriage and family therapy graduate programs.

Linville, D., & Prouty, A., & Hertlein, K. M. (manuscript in preparation). Medical family therapy efficacy: Reflecting on the necessity of collaborative health care teams.

Edited Books

Hertlein, K. M., & Viers, D. (manuscript in preparation). *The Couple and Family Therapists' Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.* Haworth Press.

Piercy, F. P., Hertlein, K. M., & Wetchler, J. L. (manuscript in preparation). *The*

Handbook for Infidelity Treatment. Haworth Press.

Book Chapters

In press

Hertlein, K. M. (in press). Jump, jump, king me: The systemic Kvebaeck technique. Manuscript submitted for publication. *The Couple and Family Therapist's Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.*

Hertlein, K. M. (in press). The pen is mightier than the sword. Manuscript submitted for publication. *The Couple and Family Therapist's Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.*

Hertlein, K. M. (in press). Speak softly and carry a big stick. Manuscript submitted for publication. *The Couple and Family Therapist's Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.*

Hertlein, K. M. (in press). Up, up and away, in my beautiful balloon. Manuscript submitted for publication. *The Couple and Family Therapist's Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.*

Hertlein, K. M. (in press). The Goodbye book. Manuscript submitted for publication. *The Couple and Family Therapist's Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.*

Hertlein, K. M. (in press). Royal flush. Manuscript submitted for publication. *The Couple and Family Therapist's Notebook: Homework, Handouts, and Activities for Use in Psychotherapy.*

Piercy, F. P., Hertlein, K. M., & Nickerson, V. (in press). Focus groups in family therapy research. In D. Sprenkle & F. Piercy (Eds.), *Research Methods in Family Therapy, Vol. 2*.

2003

Milewski-Hertlein, K. A. (2003). Anger collage. *The Therapist's Notebook for Children and Adolescents: Homework, Handouts, and Activities for Use in Psychotherapy* (pp. 291-295). New York, NY: Haworth Press.

Milewski-Hertlein, K. A. (2003). Champion pack. *The Therapist's Notebook for Children and Adolescents: Homework, Handouts, and Activities for Use in Psychotherapy* (pp. 252-260). New York, NY: Haworth Press.

Milewski-Hertlein, K. A. (2003). Director's chair. *The Therapist's Notebook for Children and Adolescents: Homework, Handouts, and Activities for Use in Psychotherapy* (pp. 296-301). New York, NY: Haworth Press.

Milewski-Hertlein, K. A. (2003). Jumanji. *The Therapist's Notebook for Children*

and Adolescents: Homework, Handouts, and Activities for Use in Psychotherapy (pp. 242-246). New York, NY: Haworth Press.

Submitted

Hertlein, K .M. (2003). Overview of infidelity research. Manuscript submitted for publication. *The Handbook on Infidelity Treatment.* Haworth Press.

Reviews

2002

Milewski-Hertlein, K. A. (2002). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 2*(1), 95-99.

Milewski-Hertlein, K. A. (2002). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 2*(3) 99-106.

Milewski-Hertlein, K. A. (2002). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice*, *2*(4), 117-130.

2001

Milewski-Hertlein, K. A. (2001). 10 steps to self-control, anger management, and feeling good about yourself. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 1*(1), 129-130.

Milewski-Hertlein, K. A. (2001). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 1*(1), 133-138.

Milewski-Hertlein, K. A. (2001). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 1*(2), 113-118.

Milewski-Hertlein, K. A. (2001). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 1*(3), 129-134.

Milewski-Hertlein, K. A. (2001). Internet therapeutics: Website Review. *Journal of Clinical Activities, Assignments, and Handouts in Psychotherapy Practice, 1*(4), 115-119.

Refereed Papers presented at University, State, and National Society Meetings

2003

Hertlein, K. M., & Lambert-Shute, J. (2003, October). *Factors impacting students' choices of marriage and family therapy programs.* Poster presented at the annual

meeting of the American Association for Marriage and Family Therapy Conference, Long Beach, CA.

Lambert-Shute, J., & Hertlein, K. M. (2003, November). *Using List-serve technology in qualitative research.* Roundtable presentation at the annual meeting of the National Council on Family Relations, Vancouver, B.C., Canada.

2001

Milewski-Hertlein, K. M., Ray, R., Wetchler, J. & Killmer, J. M. (2001, April). *The role of differentiation and triangulation in extradyadic relationships.* Poster presented at the annual meeting of the Indiana Association for Marriage and Family Therapy Conference, Indianapolis, IN.

Milewski-Hertlein, K. M., Ray, R., Wetchler, J. & Killmer, J. M. (2001, October). *The role of differentiation and triangulation in extradyadic relationships.* Poster presented at the annual meeting of the American Association for Marriage and Family Therapy Conference, Nashville, TN.

2000

Hope, L. B., Milewski-Hertlein, K. A., & Rodriguez, A. (2000, April). *To be or not to be PC: The effects of political correctness on family therapy*. Poster session presented at the annual meeting of the Indiana Association for Marriage and Family Therapy Conference, Indianapolis, IN.

Milewski-Hertlein, K. A., & Hope, L. B. (2000, April). *Silence and other creative communication strategies in adolescent therapy*. Poster session presented at the annual meeting of the Indiana Association for Marriage and Family Therapy Conference, Indianapolis, IN.

1996

Bonnell, M. K., Baack, D. W., Parmenter, R. T., Milewski, K. A. (1996, April). *Attributes, memory, and choice behavior: A test of the unique-features model with consumer product preferences*. Symposium conducted at the Undergraduate Research Symposium, Kirksville, MO.

Hatala, M. N., Bonnell, M. K., Baack, D. W., Parmenter, R. T., Milewski, K. A. (1996, May). *Attributes, memory, and choice behavior: A test of the unique-features model with consumer product preferences*. Poster session presented at the annual meeting of the Midwestern Psychological Association conference, Chicago, IL.

Hatala, M. N., Milewski, K. A., Baack, D. W., & Bonnell, M. K. (1996, May). *The effects of odor, time, and recall strategy on memory for concrete nouns.* Paper presented at the annual meeting of the Midwestern Psychological Association conference, Chicago, IL.

Hatala, M. N., Parmenter, R. T., Baack, D. W., Sievert, T., Bonnell, M. K., & Milewski, K.A. (1996, May). *HIV status and dating: A content analysis of gay male personal advertisements*. Paper presented at the annual meeting of the

Midwestern Psychological Association conference, Chicago, IL.

Milewski, K. A., Siener, N., & Marquart, J. (1996, April). *The effect of group membership in morality ratings*. Symposium conducted at the Undergraduate Research Symposium, Kirksville, MO.

Parmenter, R. T., Baack, D. W., Sievert, T., Bonnell, M. K., & Milewski, K. A. (1996, April). *HIV status and dating: A content analysis of gay male personal advertisements*. Symposium conducted at the Undergraduate Research Symposium, Kirksville, MO.

Other publications

Milewski-Hertlein, K. (2001). Surviving the Graduate Thesis (unpublished). Distributed to incoming Master's level MFT students at Purdue University Calumet.

Milewski-Hertlein, K. (2000, March 27). After the affair: Rebuilding trust and intimacy. *The Chronicle, 18*(22), 3.

Milewski-Hertlein, K. (1999, November 22). Marriage and family therapy update. *The Chronicle, 18*(10), 3.

Grants and Research Awards

Hertlein, K. M. (2003). Internet Infidelity: An Examination of Family Therapist Gender Biases and Treatment Decisions. James D. Moran III Dissertation/Thesis Award ($1000)

Hertlein, K. M. (2002). Internet Infidelity: An Examination of Family Therapist Gender Biases and Treatment Decisions. AAMFT Graduate Student Research Award ($1250)

Milewski-Hertlein, K. (2000). The role of differentiation and triangulation in extradyadic relationships. Purdue Calumet Student Research Award (funded for $750)

Piercy, F., & Hertlein, K. (recently submitted). Internet infidelity: An examination of family therapist treatment decisions and gender biases. American Foundation of Addictions Research. Proposal for $30,757 (While this proposal needed to be submitted under Fred's name, I was the primary author.)

Research Interests

Sexuality/Infidelity
Parent-child relationships
Transgenerational theories
MFT theory validation
Couple therapy
Research Methodology
MFT Training
Clinician-Researcher gap

Activities

Toastmaster's International
Kirksville, MO 63501

1994-1996
President
Duties included judging speech competitions, networking with other community organizations, organizing and leading group and executive meetings, assigning tasks to other group members, and maintaining membership with the National Organization.

1993-1994
Vice- President
Duties included creating public service announcements and other public relations tasks, attending group and executive meetings, and assisted President in organizational tasks.

Affiliations

American Association for Marriage and Family Therapy
Student Member

Virginia Association for Marriage and Family Therapy
Student Member

PREPARE/ENRICH Certified Counselor

Volunteer Experience

American Association for Marriage and Family Therapy
Volunteer for annual conference
Chicago, 2000

Abstract reviewer for 2004 annual conference
December 2003

Other Honors and Awards

- GRADUATE STUDENT TRAVEL FUND AWARD ($217) (2003)
- AAMFT GRADUATE STUDENT RESEARCH AWARD (2003)
- PURDUE UNIVERSITY GRADUATE RESEARCH AWARD (2000)
- HONORS GRADUATE FROM TRUMAN STATE UNIVERSITY (1997)
- NATIONAL BATON TWIRLING TITLE (1995)

- CHANDLER MONROE ORATORICAL CONTEST WINNER (1993)
- FIVE ILLINOIS STATE BATON TWIRLING TITLES (1990-1995)

Reference list for K. M. Hertlein

Fred Piercy, Ph. D.
Department Head
Human Development
Virginia Tech
366 Wallace Hall
Blacksburg, VA 24061
(540) 231-4794

Scott Johnson. Ph.D.
Virginia Tech
Marriage and Family Therapy Center
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Suite 1
Blacksburg, VA 24061
(540) 231-3311

Joe Wetchler, Ph.D.
Purdue University Calumet
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2200 169th St.
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(219) 989-2579

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8955 Columbia Ave
Munster, IN 46321
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360 Campbell Rd.
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