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## Mixed Methods Analysis of Counselor Views, Attitudes and Perceived Competencies Regarding the Treatment of Internet Pornography Addiction

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MIXED METHODS ANALYSIS OF COUNSELOR VIEWS, ATTITUDES AND  
PERCEIVED COMPETENCIES REGARDING THE TREATMENT OF  
INTERNET PORNOGRAPHY ADDICTION

by

Bradly K. Hinman

A dissertation submitted to the Graduate College  
in partial fulfillment of the requirements  
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Western Michigan University  
December 2013

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# MIXED METHODS ANALYSIS OF COUNSELOR VIEWS, ATTITUDES AND PERCEIVED COMPETENCIES REGARDING THE TREATMENT OF INTERNET PORNOGRAPHY ADDICTION

Bradly K. Hinman, Ph.D.

Western Michigan University, 2013

The Internet offers unprecedented opportunity for individuals to have anonymous, inexpensive, and unrestricted access to an essentially unlimited range of sexually explicit materials. Counseling clients are increasingly presenting with problematic issues regarding Internet pornography use. The purposes of this mixed-method study were (a) to examine the current status of counselors' attitudes and self-efficacy about treating clients with Internet pornography addiction, and (b) to ascertain the opinions of counselor educators who are experts in the field of Internet pornography addiction on the current status of counselor training and best practices for preparing counselors.

The quantitative data was obtained from a 90-item online survey which was completed by 286 professional members of the American Counseling Association. Counselors had the most comfort with sexual expression and tolerance toward sexual expressions different than their own. Counselors indicated less comfort around talking about pornography, and finding something positive in pornography use. Respondents had a less negative attitude regarding pornography when it is used as a relationship aid, when women also view it, and when it was used for fantasy. Respondents had the most negative attitudes about topics that dealt specifically with pornography and topics addressed in pornography; both are topics clients will be likely to discuss. Male

counselors were more likely to feel competent in their ability to counsel individuals with an addiction. Counselors whose identified religiosity was very important to their counseling work have a significantly lower attitude toward pornography. Men were more comfortable discussing client sexual concerns including Internet pornography use than female counselors.

The qualitative findings resulted from phone interviews with seven counselor educators who are also experts in the field of Internet pornography addiction. The seven global themes that emerged are: (1) Need for Process Addictions Training, (2) Process Addiction Training Critical, (3) CACREP Acknowledgement of Process Addictions/Internet Porn Addictions, (4) Addiction Course Content Delivery, (5) Counselor Education Programs' Inclusion of Process Addiction Training, (6) Qualifications for Teaching Addictions Courses, and (7) Addiction Class Course Design. The qualitative findings are compared to the survey results. Implications for counselor training are offered and recommendations are made for the counselor education profession.

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## **CHAPTER I**

### **INTRODUCTION**

The Internet offers unprecedented opportunity for individuals to have anonymous, cost-effective, and unrestricted access to an essentially unlimited range of sexually explicit text, pictures, videos, and audio materials (Haney, 2006). Men and women can acquire sexually explicit content on the Internet, effortlessly and privately, as a direct expression of their sexual and personal characteristics and preferences. The Internet provides a perceived sense of safety and a discreet arena for users to express their individual sexuality without a perceived fear of repercussions. Internet pornography differs from other forms of pornography because it is so easily accessed, free samples are prevalent, and many people feel their computer is a private medium with which to explore their sexuality (Cooper, 1998; Manning, 2006). For the purposes of this study, pornography will be defined as sexually explicit text, pictures, videos, and audio materials designed, produced and distributed for the purpose of sexual enticement, excitement and gratification (Haney, 2006; Kingston, Malamuth, Fedoroff, & Marshall, 2009). Men prefer visual erotica, such as pictures and video, at the rate of 2 to 1 more than women (Cooper, Morahan-Martin, Mathy, & Maheu, 2002; Hald, 2006; Kort, 2009). Women prefer interactive erotic communication, such as chat rooms, explicit social media sites, and webcams, at the rate of 2 to 1 more than men (Paul, 2009; Schneider, 2000; Yoder, Virden, & Amin, 2005). Males are also more likely to experience boredom, tend to have less social connectedness and engage in solitary sexual behaviors such as



masturbation and viewing pornographic material (Briken, Habermann, Berner & Hill, 2007; Chaney & Chang, 2005; Cooper, Scherer, Boies, & Gordon, 1999; Hald, 2006). Internet pornography can relieve boredom with life, work, the coupled relationship and daily routine because of the secrecy, instant access and its forbidden nature (Arterburn, 2006; Cavaglione, 2008; Cooper, Delmonico, Griffin-Shelley, & Mathy, 2004). The boredom is replaced with excitement, a false sense of connectedness, arousal and eventually a sexual release which bathes the brain in chemicals that have been likened to the effects of cocaine (Bostwick & Bucci, 2008; Delmonico & Carnes, 1999; Dew & Chaney, 2004). Not all people who are on the Internet use pornography, and not all people who use pornography are addicted, but the number of people who are is increasing (Cooper, Delmonico, & Burg, 2000; Gardner, 2001). This increase has been accompanied by an increase in the availability of online pornography and an increase in the accessibility of free pornographic images (Young, Griffin-Shelley, Cooper, O'Mara, & Buchanan, 2000). Many individuals have private access to the Internet and can access pornography without fear of being discovered or recognized by others (Cooper, Putnam, Planchon, & Bois, 1999).

Internet pornography can be a public health hazard that is hidden because not many researchers or public health practitioners are identifying it as an area of importance (Abell, Steenbergh, & Boivin, 2006; Ciclitira, 2004; Cooper, et al., 2004; Manning, 2006). The research shows significant challenges to multiple aspects of life and substantial risks for individuals who compulsively use Internet pornography. Areas of challenge include, but are not limited to, a negative impact in the job, family life, sexual practices within and without a coupled relationship, emotional, physical and

psychological health, and legal problems (Daneback, Ross, & Mansson, 2006; Dew & Chaney, 2004; Griffiths, 2001; Laaser & Gregoire, 2003; Manning, 2006). The problems associated with compulsive Internet pornography use seem to be irrespective of sexuality, gender, age, race, nationality, or religious affiliation. Internet pornography addicts suffer from powerlessness over their addictive sexual behavior and the resulting unmanageability of their life. Those who compulsively use Internet pornography often suffer from feelings of shame, breakdown of self-esteem, lower productivity at home and at work, pain, self-loathing, failed promises and attempts to stop acting out, progressive isolation, and sexual problems (Cavaglioni, 2008; Chaney & Chang, 2005; Levert, 2007; Widianto & Griffiths, 2007). Individuals addicted to pornography also often experience a preoccupation with sex leading to ritualized behavior and also may ask their partner to engage in new sexual acts, or acts the partner finds objectionable. It stands to reason that counselors will tend to see more and more clients with this presenting problem (Cooper, Galbreath, & Becker, 2004; Hertlein & Piercy, 2008). If practitioners are unwilling or unable to discuss this issue intelligently with their clients, then their clients will be unable to evaluate the harm that has come from Internet pornography in their lives and they will be prohibited from developing positive relationships and having fulfilling sexual relationships (Delmonico & Carnes, 1999). It is imperative that counselors gain knowledge of and comfort with discussing the experiences of a person addicted to pornography so as to be better prepared to offer treatment options (Delmonico & Carnes, 1999; Turner, 2009).

There is, unfortunately, a lack of diagnostic codes or even a description of Internet pornography addiction or compulsivity in the current version of the Diagnostic

and Statistical Manual of Mental Disorders. The DSM-5 work group was at one point considering the inclusion of “Hypersexual Disorder” in the appendix as a possible related sub-classification of the heading “Sexual Dysfunction.” At the time the data was collected for this study, the DSM-5 had not been released yet. Since the publication and release of the DSM-5, pornography is listed as a specification of Hypersexual Disorder in Section III. This is a section of the DSM-5 that the work group uses for topics which require further research but that are not included as distinct disorders (DSM5.org). Definitions, diagnosis, etiology, pathogenesis and treatment options currently available to counselors have been developed, researched and implemented without the support or guidance from this widely accepted and required manual.

There is considerable debate in the profession as to whether Internet pornography addiction is a real addiction at all (Cavaglioni, 2008; Griffiths, 2001; Kwee, Dominguez & Ferrell, 2007; Laaser & Gregoire, 2003). Pornography addiction, if it exists, would be classified as a behavioral or process addiction, and is still controversial in the counseling field (Delmonico & Carnes, 1999; Griffiths, 2003; Hagedorn, 2009b). Despite the difference of opinion of how to classify pornography addiction, researchers have found a high percentage of Americans are struggling with the harmful consequences from continued engagement in these behaviors (Carnes, 2003; Hagedorn, 2009b). Clearly, since Internet pornography was not in the DSM-IV-TR as a diagnosis, nor is it in the DSM-5, counselors are unable to diagnose clients with this as a disorder. Also, until the 2009 addiction counseling competency standards requirement, addiction training was not a required component in CACREP accredited programs. It is still not clear how some programs are complying with these standards, so counselors-in-training are likely to be

unprepared to handle pornography addiction as a presenting problem. It is only in the last decade that empirical research has begun to determine the etiology, co-morbid factors, psychobiology, and optimal treatment modalities for sexual addiction (Manning, 2006). Unless counselors are free to explore and discover where their knowledge is lacking and how to get the knowledge they need, they will continue to be stifled in their ability to handle Internet pornography addiction as a topic in the counseling session (Cooper et al., 2000). One way to help discover where knowledge is lacking is for the experts to tell counselors-in-training what they know about Internet pornography addiction, to hopefully spark greater interest in the topic, call for more research, and to create training modules for counselor education programs.

### **Statement of Problem**

The Internet has been linked to human sexuality in a way that has made both more mainstream and widely accepted literally since it began (Manning, 2006). While the coupling of technology with sexuality has brought forth a unique range of benefits for society, it has also brought with it new risks. Although most individuals utilize the Internet for occupational, educational, recreational, and shopping purposes, a sizable minority, comprised mostly of males, exists who spends an inordinate amount of time and energy in the pursuit of sexually explicit photographs and videos on the Internet. Approximately 10-17% of those using the Internet for sexual purposes report having online sexual problems which might include spending more time online than planned, partner unhappiness with Internet use and browsing history, and using the Internet for infidelity (Daneback et al., 2006; Dew & Chaney, 2004). Online sexual problems can result in negative intrapersonal and interpersonal ramifications including depression,

anxiety, shame, guilt, and problems with felt intimacy with real-life partners (Gana, Trouillet, Martin, & Toffart, 2001; Meerkerk, Van Den Eijnden, & Garretsen, 2006). Time spent compulsively using the Internet for sexual purposes is often spent pursuing the “perfect” sexual visualization that will match the image in their head, only to get disappointed time after time with failed attempts to repeat the experience they had the first time (Cooper et al., 2004). Using the Internet for sexual activity includes, but is not limited to, problematic Internet pornography use, and it is important to understand the reality of this problem but not over-emphasize it. The focus of this study will be on problematic Internet pornography use, which has been a relatively ignored topic in research (Hertlein & Piercy, 2008). There is a lack of reliable, empirically sound research which limits the conclusions that may be drawn regarding the effects of addictive pornography use on individuals, relationships, families and society (Griffiths, 2001; Hagedorn, 2009a).

Couples who mutually benefit from using pornography are unlikely to address their use in counseling. Solitary Internet pornography consumption by one member of the couple, especially if this is done in secret, can strain a relationship, as well as create emotional and sexual distance between partners (Parker & Wampler, 2003; Schneider, 2000). In addition to the aforementioned risks, when pornography is consumed in a solitary, secret fashion an individual has the potential for compulsive or addictive behaviors to develop. This could be because consumption of pornography is occurring outside of a relational context which has social norms that are inherently a part of the relationship and is a place where antisocial behavior is kept in check (Zitzman & Butler, 2005). The majority of people struggling with sexual addictions and compulsivities

involving the Internet are married, heterosexual males (Daneback et al., 2006). The majority of Internet users in the United States are college-educated, Caucasian, married males in their mid-thirties (Manning, 2006). More than half of Americans use the Internet and 20-33% of users go online for sexual purposes (Ayres & Haddock, 2009; Hertlein & Piercy, 2008).

Married women are significantly more distressed by a partner's online pornography consumption than women in dating relationships (Ayres & Haddock, 2009; Parker & Wampler, 2003; Zitzman & Butler, 2009). The distress reported by married women increased according to the perceived frequency of online sexual activities. The measure of distress of their partner's online pornography consumption was not as strongly influenced by religious beliefs, as was their perceived frequency of online sexual activities. Married women generally are distressed by their husband's use of sexually explicit material and worry that Internet pornography consumption could be a threat to the relationship (Hertlein & Piercy, 2008; Zitzman & Butler, 2009). Often, women view their partner's consumption of pornography on the level of infidelity in terms of loss of trust, loss of intimacy, and the overall impact on the relationship (Maltz, 2009; Parker & Wampler, 2003). Pornography users risk becoming obsessed with specific sexual behaviors they have never experienced or even heard of before (Carnes, 2003). Internet pornography addiction has been noted as a major contributing factor to separation and divorce for some affected couples (Hagedorn & Juhnke, 2005). The research seems to be suggesting that it is not troubled marriages that lead to Internet pornography addiction, but Internet pornography addiction that has negative effects on marriages.

Not all sexuality on the Internet is unhealthy or addictive. The Internet can be used for healthy sexual expression, especially by sexually marginalized groups such as the LGBT community (Chaney & Chang, 2005; Cavaglione, 2008), those with paraphilias, and those in rural areas who do not have ready access to like-minded individuals (Christensen, 1990; Ciclitira, 2004; Cooper, et al., 2000; Dew & Chaney, 2004). However, the pornography industry has proven itself to be a poor teacher of healthy sexuality, and the industry will be the first to assert that education has never been its intention or focus, but that it does serve a purpose (Arterburn, 2006; Christensen, 1990; Court, 1980; Flood, 2009; Jensen, 1995).

Reason dictates that if problematic Internet pornography use is on the rise (Schneider, 2000), and it can cause significant challenges both intrapersonally and interpersonally, then counselors are going to see more and more clients presenting with this as an issue in counseling (Cooper, et al., 2000; Dew & Chaney, 2004; Hagedorn, 2009a). There are few studies that look specifically at the counseling process, counselor preparation, and pornography (Hertlein & Piercy, 2008). Treatment plans for Internet pornography addiction are not readily available for counselors-in-training to access, and process addictions are not usually taught in academic programs. Swisher (1995) surveyed 250 mental health counselors and 250 addictions counselors and found that requiring a course in sexual addiction in all counselor education programs, regardless of specialty, would help rectify this lack of consensus that occurs in the profession regarding diagnosis and treatment of sex addiction.

When looking at multiple disciplines and how these disciplines deal with client sexuality, we find that client sexuality is a common issue discussed, but that formalized

training is scarce. Clients are regularly bringing up pornography use in session, and Ayres & Haddock (2009) found that American Association for Marriage and Family Therapy (AAMFT) clinicians have not received much training to prepare them to know what to do with clients that present with pornography use problems. In her dissertation, Berman (1996) found that many medical and nursing schools require at least one class about sexuality in their educational curricula, however, training programs in social work are not necessarily attaining the same sexuality educational opportunities. In spite of Freud attributing human sexuality as the most significant cause of multiple types of mental illnesses, and even calling on physicians to investigate and discuss these issues with clients (Freud, 1905), the majority of professional psychology training programs do not have a required course in either healthy or unhealthy sexual expression, and only about half of the doctoral programs in psychology surveyed by Ng (2006) covered even some sexual issues in their curriculum. The hesitancy to cover sexuality in practitioner training programs persists in spite of studies that show the majority of psychologists surveyed have been asked about sexual concerns by their clients (Miller & Byers, 2008; Miller & Byers, 2009; Nasserzadeh, 2009). The fact that clients are bringing sexual issues up in session but practitioners are not being trained consistently is problematic because if therapists are not trained how to handle sexuality and sexual addictions as a topic in counseling sessions, but they are likely to face such issues, they will have less confidence in their ability to address these issues competently and may even cause harm to clients. Wiederman and Sansone (1999) found that sexual disorders as a category of problems for clients are so common that they probably come in just behind substance-related disorders in order of prevalence.



## **CACREP Standards**

In 2009 the Council for Accreditation of Counseling and Related Educational Programs (CACREP) released their new standards. Under the heading of “Addiction Counseling” they state:

Students who are preparing to work as addiction counselors will demonstrate the professional knowledge, skills, and practices necessary to work in a wide range of addiction counseling, treatment, and prevention programs, as well as in a mental health counseling context. (p. 18)

However, even within addictions counseling there is no required class on healthy or unhealthy sexuality or dealing specifically with sexual issues and addictions (Hagedorn, 2009b; Miller & Byers, 2009). At best, pornography addiction might earn honorable mention among other process addictions (i.e., gambling, Internet, sex).

Under the heading of “Clinical Mental Health Counseling” the 2009 CACREP standards have a number of statements that pertain to process addictions, and not just addiction to substances. “Students who are preparing to work as clinical mental health counselors will demonstrate the professional knowledge, skills, and practices necessary to address a wide variety of circumstances within the clinical mental health counseling context” (p. 30). Included in this same section under the subcategory of “Knowledge” is the requirement that a counselor “Knows the disease concept and etiology of addiction and co-occurring disorders” (p. 31). In the next section, “Skills and Practices,” is a standard that states, “Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders” (p. 32). On the next page, still under the heading of “Skills and Practices” CACREP further asserts that a counselor, “Screens

for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders” (p. 34). In spite of the fact that CACREP has implemented these standards, many programs are still not requiring process addictions to be part of their addictions course, even if an addictions course is required. On the outside chance that there is a discussion about process addictions, it is unlikely that pornography addiction will be included in the list of process addictions (Hagedorn, 2009b; Hollis & Dodson, 2000; Manley & Koehler, 2001).

### **Counselor Comfort With Sexual Topics**

Due to the lack of training in counselor education programs and the lack of diagnostic criteria, treatment interventions, and even a lack of counselor comfort in discussing sexual issues, many clients turn to self-help groups, church seminars, and friends who serve as accountability partners (Abell, et al., 2006; Hagedorn & Juhnke, 2005). Many of these resources do not have licensed mental health practitioners present, and are not governed by agreed upon ethical standards or empirically-based treatment protocols so the potential for unintended harm to the addicted individual increases (Hagedorn & Juhnke, 2005; Harris & Hays, 2008; Hertlein & Piercy, 2008). If counselors-in-training were given opportunities to discuss sexual issues in general, and Internet pornography addiction in particular during their program, then their comfort level might increase, thus allowing the counselor to handle sexual issues in counseling better. Many mental health practitioners, in a variety of professions, are reporting that they currently are not comfortable discussing sexual issues with clients (Berman, 1996; Hagedorn & Juhnke, 2005; Harris & Hays, 2008; Hertlein & Piercy, 2008; Lerza & Delmonico, 2002; Maltz, 2009; Ng, 2006). Mental health practitioner comfort with

sexual issues has a direct correlation to client comfort with discussing this topic with the practitioner (Ayers & Haddock, 2009; Berman, 1996; Gray & House, 1991).

Research has shown that it is important for counselors to ask clients about their sexual concerns and not wait for the client to bring these up in session. The counselor should be prepared to discuss these issues comfortably and openly (Haney, 2006; Harris & Hays, 2008). A correlation has been established between sexual education in graduate school and counselor comfort in discussing this with clients (Fife, Weeks, & Gambescia, 2008; Miller & Byers, 2008, Miller & Byers, 2009). Counselors who are embarrassed or uncomfortable discussing sexual topics may inadvertently harm clients who are dealing with sexual issues (Gray & House, 1991; Hagedorn, 2009a; Hagedorn, 2009b; Hagedorn & Juhnke, 2005; Harris & Hays, 2008; McCarthy & McDonald, 2009). All practicing counselors need to be comfortable and competent in responding to clients' sexual concerns as sexuality is an integral part of humanity.

### **Purpose of the Study**

The purpose of the proposed study was to assess counselor comfort with, attitudes toward, and perceived sense of competence in working with clients who have a self-assessed Internet pornography addiction. In addition, this study assessed counselors' perceptions of their training related to problematic Internet sexual activity. These assessments were conducted by an electronic survey. An invitation to participate in this electronic survey was distributed by postal mail to members of the American Counseling Association and was only open to counselors who had identified themselves as professional members of the ACA and not student members. Furthermore, since there is no mandatory addiction training in CACREP-accredited programs, and since this training

is something counselor training programs should be implementing according to the 2009 standards, this study also obtained the viewpoints of Counselor Educator experts who are well-published in the field of sexual and Internet addictions in an effort to determine what the best practices in Internet pornography addiction training should be. The viewpoints of the experts were obtained through an interview process over the phone. The following are the research questions which guide this study:

- 1) What is the perceived sense of competence counselors have in regards to treating the process addiction of Internet pornography?
  - i) How satisfied are counselors with the amount of training they have received in regards to the process addiction of Internet pornography addiction?
  - ii) How competent do counselors believe they are in counseling clients who are addicted to Internet pornography?
  - iii) How comfortable are counselors in discussing Internet pornography addiction issues with clients?

Assessing counselors' perceived sense of competence in working with clients who have a self-assessed Internet pornography addiction helped determine whether counselors are satisfied with their competence when faced with a client who is addicted. If counselors feel prepared, then likely their confidence to adequately assist the client will be bolstered (Miller & Byers, 2008; Miller & Byers, 2009; Ng, 2006). If counselors are confident in their training and ability then they will tend to more effectively benefit clients (Harris & Hays, 2008; Snyder, Baucom, & Gordon, 2008; Swisher, 1995) and be

less likely to miss or ignore issues with pornography that are brought up by clients (Turner, 2009).

- 2) What are the relationships between counselor demographic variables (ethnicity, age, gender, program emphasis, and religiosity) and counselors' self-assessed attitudes and skills?
  - i) What are the relationships between counselor demographic variables and counselor self-efficacy with treating addictions?
  - ii) What are the relationships between counselor demographic variables and counselor attitude toward pornography?
  - iii) What are the relationships between counselor demographic variables and counselor comfort discussing sexual issues with clients?

Counselors with adequate knowledge and comfort regarding pornography should be better able to serve clients and avoid ignoring client concerns, imposing counselor values, or giving inaccurate information (White & Kimball, 2009; Wiederman & Sansone, 1999; Yarris & Allgeier, 1988). Ayers and Haddock (2009) found that therapists' personal attitudes about pornography have an effect on the treatment approach they use with clients. The authors called for more continuing education opportunities to be available to clinicians in order to help change preconceived thoughts about pornography addictions.

- 3) What do counselor educators with expertise in process addictions related to sexuality view as best practice in the education of counselors regarding sexual addictions?
  - i) What are these experts' current assessments of the training counselors receive in regards to sexual addiction in general and Internet pornography addiction in particular?
  - ii) What do these experts view as best practice in the training and continuing education of counselors regarding process addictions related to sexuality?
    - a) What are recommended by experts as the preferred ways to develop adequate knowledge and competency in this area?
    - b) Should a class in sexual addictions in general be required in counselor education training programs?
    - c) Should counselors be required to receive continuing education units involving the assessment and treatment of Internet pornography addiction?

This study will be the first to be identified which has ascertained counselors' comfort with, attitudes toward, and perceived sense of competence in working with clients who have a self-assessed Internet pornography addiction. The purpose of obtaining expert opinions is to ascertain if there is a discrepancy between what is

occurring and what should be occurring according to those most able to make the assessment by their education, experience, and research surrounding Internet pornography addiction.

### **Significance of the Study**

Continued research in the field of counselor education is needed to maintain accountability, foster excellence, and create distinction from other fields of mental health practitioners. Counselor educators are in the unique position to be most able to affect change in multiple professions such as clinical mental health counselors, marriage and family therapists, school counselors and counseling psychologists (Hagedorn, 2009a; Hagedorn, 2009b). These professions are also likely to encounter clients who self-assess as Internet pornography addicts (Ayres & Haddock, 2009; Carnes, 2003; Cooper, et al., 2000; Cooper, et al., 1999; Delmonico & Carnes, 1999; Flood, 2009; Gray & House, 1991; Haney, 2006; Ng, 2006). This study is timely in light of CACREP's 2009 Accreditation Standards which mandates that the training of all counselors include the prevention, intervention and treatment of addicted clients (CACREP, 2009). This study is significant because the information gained will provide guidance to CACREP-accredited programs through the use of "expert testimony" to help identify areas where counselor education programs could improve process addiction education and training.

According the Bureau of Labor Statistics Occupational Outlook Handbook's 2010-2011 edition, employment for the field of counseling in general is expected to grow faster than the average for all occupations. Projected job growth varies by specialty, but job opportunities for Clinical Mental Health Counselors are projected to grow 24% by 2018. This means that job openings are expected to exceed the number of graduates from

counseling programs, especially in rural areas (Bureau of Labor Statistics, 2008). This is the highest percentage of growth for the six classifications of counselors listed which also included Rehabilitation Counselors; Marriage and Family Therapists; Educational, Vocational, and School Counselors; Substance Abuse and Behavioral Disorder Counselors; and Counselors, All Others. All six classifications of counselors are projected to have double digit percentages of growth by 2018, though, so the training of these needed counselors will be important to a vital and in-demand profession. This study will add to the body of literature available in training and preparing these future counselors and will benefit the profession by preparing counselors to better serve the clients that will present to these counselors in ever increasing numbers (Hagedorn & Juhnke, 2005; Kwee, et al., 2007; Lerza & Delmonico, 2002; Maltz, 2009).

### **Definition of Terms**

*CACREP* – The Council for Accreditation of Counseling and Related Educational Programs is an independent agency that is recognized by the Council for Higher Education Accreditation which accredits master's degree programs in addition counseling, career counseling, clinical mental health counseling, marriage, couple, and family counseling, school counseling, student affairs and college counseling and doctoral degree programs in counselor education and supervision.

*Compulsive Pornography Use* – includes a heightened desire and tolerance and could include harm to self and others. There is often a denial or minimization of negative consequences which often include repeated attempts to stop or reduce sexual behavior; repetition of the sexual behaviors despite negative consequences; behavior interfering with social, academic, occupational, or recreational activities; and can include obsession



with the activity, and compulsion or loss of freedom in choosing whether to engage in a behavior (Cooper et al., 2000). Some authors include the time dimension of spending 11 or more online hours per week pursuing sexual activities as part of this definition (Daneback et al., 2006).

*Cybersex* – is a subcategory of Online Sexual Pursuits. Cybersex involves the use of computerized content which might include text, sound or images for sexual stimulation and gratification. This might take the form of pictures, video or email chat, or sharing mutual fantasies while masturbating (Cooper et al., 2002).

*Internet Addiction* – A condition in which the addict loses track of time when surfing the Internet and spends more time on the Internet than with family and friends despite negative consequences (Lerza & Delmonico, 2002). Internet addiction can take the form of compulsively viewing websites, which may or may not be pornographic, shopping, gambling, social networking, and many others. The surfing can be done without aim or goals.

*Internet Infidelity* – is defined as a romantic or sexual contact that is either physical or emotional, which is facilitated by Internet use. This contact is seen by at least one partner as an unacceptable breach of their relationship contract of faithfulness, which was either implied by their coupled relationship or stated through a marriage contract (Hertlein & Piercy, 2008). The partner who feels their relationship has been breached finds it difficult to compete with the perfection of an online entity and often reacts in much the same way as people react to a traditional affair (Parker & Wampler, 2003).

*Internet Pornography*- the use of the Internet for downloading and/or viewing sexually explicit text, pictures, videos, and audio materials designed, produced and

distributed for the purpose of sexual enticement, excitement and gratification (Haney, 2006; Kingston, Malamuth, Fedoroff, & Marshall, 2009). Pornography shows genitals and sexual activities in unconcealed ways (Flood, 2009).

*Internet Pornography Addiction* – compulsively using the Internet to pursue, find, view and/or download pictures, movies or pornographic text for the sole purpose of sexual gratification (Hagedorn & Juhnke, 2005). The individual develops dependency upon and tolerance toward Internet pornography, has trouble controlling impulses to view Internet pornography (Bancroft & Vukadinovic, 2004) and suffers from repetitive and progressive compulsions to view pornography on the Internet in spite of adverse social, biological, relationship or career consequences (Kafka, 2010).

*Internet Sexual Activity Or Online Sexual Activity* –include the use of the Internet for text, audio, or graphic activities that involve sexuality. Uses of the Internet for these purposes might include education, shopping for sexual materials, seeking potential partners, or using the Internet for sexual gratification of self or others (Cooper et al., 2004).

*Pornography* – sexually explicit text, pictures, videos, and audio materials designed, produced and distributed for the purpose of sexual enticement, excitement and gratification (Haney, 2006; Kingston, Malamuth, Fedoroff, & Marshall, 2009). Pornography shows genitals and sexual activities in unconcealed ways (Flood, 2009).

*Process or Behavioral Addictions* – those addictions that do not require the ingestion of substances. The person becomes addicted to a set of behaviors that can powerfully alter the brain chemistry, which results in the same process regardless of the

“drug” or behavior of choice (Delmonico & Carnes, 1999; Maltz, 2009). These can include gambling, sex, pornography, eating, or shopping for example (CACREP, 2009).

*Rape Myths* – first used by Burt in 1980 to describe beliefs a person holds regarding the act of rape, rapists, and the victims of rape. Males who subscribe to rape myths are less likely to convict if serving on a rape-trial jury and are less tolerant of rape victims. Instead, they tend to blame the victim’s clothing, mannerisms, the lack of saying no assertively, and other things. Women who accept rape myths not only buy into the above statements but are also less likely to report rape as a crime or offer social support to victims. People who regularly use pornography have an increased likelihood of accepting rape myths (Manning, 2006).

*Sexual Addiction* – involves a loss of control over sex, sexual fantasies and urges (Hook, Hook, Davis, Worthington, & Penberthy, 2010). This addiction results in the persistence of sexual behaviors in spite of adverse social, psychological, and biological consequences (Hagedorn & Juhnke, 2005). Sexual addiction, like other addictions, is considered progressive, chronic, and potentially fatal (Dew & Chaney, 2004). Sexual addiction is characterized by high tolerance, craving, compulsion, mood modification, secrecy, dependence, withdrawal, conflict, obsession, relapse and personality change (Levine, 2010; Kwee, Dominguez, & Ferrell, 2007). Pornography addiction is considered by some scholars to be a form of sexual addiction.

*Sexual Fantasies* – an individual’s innermost uninhibited thoughts, aspirations and desires related to what is attractive, sexually appealing, and pleasurable sexually. An individual does not have to worry about criticism, taboo, and embarrassment within sexual fantasies, except where allowed by the self. These erotic desires serve to arouse

and excite, especially if they involve situations or people who would deem these desires to be inappropriate (Jones & Wilson, 2009). Sexual fantasies may also enhance an insufficiently sexually exciting event and provide partial or temporary relief of an unfulfilled or forbidden sexual desire (Nicholas, 2004).

## **CHAPTER II**

### **LITERATURE REVIEW**

In this chapter a historical overview of the issues and controversies surrounding pornography as a genre and the concept of it being a problem for mental health workers in general, and counselors specifically will be provided. Along with this historical overview, a glimpse of the international scope of Internet pornography use and addiction will also be provided, as well as a discussion of what Internet pornography consumption does for an individual, being that it is used for more than just a substitute for sexual activity with a partner, and may be used as an escape from the user's dysphoric mood. The reader will encounter how pornography affects children as well as the other negative effects of using the Internet for sexual activities, including its social, occupational, relationship, and financial impact on the user, and on the family, whether the user is in a heterosexual or same-sex relationship. The impact on the user and the couple relationship in a Christian environment and what impact that environment has on the user will also be discussed. The diagnosis, prevalence, and etiology of problematic Internet pornography use and compulsion will be outlined as well. A section is included to help counselors understand how to assess for compulsive Internet pornography use, along with treatment options which include psychopharmacology and other modalities such as 12-step groups, and individual, couple, and family counseling. Finally, a review of the literature regarding counselors' attitudes toward clients who are addicted to Internet pornography is included.

## Historical Overview

Attitudes and beliefs about sex have been present in society since time began.

Pornography has been widely available in the United States since the mid-1800s and was originally labeled “erotica” (Jones & Wilson, 2009). Most societies have been aware of and have acknowledged the presence of sexually explicit materials, but people’s reactions to those materials have always varied dramatically (Report of the Commission on Obscenity and Pornography, 1970). The Report of the Commission on Obscenity and Pornography was commissioned in 1967 by President Lyndon B. Johnson and was published during the presidency of Richard M. Nixon, was wholly rejected by both the Senate and the President as “morally bankrupt conclusions” (Statement About the Report of the Commission on Obscenity and Pornography, 1970). The Commission had recommended that legislation prohibiting the sale, exhibition, or distribution of sexual materials to consenting adults should be repealed because pornography consumed by consenting adults was doing no harm to society.

The President’s Commission on Pornography led to a whole range of studies attempting to examine the effects of pornography on attitudes and behavior. Some people were desperate to prove the horrible effects pornography has on those who view it and its potentially devastating effect on children who may be exposed to it accidentally or through curiosity (Statement About the Report of the Commission on Obscenity and Pornography, 1970). Indeed, as humans, we have a tendency to condemn that which we do not understand or that which we would not choose to participate in as being morally wrong. Not only morally wrong, but we accuse the individual of being perverted and even a menace to society (Christensen, 1990). These charges are often accepted by some

members of the general public without the benefit of supporting literature or knowledge about mental illness or emotional development. Not everyone is opposed to the manufacture, sale and distribution of pornography. Even feminists, who have traditionally been vehemently protective of every aspect of women's health and welfare, do not agree on the appropriate reaction to pornography (Ciclitira, 2004). There are feminists that have been quite vocal in their opposition to the exploitation of women that they feel is present in pornography, but others have taken a strong anti-censorship position (Ciclitira, 2004). Some feminists have proclaimed that if pornography's intention is to keep women in a subordinate position then right-wing authoritarian men should be more favorable toward pornography (Strossen, 1995). The extremist goals of the pro-censorship community, coupled with the radical religious views of the conservative political forces have made some feminists quite uncomfortable with the direction and tenor of the anti-pornography campaign (Strossen, 1995). They feel that the censorship of pornography could be another way to silence women exploring their sexual power and control and therefore may not be as degrading to women as it might first appear.

In a chapter entitled *The Case for Pornography*, Court (1980) outlines several social benefits of pornography including that it: is informative; increases communication and intercourse with partners; is useful for "the lonely or the handicapped" who may have few sexual outlets; assists in resolving sexual problems; and is protected as free speech (p. 16). In a chapter entitled *Sex and Psychological Health*, Christensen (1990) reported that there "is no evidence at all that fantasies or fantasy aids themselves are unhealthful" (p. 106). Christensen goes on to point out that pornography use along with solo sexual

stimulation may be a useful form of birth control as well as may reduce the spread of sexually transmitted diseases. Masturbation seems to be a common, though not universal, behavior among males. Dr. Alfred Kinsey found that even 60 years ago approximately 95% of males had masturbated to orgasm prior to marriage as reported by Kwee and his associates (Kwee et al., 2007). The argument has been presented that pornography is simply a masturbatory aid for men (Paul, 2009).

Clearly, sexuality has been an integral part of the mental health profession for some time, but pornography has had varying uses and has been interpreted differently over time. Pornography used to be recognized as a legitimate relationship aid, used by sex therapists, psychiatrists and psychologists, marriage and family therapists and social workers as a homework assignment to be viewed as a couple as an incentive to explore and discuss their bodies and learn new information about what is pleasurable for both the individual and couple (Zitzman & Butler, 2005). Some therapists supported using pornography in session with clients as one would a sex therapy manual or a psychoeducational training tool (Maltz, 2009). Another use of pornography within the counseling field has included having clients look at pornography as a way to boost hormones, through the release of dopamine, which drives up testosterone and increases sex drive (Kort, 2009). Counseling, as a profession, has changed from viewing sex as a philosophical foundation of all things psychological like Freud to making sex mechanical and uninteresting like in the tradition of Masters and Johnson (Ventura, 2009). Many contemporary counselors and psychotherapists seem to minimize sexuality to something that is just a small piece of a relationship rather than a force in and of itself and are thus either unwilling or unable to discuss it freely in session.



The DSM-V work group is currently discussing the inclusion of Internet pornography addiction under the heading of “Hypersexual Disorder” in the appendix as a possible related sub classification of the heading “Sexual Dysfunction.” Under the current proposed version (April, 2012) pornography is listed as a specification of Hypersexual Disorder which the work group is proposing for inclusion in Section III. This is a section of the DSM-5 that the work group will use for topics which require further research but that will not be included as distinct disorders (DSM5.org). With its current line of logic regarding Internet pornography addiction the DSM would classify this as a disorder of excessive sexual drive (hypersexual) rather than a disorder of sexual preference (paraphilia). Historically females with sexual addiction issues who present to counseling have more often been diagnosed with disorders of excessive sexual drive where men have more often been diagnosed with disorders of sexual preference (Briken et al., 2007). The negative impact of Internet pornography addiction on the individual, couple and family will be discussed in a later section.

### **An International Problem**

The argument has been presented that Internet pornography addiction is particularly prevalent in the United States because Americans are overly sexualized by imagery, but repressed when it comes to discussing sexual issues. A number of studies were found that would tend to indicate Internet pornography is an international problem, and not just an American issue. A study included a nationally representative sample of the adolescent population in Israel found weak ties to mainstream social institutions were correlated to frequency of use of Internet pornography (Mesch, 2009). These adolescents also reported a lower level of bonding with their parents. A three-wave panel study

among 959 Dutch adolescents found that the best predictors of adolescents' use of pornography were being male and having sensation-seeking personality characteristics (Peter & Valkenburg, 2010). In a longitudinal study done in the Netherlands, Meerkerk and associates (2006) found that spending a lot of time pursuing Internet pornography predicts an increase in compulsive Internet use one year later in adults. Respondents in this study had a mean age of mid to late 30s, were more often female, and tended to be educated (Meerkerk et al., 2006). A correlation between accessing Internet pornography and permissive sexual attitudes and behavior was found in a survey of 2,001 Taiwanese adolescents where 38% of the youth self-identified as having accessed Internet pornography (Lo & Wei, 2005). In a study that investigated the association between religiosity and sexual fantasies coupled with using sexual materials among 1,292 Black South Africans revealed that the more self-reported religiosity the greater the likelihood the men were to report sexual fantasies, but the less likely to have been exposed to almost all types of sexual material (Nicholas, 2004).

Using traditional pornographic printed materials, researchers found that 60 male Canadians were more likely to treat women as sexual objects after having been exposed to pornography indicating it may have an effect on what males think of women (McKenzie-Mohr & Zanna 1990). Qualitative research done on an Italian self-help Internet community for people who considered themselves cyberporn dependent revealed pornography gives certain individuals a sense of power, exhilaration, and intensity that is enhanced by the fact that pornography is so widely and easily accessible, preserves the anonymity of the user, and does not damage the user's public image (Cavaglioni, 2008). In a study conducted in the United Kingdom, Ciclitira (2004) looked at women's attitudes

toward pornography and their attitudes toward feminism and found that the lines are not as clear cut as was once thought. This study demonstrated that it is possible for the same women to both criticize and defend pornography. Some women have distanced themselves from the feminist movement because of this debate, and the author points out that there has been a decline in the popularity of anti-porn feminism. Feminists are accepting the need for women to assert their own sexual pleasure and are calling for more discussion on this topic (Ciclitira, 2004). In 2006 Hald studied the gender differences in pornography consumption among 688 heterosexual young adults in Denmark. The study found that men were exposed to pornography at a younger age, consumed more pornography in a shorter amount of time each session, and used pornography for solo sexual gratification. Women tended to use pornography with a regular sexual partner more than men (Hald, 2006).

Out of nearly 1500 online respondents to a survey in Swedish about 6% were classified as sexually compulsives who pursued pornography and other sexual interests both online and off. The sexually compulsive group in this Swedish study was made up of 74% men and 26% women (Daneback et al., 2006). A survey among German sex therapists revealed that among their clients with sexual addiction problems, the most common presenting issues were pornography addiction, compulsive masturbation, and problematic promiscuity (Briken et al., 2007). The German sex therapists also reported that “excessive sexual drive” was more often diagnosed in women, while “disorder of sexual preference” was mainly diagnosed in men (p. 131). In a sample composed of 155 French adults who were comprised of 40% men and 60% women, Gana and associates (2001) found that boredom proneness, age, and sexual satisfaction were the most frequent

predictors of individuals engaging in solitary sexual activities such as viewing and masturbating to pornography (Gana et al., 2001).

### **More Than Just Sex**

Although some individuals use Internet pornography as a means of sexual gratification (Meerkerk et al., 2006), and some use Internet pornography as a means of sexual education and experimentation (Mesch, 2009), some people also use Internet pornography as a means of psychological escape (Young et al., 2000). Those individuals are perhaps at greatest risk to develop a dependence upon, compulsion with, and addiction to Internet pornography (Delmonico & Carnes, 1999). This could partially be due to the fact that, generally, these men feel that viewing pornography is nothing more than a visual form of stimulation or entertainment, where, on the other hand, their partners might feel betrayed and cheated on (Ayres & Haddock, 2009; Cannon, 2000; Limacher & Wright, 2006). There has been at least one landmark case (United States vs. McBroom) where the courts have determined that the “downloading, viewing, and transferring of Internet pornography was less about erotic gratification and more about an emotional escape mechanism to relieve mental tension” (Young et al., 2000, p. 64). Other factors that relate to the appeal and the addictiveness of Internet pornography include isolation and secrecy, and fear of the consequences of exposure (White & Kimball, 2009). Some Internet pornography addicts either sought out or accidentally stumbled upon the pornography when they were bored or depressed (Stein, Black, Shapira, & Spitzer, 2001). Pornography alleviates the depression or boredom and, if accompanied by masturbation, increases the likelihood the individual will instinctively return to the pornography the next time the boredom or depression returns. Internet

pornography addiction may develop as part of a response to past physical, sexual, family and social trauma (Maltz, 2009; Putnam & Maheu, 2000) as a way to safely explore the individual's sexuality without the coercion or interference by another person. The relative anonymity, convenience, cost-effectiveness and lack of embarrassment afforded by online pornography are often cited reasons for people to become comfortable and habitual in their Internet pornography use (Philaretou, Mahfouz, & Allen, 2005).

The concepts above eventually became known as the Triple-A Engine and was developed by Stanford researcher Al Cooper (Cooper et al., 2000) to explain how Internet pornography becomes so addicting. Cooper believed that the accessibility, affordability, and anonymity of Internet pornography account for the Internet's power to attract people into a cycle of addiction. The availability of Internet pornography is obvious to nearly anyone who has ever accessed the Internet for any reason (Cooper, Delmonico et al., 2004). It is seemingly everywhere on the Internet through advertisements, email links, search engines, spamming, mousetrapping, page jacking, and customized searches (Garlick, 2010). Pornography sites also buy the domain names of sites that are similar in spelling to well-known sites so as to "accidentally" get traffic that, once exposed to the adult content, may stay and browse out of curiosity or out of shock. Although there are millions of pornography sites that charge the user a monthly, yearly, or one time access fee, there are also millions of sites that offer potential customers free tours of their sites, often including access to hundreds of thumbnail images which can be enlarged in order to view samples of their pornographic pictures and videos for free. Competition on the World Wide Web between the vast numbers of pornographic sites keeps the prices low, and keeps the pornography industry offering free samples (Cooper et al., 2000). The

anonymity of the medium lures many unsuspecting people into secret virtual sexual encounters. It allows individuals with sexual proclivities they keep hidden from public view to experiment, explore, and live out fantasies without leaving the privacy of their home or office (Carnes, 2003). That anonymity encourages users to communicate and express themselves in a more open and frank manner than would be their norm.

Anonymity also allows the addiction process to flourish and accelerate faster than would normally happen without the Internet (Delmonico & Carnes, 1999). The Internet allows individuals to become obsessed with specific genres of sexuality and sexual media that they have never experienced before, nor even knew existed (Carnes, 2003). As many Internet pornography addicts have found out, their use of the Internet to access sexually explicit pictures and video at home or work is not as anonymous as they once thought and their history can be discovered and exposed, often with negative consequences on many aspects of their life (Landau, Garrett, & Webb, 2008; Manning, 2006).

### **Minors' Use of Internet Pornography**

The Report of the Commission on Obscenity and Pornography (1970) recognized that most people learn about sex from their peers and that the first exposure to pornography usually occurs within the context of a peer group. The Report went on to explain that for people who received the majority of their sexual information from their parents while growing up were less likely to use pornography than those for whom the major source of sexual information came from their peers. A danger, especially for men, of learning about sex, sexuality, and physical pleasure from pornography, and using pornography to masturbate, is that the repetitive pattern can train the brain that not only is another person not needed to ejaculate, but that ejaculation may become difficult or

impossible to achieve without a pornographic presence (James & Thomas, 2009; Maltz, 2009). This effect can be particularly dangerous for youth whose attitudes and behaviors may be particularly malleable due to their inexperience and because their sexual activities are viewed as inappropriate by mainstream society (Kingston, Malamuth, Federoff, & Marshall, 2009). Pornography seems to be more appealing to individuals who are sexually ignorant, fearful, or frustrated which could well describe youth who are just beginning to experiment with their sexuality (McCuen, 1985). Pornography offers positive acceptance of oneself as a sexual being without having to risk being rejected by the potential “partner.”

Many adolescents, particularly males, use pornographic Internet material (Hald, 2006; Peter & Valkenburg, 2010), although it is estimated that females comprise about 40% of the consumers (Haney, 2006). Access to pornography is available from early on. The average age of a child’s first exposure to pornography is 11. A total of 90 percent of young people ages 8-16 have viewed pornography online (Internet Filter Review, 2011). The literature, much of which is gathered through self-report, suggests a number of negative consequences of exposure to pornography frequently over time by young people. Childhood and adolescence are foundational developmental stages in the formation of habits, values, attitudes, beliefs and worldviews, especially as they relate to sexuality. Experiences that distort or constrain healthy development or affect one’s long-term success in marital and family relationships need to be examined in order to get to the bottom of the root causes and possible treatments for Internet pornography addiction. This exposure could lead to an increased focus on sex and result in more liberal sexual attitudes and a lead a young person to believe that all or most of their peers are sexually

active, which will increase the likelihood of first intercourse at an early age (Mesch, 2009). Second, adolescents may develop an unrealistic picture of sex as being more selfishly physically centered and more casual as opposed to a meaningful expression of the love within a relationship and they may develop a desire for emotionally uncommitted sexual involvement (Flood, 2009). Third, youth exposed to pornography may frequently develop over time attitudes that support blaming the victim for assault or aggression, or that promote violence in a relationship (James & Thomas, 2009). A fourth negative consequence of frequent, secretive exposure to Internet pornography is the development of a “heterosexual schema” which is described as the belief that males are dominant, powerful, and have greater sexual needs than women. Women, in the heterosexual schema are viewed as weaker, less intelligent, submissive, and secretly willing to be raped, assaulted or dominated sexually (McKenzie-Mohr & Zanna, 1990, p. 296). These negative consequences coupled with the reluctance of many teens to talk about their sexual habits, and the ethical dilemmas of setting up research studies involving youth and exposure to pornography makes this a difficult and understudied topic (Haney, 2006). While it is true that children, especially adolescents, are naturally curious, pornography is a poor and dangerous sex educator. Young people are, however, also sexual beings and deserve age-appropriate materials on sex and sexuality (Flood, 2009; Haney, 2006).

Young people are routinely exposed to pornography and other explicit images that are more socially acceptable but are nonetheless sexually charged and sexually explicit (Haney, 2006). These images are everywhere in mainstream society from music videos, clothing stores, television shows, movies, advertisements, magazines, and the Internet.



Research has shown that exposure to sexually charged images does have an effect on subsequent choices of entertainment (Zillman & Bryant, 1986). Children and adolescents are the most frequent users of the information and communication technologies in the home (Mesch, 2009). For many adolescents the Internet is the main source of information and entertainment, and an important tool for communication. The Internet provides children with new opportunities for creativity and active learning. America is increasingly viewing computer literacy as being necessary for more and more occupations, but perhaps we should be concerned about the negative effects of the Internet on teenagers (Oravec, 2000; Young, 2008).

Adolescents and young people are attracted to the Internet and electronic gadgets. The Internet has, since its inception, contained lots of functions that have made it accessible and attractive. Chat rooms, instant messaging systems, interactive games, research, virtual casinos, pornography, online auction houses, news groups, databases, blogs, and dating services are but a few of the systems that make the Internet an attractive and time-consuming hobby (Young, 2009a). Because of its attractiveness and the sheer volume of what it contains, the Internet has consumed a great deal of time, as well. As Internet use has increased exponentially in the last decade, so has exposure to sexually explicit materials on the Internet, whether or not a person was intentionally seeking pornography (Abell, Steenberch, & Boivin, 2006). A person can begin using the Internet as an informational tool, but it can quickly become a psychological escape and can develop into compulsive behavior and eventually an addiction for some people (Young, 2004). Given the popularity of the Internet and its required use for school and work for many people, detecting and diagnosing Internet addiction and the addiction of things

consumed on the Internet (e.g., gambling, gaming pornography) is often difficult (Young, 2009b). Young (2008) found that new users are more at risk to become hooked on online pornography and sex chat rooms because of the freedom, privacy, secrecy and accessibility many young users experience while surfing the web.

Unsuspecting youth are commonly tricked into opening porn websites because pornography webmasters attach commonly misspelled words to pornographic pages and they make it difficult to shut down or get out of a site once it is opened, which is called mouse-trapping (White & Kimball, 2009). The average age of people in the United States who are first exposed to Internet pornographic images is 11 years old (Internet Filter Review, 2011; Maltz & Maltz, 2008). The largest consumers of Internet pornography come from the 12-17 year old age group (Maltz, 2009; Yoder et al., 2005). Children aged 12-17 represent about 14% of all online pornography consumption. Even while 25% of kids aged 7-16 have been upset by online materials, few have reported this to an adult (Yoder et al., 2005). This accidental exposure, upsetting experiences, and forbidden pleasure can lead to disinhibition in sexuality, aggression in race relations; early sexual priming, modeling of racism, and personal and social irresponsibility. The protection offered by sexually explicit sites to minors, usually in the form of "Click Here Only if You are 18 or Older," is a farcical honor system which fails at protecting youth from inappropriate material (Young, 2008). About 75% of pornographic websites display visual teasers on their homepages before asking if the consumer is of legal age. Only about 3% require proof of age through the use of a credit card age verification system. Well over two-thirds do not include adult content warnings on their home page (Yoder et al., 2005). Many youth believe that they will stop accessing Internet

pornography once they find someone special and begin a committed relationship. By this time, they may have been accessing Internet pornography for 10 years or more, and the sexual images, thoughts, mannerisms, compulsions and addictions may have deeply rooted consequences and ramifications for their newly found committed relationship (Maltz & Maltz, 2008).

### **Negative Effects of Internet Pornography Addiction on Individuals**

Many individuals who are addicted to Internet pornography addicts are surprised at how easily porn changed from an occasional diversion or fantasy to a habitual problem that has a very real danger to destroy almost every aspect of their lives (Maltz & Maltz, 2008). It is not difficult to imagine how a lack of control in one's sexual life can lead to a variety of problems; numerous headlines in the last decade have exposed the famous and not-so-famous as having seemingly uncontrollable sexual urges and an addiction to pornographic material. As a pattern of out-of-control behavior continues, there are significant and severe consequences that have a high likelihood of occurring (Struthers, 2009). Users become unable to stop their use despite repeated attempts to limit or reduce their pornography usage (Galbreath, Berlin, & Sawyer, 2002). It can escalate into high-risk behaviors, and the amount of time and resources devoted to pornography increases in spite of a perception of only a short time passing. Users may have significant changes in mood and often neglect social, professional, recreational and physical opportunities and needs (Cooper et al., 2002). Much of their time becomes consumed on the Internet seeking opportunities for sexual arousal. Eventually it may become difficult for some individuals to feel pleasure and safety from anxiety and stress without masturbating to pornography because they have bonded with the porn as a means of regulating and

calming their mood (Kwee et al., 2007). Areas of challenge include, but are not limited to, negative impact on one's job, family life, sexual practices within or without a coupled relationship, or emotional, physical and psychological health, and legal problems (Daneback, Ross, & Mansson, 2006; Dew & Chaney, 2004; Griffiths, 2001; Laaser & Gregoire, 2003; Manning, 2006). In addition to personal and professional problems, there are a range of problems for society that have been associated with regular pornography use. Those problems include a significant correlation with sexual deviancy, sexual perpetration, increased risk of relationship problems, and an increase in acceptance of rape myths (Manning, 2006; McCuen, 1985; Williams, Cooper, Howell, Yuille, & Paulhus, 2009).

When discussing the problematic effects of online pornography addiction it is important to point out that there are three general categories of "cybersex users: recreational, sexually compulsive, and at-risk" (Cooper, Delmonico et al., 2004, p. 131). The authors go on to explain that recreational users are generally seeking pornography for fun, to learn something about sex and sexuality, or to experiment sexually. Recreational users generally maintain reasonable levels of involvement in pornography over time and do not necessarily progress into the next category of use. Recreational users do not normally encounter many problems socially, financially or relationally with their Internet pornography consumption. Often, men who are recreational Internet pornography users report increased sexual activity with a partner, increased experimentation with new behaviors offline, and a lower frequency of masturbation (Cooper, Galbreath et al., 2004).

Cooper's second category of cybersex users, the sexually compulsive group, contains people who may have had sexual issues in their lives before their use of Internet pornography. These people simply find the Internet to be a convenient forum with which to pursue their pre-existing sexual interests. This group could, but will not necessarily, progress into the at-risk group. A member of the sexually compulsive group could quite likely develop difficulties in life associated with online pornography consumption. However, if pornography was removed entirely from their life, they still may not have an increased desire for face-to-face sex with their partner (Carnes, 1993).

The "at-risk" users may never have had significant problems in their life related to pornography or their sexual interests if it were not for the Internet. These users often access Internet pornography as a reaction to the stress or depression in their life and use porn as a distraction to cope with these uncomfortable feelings. This group is quite likely to develop some sort of social, financial or relational problems associated with their Internet pornography consumption, especially during times of high stress or prolonged depression (Cooper, Delmonico et al., 2004). Often, men who use Internet pornography for stress relief receive more complaints from their partners about their use of pornography, report more frequent masturbation, and receive complaints about turning inward as a coping strategy (Cooper, Galbreath et al., 2004).

### **Escape From Dysphoric Mood**

Since it is the sexually compulsive and especially the at-risk users that might be most likely to present for counseling, the remainder of this study will focus on those groups. Being prone to boredom, depression, stress or anxiety, having limited social connectedness, and having increased interest in the Internet seem to be factors that

contribute to the development of an Internet pornography addiction (Chaney & Chang, 2005; Cooper et al., 1999; Parsons et al., 2007; Paul, 2009). Males are more likely than females to experience boredom and to engage in solitary sexual behaviors, such as masturbating and viewing pornographic videos (Kort, 2009). Men may turn to online sexual activity for immediate stimulation and relief of boredom. When boredom is identified as the primary cause of Internet pornography addiction, patterns of when boredom is experienced will need to be identified in order to implement boredom prevention strategies that do not include compulsively accessing Internet pornography (Daneback et al., 2006). According to Cooper and his associates who conducted a massive study (N=7,037) in conjunction with MSNBC, more than 75% of those who accessed Internet pornography did so to distract themselves from boredom or stress (Cooper et al., 2002). The ultimate goal is to avoid feelings of hurt, anxiety rejection or loneliness and replace reality with a false sense of intimacy through Internet pornography that provides the illusion of acceptance (Levert, 2007; Struthers, 2009; Yoder et al., 2005).

Accessing pornography temporarily relieves these feelings of dysphoria, replacing them with euphoric sexual tension and release (Hagedorn & Juhnke, 2005). This euphoric feeling gives certain individuals a sense of power, exhilaration, and intensity that they crave when the boredom or stress returns (Cavaglioni, 2008). The process of replacing dysphoria with euphoria is the same cycle that drug addicts go through, and the addiction of Internet pornography has been likened to chemical addiction in its inducing pleasant states to relieve stress (Levine, 2010). The boredom is replaced with excitement, a false sense of connectedness, arousal and eventually a sexual release which bathes the

brain in chemicals that have been likened to the effects of cocaine (Bostwick & Bucci, 2008; Delmonico & Carnes, 1999; Dew & Chaney, 2004). Sexual addicts tend to be dependent on sexual stimulation which acts like a drug on the nervous system and can be as dangerous to an otherwise non-addicted person as heroin (Levine, 2010). This cycle, combined with Cooper's Triple-A Engine of the accessibility, affordability and anonymity of Internet pornography, becomes problematic for those who either already have a problem with sexual compulsivity or those who have psychological vulnerabilities rendering them at risk for developing such compulsivity (Cooper et al., 2000).

Masturbation can be healthy, satisfying and a useful means of sexual expression and self-love (Cooper, Delmonico et al., 2004). When masturbation is done in combination with feelings of dysphoria, and with the goal of replacing those feelings with euphoria, it can be a dangerous and addictive cycle for some people (Dew & Chaney, 2004). Solitary, secretive, and compulsive Internet sexual activities eventually serve to reinforce the feelings of boredom, loneliness, social isolation, depression, anxiety, hopelessness, and guilt, though, so the very thing being used to relieve those feelings is now creating those consequences (Gana et al., 2001; Yoder et al., 2005). There is an association between Internet pornography addiction and depression as expressed through loneliness and isolation, so much so that the more time that is spent on pornographic sites, the higher the individuals score on the loneliness scale (Yoder et al., 2005). When individuals are exposed to a sexually graphic images epinephrine, serotonin, adrenaline, endorphins and dopamine are released into the bloodstream which create a euphoric state where impulse control decreases and the sex drive takes over (Haney, 2006). Once this

has occurred even the thought of the pornographic image can trigger a feeling of sexual arousal and the desire to repeat the pleasurable experience.

### **Financial Impact**

In addition to the negative mental and emotional impacts outlined above, individuals who are at risk or who have a compulsive Internet pornography problem can also experience a whole range of difficulties in multiple areas which may include financial, legal, occupational, or personal and may occur in one or more areas on more than one occasion (Daneback et al., 2006; Dew & Chaney). In spite of the fact there are numerous sites that offer free thumbnail galleries of pornographic pictures, and sites where you can view short clips of a few seconds up to several minutes of pornographic movies as well as sites that contain user-generated content; the industry is making lots of money on Internet pornography (Garlick, 2010). More than a decade ago, the online pornography revenues of the top companies were estimated at \$100 million per year, with the industry as a whole topping \$1 billion annually (Delmonico & Carnes, 1999). More recently the estimates are exceeding \$13 billion annually and \$100 billion worldwide (Maltz, 2009; Young, 2008; Zitzman & Butler, 2005). It is not unusual for an Internet pornography addict to spend hundreds of dollars a month downloading pornographic images and stay up all night accessing pornography (Stein et al., 2001). Often, that is how an Internet pornography addict's secret habit is uncovered; an unsuspecting partner intercepts a credit card bill or stumbles upon the computer's browser history. The industry has designed its websites to draw people in, can customize its galleries to the user's preferences, and always leaves the addict wanting more (Philaretou et al., 2005).



The financial impact of an Internet pornography addiction is not limited to the amount of money an individual spends on downloading pornography and in purchasing memberships to pornographic sites. The financial impact can come from relationship breakup including divorce attorney costs, loss of dual income, and the financial impact of having to maintain a separate dwelling (Philaretou et al., 2005; White & Kimball, 2009; Young, 2008). Another source of financial struggle due to an Internet pornography addiction could result from legal fees for the type of pornography downloaded. Child pornography is something that is much more accessible as a result of the Internet, but yet is still illegal and prosecutors seem to be increasing the pressure to go after those who possess child pornography on their computers (Carnes, 2003; Ciclitira, 2004; Jensen, 1995). Yet another financial impact could include a loss of income from being terminated because of either accessing pornography at work or losing too much time because of staying up all night accessing pornography.

### **Occupational Impact**

One of the most problematic consequences of addictively accessing Internet pornography is doing so at work. Excessively large amounts of time spent on these websites in the workplace become ethically, legally and financially detrimental to the employer and the employee (Cavaglioni, 2008). Some estimate that 59% of Internet use at work is non-work related (Griffiths, 2003) which is costing employers millions of dollars a year in lost productivity. With the Internet being the newest way employees have found to engage in non-work activities, this is becoming known as “cyberslacking” (Cooper et al., 2002). Pornography addicts whose job allows them a great deal of freedom, or those who work at home, are especially vulnerable to spending great amounts

of time accessing pornography while they are supposed to be working (Laaser & Gregoire, 2003). Many employers are now blocking certain websites, for example social media or sexually explicit sites, to help prevent wasted productivity. Lerza and Delmonico (2002) reported that in at least two different studies more than four out of five sexual addicts' behaviors have interfered with their work (Lerza & Delmonico, 2002). When researchers look at Internet pornography traffic it appears that over 70% of pornography traffic occurs between 9AM and 5PM (Carnes, 2003; Lerza & Delmonico, 2002). More than two-thirds of cases involving the misuse of the Internet at work are due to employees accessing pornographic websites (Carnes, 2003). Maltz (2009) reported that according to a 2008 Nielsen online survey, one quarter of all employees in the United States are accessing pornography at work in spite of the risks involved.

Even if an individual who is addicted to Internet pornography does not access porn while at work, the individual can bring the effects of the addiction to work. Many people who are addicted to Internet pornography feed their habit while everyone else in the home is asleep; sometimes staying up until 3 or 4 AM or going without any sleep and still reporting for work in the morning. Besides taking up time that could be spent sleeping, a person who is addicted to pornography can have difficulty falling asleep even after accessing it. The brain can have a hard time calming down after all that stimulation (Maltz, 2008). The resulting loss of productivity often does not go unnoticed by employers which can result in termination or discipline at work (Delmonico & Carnes, 1999). While awake, at work, and not accessing pornography, the Internet pornography addict is quite likely still obsessing about and planning the next time pornography can be accessed, how to arrange for privacy, and how to not get caught (Maltz, 2008). While the

research on these sexual behaviors has demonstrated that they can seriously interfere with work and an individual's personal life, little has been written to inform executives, managers, and Human Resource professionals who need the skills necessary to comprehensively manage the impact of this problem in the workplace.

### **Negative Effects of Internet Pornography Addiction on Couples/Families**

As was stated before, not every person who accesses Internet pornography becomes addicted, but some do. Equally as important to point out is that not every person who becomes addicted to Internet pornography is in a coupled or long-term relationship, but some are. Couples who mutually benefit from using pornography are unlikely to address their use in counseling. Solitary Internet pornography consumption by one member of the couple, especially if this is done in secret, can strain a relationship, as well as create emotional and sexual distance between partners (Parker & Wampler, 2003; Schneider, 2000). As a general rule, habitual pornography consumption by an individual that is accompanied by masturbation is at best a distraction for the individual during subsequent sexual intercourse with a partner (Carnes, 1993). This could reduce pleasure, affect the ability to reach orgasm, and diminish satisfaction. As was mentioned before, if pornography is consumed in a solitary, secret fashion an individual has greater potential for compulsive or addictive behaviors to develop. This could be because consumption of pornography is occurring outside of a relationship which inherently has social norms that are inherently a part of the relationship and the relationship itself may serve to keep in check some of the behaviors that are not as socially acceptable (Zitzman & Butler, 2005).

The majority of people struggling with sexual addictions and compulsivities involving the Internet are married, heterosexual males (Ayres & Haddock, 2009; Hertlein & Piercy, 2008; Manning, 2006). Although it is understood that there is not one way to have a stable and satisfying marriage, there are some common factors that are worth highlighting because of their empirical support and widespread applicability to diverse couples. Online pornography addiction is “a hidden public health hazard exploding in part because very few are recognizing it as such or taking it seriously” (Manning, 2006). In the last ten years the rate of compulsive pornography use has steadily increased (Maltz & Maltz, 2008). This increase has been accompanied by an increase in the availability of online pornography and an increase in the accessibility of free pornographic images (Young et al., 2000). Time spent on compulsive Internet pornography use is often spent pursuing the perfect sexual visualization that will match the image in the addict’s head, only to get disappointed with its fleeting nature. There is a lack of reliable, empirically sound interpretation of the findings within a family systems framework, thereby limiting the conclusions that may be drawn regarding the impact on marriages and families at large (Parker & Wampler, 2003).

When one partner develops a problem with pornography it can have profound consequences on a relationship, even when the user makes a sincere effort to quit. For some couples it is not necessarily the pornography that creates a problem in the relationship, it is the fact that it is often accessed in secret and accompanied by masturbation. Zitzman and Butler (2009) found that a partner’s secret pornography use precipitates self-doubt in the other partner as well as an erosion of self-esteem and a threat to the attachment to the relationship. Quitting is not the only issue that needs to be

dealt with in order to heal the damage done to the partnership (Hertlein & Piercy, 2008; Parker & Wampler, 2003; Zitzman & Butler, 2005). Both partners need to understand the other's emotional experience and trust needs to be restored. For individuals who have lost control over their online sexual activities, negative consequences can occur such as social isolation, relationship conflicts, financial difficulties, and health risks for both the user and his family (Dew & Chaney, 2004). Researchers in the field of human sexuality have studied for decades the impact and predictors of sexual addiction. However, with the onset of online pornography, people who have had no prior history of sexual compulsivity are now developing problems (Levert, 2007).

Not only does the discovery of a partner's secret use of pornography damage the trust in a relationship, couples often report a decrease in their sexual relationship (Ayers & Haddock, 2009; Schneider, 2000; Zitzman & Butler, 2009). Married women generally are distressed by their husband's use of sexually explicit material and worry that this may threaten the stability of the marital bond (Zitzman & Butler, 2009). Cybersex addiction has been noted as a major contributing factor to separation and divorce for some affected couples (Hagedorn & Juhnke, 2005). The research seems to be suggesting that it is not troubled marriages that lead to Internet pornography addiction, but Internet pornography addiction that has negative effects on marriages. Clinicians are increasingly observing the negative effects of pornography consumption on relationships. Couples are coming to counseling with pornography use as the primary presenting issue and are describing the damaging effects it has on the individual and the relationship (Ayres & Haddock, 2009). Intimate partners who have discovered that a pornography addict lives in their home must not only be concerned with their own relationship to the addict and what the

future will hold, but also must be concerned about whether their children (if present) will be exposed to pornography (Maltz & Maltz, 2008).

The negative effects of Internet pornography can impact children in homes where a parent's addictive sexual behavior is occurring. These negative effects include decreased time and attention from the parent, encountering pornographic material themselves, encountering a parent during masturbation, overhearing phone sex, parental separation and divorce, parental job loss, financial strain, increased risk of consuming pornography themselves, exposure to objectification of human beings, parental conflict, and stress and premature sexual dialogue between the parent and child (Manning, 2006). Dialogue about sexuality may surface before the parent and especially the child is ready. Many youths experienced anger for the pain, embarrassment, fear, guilt, and confusion. Many also felt obligated to reach out emotionally to take care of the other parent (Schneider, 2000). The children in many families may already know of their parent's addictive pornography use before it is disclosed (Manning, 2006). The number of children exposed to such risks unfortunately is increasing as Internet usage starts earlier and becomes more popular.

Pornography can be a negative experience for the non-addicted partner because it contributes to a loss of trust, respect, self-esteem and emotional connection with a partner (Ayers & Haddock, 2009; Schneider, 2000). Internet pornography addiction affects all of the people in the family physically, mentally, emotionally, spiritually and behaviorally, which really makes it a family disease (Cannon, 2000). As it says in the Sexaholics's Anonymous "white book," (1989):

within any given moment of our lives, however, we were unaware of the extent it [sex addiction] had driven us and refused to see where it was leading. We were unaware of the awesome power of the rapids or the whirlpool ahead. We took from others to fill up what was lacking in ourselves (p. 27).

Some individuals and couples use pornography either together or separately as a potentially beneficial relationship aid to help educate themselves and each other about what is pleasurable or to learn new things (Zitzman & Butler, 2005). However, since the Internet has arrived on the scene and taken over almost every aspect of our lives, clinicians are increasingly seeing the negative effects of the use of Internet pornography on relationships. There has been a steady increase in couples who are seeking counseling with pornography use as the primary presenting problem, and are discussing a long list of the damaging effects on relationships brought about by the use of pornography (Ayers & Haddock, 2009; Schneider, 2000; Zitzman & Butler, 2005). Typically, if the compulsive pornography use is done in secret and is accompanied by masturbation, the partner suffers a loss of a sense of stability that the relationship once had and this is replaced by feelings of betrayal, infidelity, loss, shock, confusion, anger, denial, grief, pessimism, and self-doubt (Fife et al., 2008).

As was said earlier, the majority of people struggling with sexual addictions and compulsivities involving the Internet are married, heterosexual males (Ayers & Haddock, 2009; Hertlein & Piercy, 2008; Manning, 2006). That means the average partner of a person addicted to Internet pornography is a married heterosexual female. A woman whose husband is addicted to Internet pornography often blames herself, at least to some degree, for her husband's addiction. She has a nagging feeling that if she were just

prettier, skinnier, younger, curvier, had larger breasts, or did the things in the pictures or videos without hesitation or reservation, then her husband's eyes would not have to stray (Gardner, 2001). In reality, the pornography addict is accessing the pornography not to satisfy an unfulfilled sex life, but out of boredom, curiosity, stress, anxiety or simply because of pornography's disinhibition (Griffiths, 2001; Haney, 2006). Pornography does not require foreplay, does not argue, is always ready, never says no, and is devoid of any relationship context or emotional attachments (Hald, 2006). Pornography thus becomes an example of fantasy that becomes reality since it does not physically involve acting out with another person, but invites the user as a voyeur (Jones & Wilson, 2009). For many individuals, pornography is a form of visual stimulation, not a precursor for adultery, but is often interpreted as the latter by the spouse or partner of an individual addicted to Internet pornography (Limacher & Wright, 2006).

Eventually most people addicted to pornography are made to see the devastating effects their habit has on their marriage, health, and career, but still find that they are still unable to stop. This realization can be a powerful drive to get help from a mental health professional (Maltz, 2009). If pornography use has escalated to the point of causing significant impairment in an individual's life it is quite probable that the pornography use is accompanied by masturbation, and thus quite likely the frequency of sexual relations with a partner has dramatically decreased (McCarthy & McDonald, 2009). Some couples continue living with less sex while just blindly hoping that it will get better on its own. This rarely happens without intervention (McCarthy & McDonald, 2009). Ignoring a problem as integral to a relationship as sex is dysfunctional. There are profoundly negative consequences of draining the relationship of intimacy which usually threatens



the stability of the pair bond (McCarthy & McDonald, 2009). Because of this, couples, families, and individuals of all ages are experiencing significant impact from compulsive Internet pornography use. Couples are coming to counseling for problems of a sexual nature more often (Miller, Yorgason, Sandberg, & White, 2003). In spite of this, research examining the impact of Internet pornography, especially on family systems, is a nearly ignored topic in the research literature (Manning, 2006). When couples present for counseling of a sexual nature the entirety of the couple needs to be taken into account, but yet there is insufficient training taking place to equip counselors to address this issue (Nasserzadeh, 2009). The majority of Internet sexual activities, including viewing pornography, are considered highly emotionally charged by at least one member of the couple, and are viewed as sexual in nature, even though there may have been no direct physical contact between the individuals (Parker & Wampler, 2003). For this reason, Internet sexual activities by a partner are perceived as a distraction to the relationship.

### **Same Sex Couples**

For some same-sex couples, especially gay men, pornography use is a fact of life for their relationship (Kort, 2009). Gay men tend to use Internet pornography as a source of information, and to self-medicate. They also use Internet pornography because it is anonymous, because they find more acceptance of self than real life as they may have few socially appropriate venues to express their sexuality, and because they are more likely than heterosexual men to use the Internet for sexual purposes (Chaney & Chang, 2005; Dew & Chaney, 2004). Perhaps the aforementioned points are true because gay men tend to be more prone to depression, may be less socially connected than heterosexual males, and by using Internet pornography, they can feel part of a more

normalized population online (Chaney & Chang, 2005). However, for gay and bisexual men, even accepted pornography use in a partnered relationship can act as both a manifestation of and a trigger for compulsive sexual behavior, such as masturbation, as was found in a qualitative study of 180 gay and bisexual men in the United States (Parsons et al., 2007). Same-sex couples are much more likely to discuss a partner's use of pornography and tolerate the use of it as long as it does not interfere with the relationship. When porn use is out in the open in the relationship there is much less chance of it becoming an out of control and damaging addiction (Kort, 2009). The fact that it is less of a problem in gay male relationships may be due to the fact that men and women view Internet pornography use within a coupled relationship differently, as was stated earlier (Ayres & Haddock, 2009; Cannon, 2000; Limacher & Wright, 2006).

However, as Chaney and Chang (2005) pointed out, a lack of social or familial connectedness, coupled with boredom and online daydreaming and fantasizing can be a recipe for addictive Internet pornography consumption, even in same sex couples. The opposite is also true that the more socially connected and connected to his partner a gay male feels, the less likely he is to engage in Internet sexual addiction.

### **Christian Couples**

Internet pornography addiction is a growing problem among Christian couples (White & Kimball, 2009). There appears to be some vulnerability specific to Christian couples in comparison to other types of couples in regards to Internet pornography addiction (White & Kimball, 2009). There is typically an inverse relationship between addictions and Christianity which seems to be conspicuously absent in regards to Internet pornography addiction (Abell et al., 2006). To some degree Christian families are often

not as educated about healthy and unhealthy sexuality and boundaries (Laaser & Gregoire, 2003). If families do not speak to their children about sex, pornography, and masturbation they may learn about it from the Internet (James & Thomas, 2009). The strict rules with which Christian parents raise their children can sometimes foster shame and guilt surrounding sexual thoughts and feelings which serves to lay the groundwork for a sexual addiction (Haney, 2006). Research has found a disconnect between a client's religious convictions and sexual practices with some individuals having strict adherence to some religious doctrines but at the same time spending 20 or more hours per week accessing Internet pornography. A correlation has also been found between "right-wing authoritarian tendencies" and developing and maintaining a cybersex addiction in both Christian and non-Christian males (Levert, 2007, p. 159). Abell (2006) and his colleagues also found that Christians who self-report higher levels of religiosity experienced more problems with Internet pornography.

Pastors and others with religious vocations seem particularly vulnerable to Internet pornography addiction. They quite possibly were raised in a right-wing authoritarian family which has been shown to increase the risk of Internet pornography addiction (Levert, 2007). Over half of pastors surveyed by Christianity Today in 2000 reported accessing pornographic websites a few times in the last year and nearly 20% said they visit such websites more than twice a month (Gardner, 2001). Pastors and other people who work from home are often socially isolated and are not afforded a close friend with whom they could confide their weakness toward pornography (Laaser & Gregoire, 2003). Pastors are held to a higher moral standard than others in their social

circles, which deepens the level of secrecy and shame surrounding their addiction (Cannon & Cannon, 1994).

Masturbation is still considered forbidden by some Catholic and Protestant Christians which would serve to drive the use of Internet pornography into more secrecy and shame, which would serve to increase the likelihood of an addiction (Kwee, Dominguez, & Ferrell, 2007). Even though many Christians would never visit an adult bookstore, massage parlor or rent a pornographic video, they may find the accessibility, affordability, and anonymity (Cooper et al., 1999) of Internet pornography to be particularly exciting and inviting (Gardner, 2001). Even though some Christians may find the lure of Internet pornography irresistible, their giving in to temptation is quickly followed by feelings of guilt, shame and remorse; especially if they are unable to control or curtail their compulsion (Cannon & Cannon, 1994).

Part of the life of a couple is being sexual. This is no less true for Christian couples. For some people the use of pornography is progressive and addictive in nature (Laaser & Gregoire, 2003). When people who are addicted to pornography become obsessed by their need for porn, it encompasses their entire world. These images can interfere with normal sexual relationships between partners, so even the casual, secret use of pornography in a coupled relationship carries some risk. The dangers of pornography need not be restricted to religious discussions. The need for intimacy is a human need. Pornography is viewed by many Christians as a corruption of the ability to be intimate. It pulls people in with the promise of intimacy, but fails to deliver the connection between two human beings (Struthers, 2009). Couples who have been successfully repaired and renewed their relationship while one partner struggles to overcome a pornography

problem often find some success in having established routines for sharing information and discussing their feelings and needs with each other (Maltz & Maltz, 2008).

### **Diagnosis, Prevalence, and Etiology**

#### **Diagnosis**

There is, unfortunately, a lack of diagnostic codes or even a description of Internet pornography addiction or compulsivity, or any pornography addiction, in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). Definitions, diagnosis, etiology, pathogenesis and treatment options currently available to counselors have been developed, researched and implemented without the support or guidance from this widely accepted and required diagnostic manual. Given the prevalence of this disorder and the lack of training available to clinicians in preparation to face this ever increasing problem, it makes the absence of a diagnosis particularly troublesome. Diagnosis and treatment of Internet pornography addictions in particular and sexual addiction in general are limited in part because there is a lack of consensus among mental health professionals regarding the definition, etiology, and prevalence of these problems (Swisher, 1995). In light of the absence of an agreed upon prevalence in the DSM-IV-TR it is wise to consult experts who have researched and published extensively in the field of sexual addiction, cybersex addiction, and pornography addiction for prevalence rates.

Because of a lack of a clear and accepted definition, statistics on Internet pornography addiction's prevalence, etiology and diagnosis are varied and sometimes discrepant. In a study involving 125 undergraduate males, 31% of these men struggled with the urge to seek out online pornography while using the Internet (Abell et al., 2006).

Cooper and his associates (2000) estimated that roughly 30% of Internet users access sex-related sites. If we estimate quite low and say only 1% of those are addicted to Internet pornography that is still well over 200,000 people in the United States alone, which makes this a formidable new disorder (Ayres & Haddock, 2009). In a study with 9,265 participants Cooper and his associates (2000) found that 17% of the sample scored in the problematic range for sexual compulsivity. In the same study, 8% of the total sample spent 11 hours a week or more accessing Internet pornography and the author also described this as more problematic and potentially compulsive than other groups in the same study (Cooper et al., 2000).

Goodman (1993, 1998) proposed a set of diagnostic criteria for addictive disorders that could be applicable to process addictions such as Internet pornography addiction. He described an addiction as a behavior used to produce gratification and to escape internal discomfort that is difficult to control and which has significant harmful consequences and yet persists. Kafka and Hennen (1999) described diagnostic criteria as perhaps including an “increase in frequency or intensity (for more than six months duration) so as to preclude or significantly interfere with the capacity for reciprocal affectionate activity” (p. 306). Pornography, in this study, was included in a list of “paraphilia related disorders” which also included compulsive masturbation, protracted promiscuity, phone sex dependency, sexual desire incompatibility, and cyber-sex dependency. Martin Kafka has been quite instrumental in getting Hypersexual Disorder to be a proposed new psychiatric disorder in the DSM-V, although the DSM-V work group is currently discussing the inclusion of “Hypersexual Disorder” in the appendix as a possible related sub classification of the heading “Sexual Dysfunction.” Under the

current proposed version (April, 2012) pornography is listed as a specification of Hypersexual Disorder which the work group is proposing for inclusion in Section III. This is a section of the DSM-5 that the work group will use for topics which require further research but that will not be included as distinct disorders (DSM5.org). Kafka conducted an extensive literature review related to hypersexuality, sexual addiction and paraphilia-related disorders which he concluded in August, 2009 and consistently found that roughly 5%-10% of the population met the criteria for Hypersexual Disorder (Kafka, 2010).

### **Prevalence**

Kafka's percentages align with what Delmonico and Cooper have reported. Over a decade ago Delmonico suggested that "cybersex addiction" was a relatively new clinical phenomenon that was being reported across the United States (Delmonico, 1997). He, along with Al Cooper, found that approximately 8% of cybersex users spend 11 hours per week or more using cybersex and experience significant difficulties in their life related to the cybersex (Cooper, Delmonico et al., 2004). In a study with a sample of 7,019, which was over 84% male and over 80% American, Cooper and his associates found that over 6% of respondents had described their online sexual activities as problematic and out of control (Cooper, Galbreath et al., 2004). In a different study conducted in 2000, Cooper collected 7,037 online respondents to a survey about online sexual activity through the cooperation of the MSNBC website. This survey found that nearly 10% of the sample self-identified as being addicted to the Internet and about 7% reported being sexually addicted (Cooper et al., 2002). In another study with a large sample size (N=9,177) that surveyed online sexual activities, Cooper and associates

found that about 12% of the sample indicated that they access online sexual material too often (Cooper et al., 1999).

Because there is a lack of agreed upon definition and diagnostic criteria, identifying exactly when compulsive Internet pornography use becomes problematic is sometimes difficult. Levert (2007) conducted a study of 120 adult males who had Internet access and found that over 20% of them accessed Internet pornography daily. Women tend to view Internet sexual activities as a more serious and damaging issue to relationships than men as was found in a study with 242 undergraduate students who were given different scenarios to rate that involved various levels of involvement from visiting adult websites to having sex with someone online or offline after having met online (Parker & Wampler, 2003). Schneider (2000) found that among self-identified sex addicts, nearly 80% of her 55 respondents reported that pornography was involved in the nature of their online sexual activities. This reinforces the belief by the partner of the Internet pornography addict that secret, compulsive use of pornography will eventually lead to real-life infidelity. Nearly 60% of the divorce cases that had been seen by members of the American Academy of Matrimonial Lawyers in 2002 involved one party having an obsessive interest in pornographic websites (Manning, 2006). When sex addicts were asked if their online sexual activities had led them to have a real-life affair, a third of respondents said that they did (Schneider, 2000). White and Kimball conducted a qualitative study of three Christian couples in which the husband was addicted to Internet pornography and found that all three couples were undereducated about healthy sexuality and masturbation. The authors also found an added stigma for these couples because



they feared how they would be seen as individuals if this addiction was revealed to their churches (White & Kimball, 2009).

### **Etiology**

There is not agreement in the counseling profession regarding the etiology of Internet pornography addiction. Is Internet pornography addiction a subset of sexual addiction? Is Internet pornography addiction a subset of Internet addiction? Is it a paraphilia? Some authors have suggested that Internet pornography addiction may develop as part of a response to a history of physical, sexual, family or social trauma (Carnes, 1993; Putnam & Maheu, 2000). Other researchers have attributed Internet pornography addiction to the self-medication of feelings of frustration, boredom, loneliness, or anxiety which is powerfully reinforced by the secrecy, shame and euphoria resulting from masturbation (Bancroft & Vukadinovic, 2004; Maltz & Maltz, 2008). Still others feel the development of an Internet pornography addiction is traced back to a typically accidental exposure at a young age, typically during Freud's latency stage, to a memorable, shocking, exciting, and forbidden secret that somehow serves to prematurely awaken the latent sexual being living inside the individual (Gardner, 2001; James & Thomas, 2009; Jensen, 1995). This jump start is revisited often enough that the individual becomes attached to Internet pornography much the way most people are attached to the memory of their first love (Cannon & Cannon, 1994; Carnes, 2003; Kwee et al., 2007). Others have reported that addicted individuals have developed a sort of dissociation resulting from an active fantasy life, a lack of social integration, or a search for like-minded individuals that has become obsessive, time-consuming and has adverse

consequences (Chaney & Chang, 2005; Cooper et al., 2000; Cooper, Delmonico et al., 2004; Jones & Wilson, 2009; Mesch, 2009).

What most authors can agree on is that no matter what the etiology of an addiction is, engaging in it gives the individual a mood change and a sense of control over their environment that was previously lacking (Nakken, 1996). Combined with the alteration of dysphoric mood, and a sense of control is the obvious convenience and escape offered by the Internet (Cooper et al., 1999; Dew & Chaney, 2004). Sexuality is a universal human behavior, and just as each human is different, the development of a sexual disorder such as Internet pornography addiction can have a unique etiology and manifestation. Internet pornography addiction usually starts in early adolescence and can take over more quickly than other addictions, due to the fact that we are sexual beings (Turner, 2009). Once a person's arousal template has been established, such as being attracted to blondes, large posteriors, Internet pornography or same gender, it is extremely difficult to alter that attraction. What is possible is for clients and counselors to work together to reduce compulsivity, acting out, and harmful behaviors (Kort, 2009). We can also work together to increase intimacy, change the meaning pornography holds for the client, and discover new ways to alter one's mood (McCarthy & McDonald, 2009).

### **Assessment**

Mental health practitioners may not find out about Internet pornography addiction or understand its connections to other problems unless they assess for it in session with clients (Mitchell, Becker-Blease, & Finkelhor, 2005). One's sexuality and sexual activities are special topics that most people and some professionals do not feel

comfortable talking about. Having a counselor come forward to deal with these issues in session could help people disclose their concerns with Internet pornography and ask for professional help (Nasserzadeh, 2009). The counselor should always consider the type and severity of the Internet pornography problem through effective assessment in order to determine the best type of treatment (Parker & Wampler, 2003). Once the severity of the addiction is discovered, the counselor should work with the client to understand that four of the most powerful triggers for accessing Internet pornography are summarized by the acronym HALT as described by Schneider (2000). The letters represent the words hungry, anxious, lonely, and tired which have been indicated as primary triggers in self-report studies (Schneider, 2000).

To help with treatment planning, valid methods of assessing pornography use are needed in order to unify the profession with regard for this topic (Kingston et al., 2009). Hagedorn and Juhnke (2005) created the acronym “WASTE Time” to work with clients who present with sexual addiction which seems to have relevance to assessing Internet pornography addiction. Each of the letters of the acronym stands for one or more diagnostic criteria which can help clinicians in diagnosing a client with sexual addiction. The ‘W’ reminds the counselor to ask if the client has experienced withdrawal symptoms, like depression or anger, when unable to access pornography. The ‘A’ stands for adverse consequences of Internet pornography addiction, which might be manifested in broken relationships or the loss of a job. The ‘S’ refers to the inability to stop, which implies failed attempts by the client at controlling the addiction. The ‘T’ is for tolerance or intensity and prompts the counselor to ask the client if there has been an increase in the amount or type of pornography accessed. The ‘E’ implies that the client may be trying to

escape from negative moods states like stress, anxiety or loneliness by accessing Internet pornography. The ‘T’ of the WASTE Time acronym covers the last two domains of time spent and time wasted (Hagedorn & Juhnke, 2005).

Another acronym to help assess the extent of Internet pornography’s effects on the life of the individual which is similar in purpose to Hagedorn’s mentioned above is the word MOUSE first published by Philaretou and associates in 2005. This acronym asks the client if more and more time is being spent online in search of sexually explicit materials, if the client is neglecting other duties in favor of the time spent viewing pornography, if the client has been repeatedly unsuccessful in stopping the problematic behavior, if the client is experiencing significant impairment in relationships with others, and if the client feels overwhelmed with excessive anxiety and obsessive thoughts while online (Philaretou, 2005).

Dr. Kimberly Young, a well-published author on the subject of Internet addiction, including social media and pornography, has developed the following questions to assess and diagnose Internet addiction (Young, 1998; 2004; 2009a; 2009b). These questions can certainly be adapted easily to assess and diagnose Internet pornography addiction:

- 1) Do you feel preoccupied with the Internet (think about previous online activity or anticipate next online session)?
- 2) Do you feel the need to use the Internet with increasing amounts of time to achieve satisfaction?
- 3) Have you repeatedly made unsuccessful efforts to control, cut back, or stop Internet use?

- 4) Do you feel restless, moody, depressed or irritable when attempting to cut down or stop Internet use?
- 5) Do you stay online longer than originally intended?
- 6) Have you jeopardized or risked the loss of a significant relationship, job, educational or career opportunity because of the Internet?
- 7) Have you lied to family members, therapists, or others to conceal the extent of involvement with the Internet?
- 8) Do you use the Internet as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression)?

### **Treatment Options**

A limited amount of empirically based literature is available to assist the counseling profession as it works with individuals, couples, and families who are dealing with Internet pornography addiction (Ayers & Haddock, 2009; Dew & Chaney, 2004; Stein et al., 2001). Early treatment of any type of sexual addiction should include psychoeducation, group therapy to help cope with the feelings of shame, family therapy to assist the individual with self-disclosure, and individual therapy for inner motivation (Briken et al., 2007). According to some authors, the neuro-chemical tolerance that is a factor in Internet pornography addiction can be reversed if the addict is willing and able to establish a period of total sexual abstinence. With treatment, this tolerance reversal can usually be achieved in 30-90 days, the first 14 of which will be the most difficult (Bostwick & Bucci, 2008). The abstinence period achieves a noticeable detoxification effect. It allows the sexual part of the brain to reset itself and be excited by appropriate

means again. Although this could be a valid treatment option for some Internet pornography addicts, one would expect the success rate of just asking someone to stop masturbating, stop looking at pornography, and to stop having sex for 30-90 days to be dismally poor.

By helping mental health practitioners get a better sense of what seems to work with these clients the profession should develop guidelines for preventing, diagnosing, intervening, and treating Internet pornography addiction (Cooper et al., 1999). The first step along this path would be for the counselor to become knowledgeable about pornography addiction, its symptoms and the secrecy that accompanies the obsession (Dew & Chaney, 2004). There continues to be a void in the counseling literature regarding training competent counselors to handle Internet pornography addiction as a topic in counseling or even healthy sexuality in general (Gray & House, 1991; Hagedorn, 2009a). The vast majority of counselors have not been adequately trained to work with clients with sexual addiction issues (Hagedorn, 2009a; Hagedorn, 2009b; Hagedorn & Juhnke, 2005). In a study of 175 clinical members of the AAMFT 48% of the variance in therapist comfort in discussing sexual issues was accounted for by sexual education and supervision experience (Harris & Hays, 2008). When dealing with sexual issues in individual, family or couple's counseling, unique ethical issues of counselor self-disclosure, informed consent, confidentiality, competency, and personal and cultural values arise and can have a profound effect on treatment effectiveness (Herring, 2001). Hertlein and Piercy (2008) surveyed 508 clinical members of the AAMFT and found a significant correlation between therapist religiosity and how sex addicted they believed

the client to be, with more religious therapists more likely to label the behavior as an addiction.

### **Psychopharmacology**

The chronic fantasy and masturbatory habits associated with Internet pornography addiction can also lead to sexual dysfunction, for which married couples may need to be treated professionally. Sometimes treatment may need to be conducted in conjunction with medication to help break the addictive cycle. Prescribed for treating alcohol, heroin, and pain medication (opioids) addictions, naltrexone blocks some of the pleasure receptors in the brain which can reduce the cravings associated with addiction (Demand Media, 2012). Naltrexone seems to have some success in allowing the client to see some reduction in tolerance, which is a need for more and more of a drug to achieve the same effect, for both opioids and alcohol (Bostwick & Bucci, 2008). By allowing the client to reduce cravings and reduce tolerance, hopefully some triggers that cause relapse can be avoided and the client can choose to not relapse. It makes intuitive sense that pharmacotherapies effective against one type of addictive behavior would also combat other types. Bostwick and Bucci (2008) discussed a case where a client had tried antidepressants, group and individual therapy, a 12 step group, and pastoral counseling, but it wasn't until he went on Naltrexone that he sustained success at avoiding compulsive Internet pornography use and acting out. For some extreme cases this drug may be necessary to equip the client with enough resolve to stand firm against pornography for long enough to establish new habits.

Those who suffer from depression or anxiety may be more prone to Internet addiction and should a dual diagnosis be made, medical treatment may be increasingly

likely. There is growing speculation that those who suffer from some forms of Attention-Deficit Disorder may also be more vulnerable to some sexual addictions, so the presence of this disorder should be evaluated and treated. The use of antidepressant medication has well-known side effects of cutting down on sexual desire. Medications such as Zoloft or Prozac have been effectively administered to control the desire to act out sexually (Hagedorn & Juhnke, 2005; Kort, 2009). A good “side effect” of using these medications in treatment of sexual addiction is that they may actually help control the depression which has been discussed earlier as a possible driving force to the pornography addiction.

### **Treatment Modalities**

**Twelve-step programs.** A program of accountability should be established. This can involve a traditional 12-step program (Hagedorn & Juhnke, 2005; Maltz, 2009; Swisher, 1995) like Sex Addicts Anonymous and others. There are a variety of groups and the most important consideration for Internet pornography addicts is that they provide daily accountability, encouragement for success, and the opportunity for the addict to become vulnerable to a number of people. Many Internet pornography addicts are lonely because they usually lack intimate connections to people who can support them. Many are victims of some form of trauma and abandonment; they may have issues of emotional, physical, sexual, or spiritual abuse that will need to be dealt with in counseling, as well. The importance of creating a social network of trusted, supportive friends will help prevent relapse, and separate groups for each member of the couple will provide a safe place for learning and sharing (Turner, 2009). One disadvantage to 12-step type group experiences is that oftentimes they are not managed by a licensed



therapist and the advice received may not be clinically reliable (Hagedorn & Juhnke, 2005). Another disadvantage is that 12-step groups can be hard to find unless the client lives in or near a larger metropolitan area (Putnam & Maheu, 2000). An optimal treatment, therefore, would include a combination of individual and group therapy (Kwee et al., 2007).

**Individual counseling.** Appropriate clinical interventions for people who are struggling with sexual compulsivity require that the counselor first be knowledgeable about sexual addiction and its symptomatology, including tolerance, craving, withdrawal, secrecy and obsession. Mental health professionals need to be aware of the various ways that people use online activities to engage in sexual activities. An awareness of Internet chat rooms, live audiovisual feeds, newsgroups, exchange of pornographic material, and personal advertisements is essential for successful individual treatment. It is unrealistic to assume that sexually compulsive individuals who use the Internet can abstain from having sex or from accessing the Internet for the duration of their life. Thus, a multimodal perspective, which is based on behavioral modification, psychodynamic approaches, and cognitive restructuring, is most often used in the treatment of sexually compulsive disorders (Hagedorn & Juhnke, 2005; Twohig & Crosby, 2010). Swisher (1995) studied 248 professional counselors and found that individual and group therapies were the most commonly suggested methods of treatment for sexual addictions including pornography addiction. A self-monitoring form can be used to record time of day, feelings, thoughts, and triggering mechanisms that precede online sexual behavior. The more detailed the history of thoughts, feelings, and behaviors relating to sexual compulsiveness, the more likely it is that the reinforcing consequences of the behavior

can be identified (Dew & Chaney, 2004). Some scholars have suggested teaching clients physical self-care which would include proper rest, eating right, and encouraging exercise to help the body naturally release the chemicals that the brain craves from the addiction (Laaser & Gregoire, 2003).

Cognitive behavior techniques, which teach patients how to identify and solve the problem driving the urge to be sexually compulsive, have been effective (Philaretou, Mahfouz, & Allen, 2005; Twohig & Crosby, 2010) and have been effectively combined with motivational interviewing techniques (Parsons et al., 2007). Effective ways of dealing with boredom proneness, social disconnectedness, and online dissociation should be discussed during individual counseling (Chaney & Chang, 2005; Gana et al., 2001; Paul, 2009). Clients can also learn coping skills to prevent relapse. Substituting time spent surfing the Internet for pornography with some other positive activity (such as developing a hobby or volunteering to help others in need) and becoming more sociable tends to break the cycle of compulsion as the individual's mental and emotional energies become channeled and expended toward more positive ends. Identifying the triggers that lead to the compulsion to consume pornography is an important goal, as well as reconditioning the client's erotic thoughts, anxiety reduction, aversion counseling, and risk recognition (Hagedorn & Juhnke, 2005).

Individual counseling will also be helpful to deal with the crisis of faith that will likely accompany the discovery of an Internet pornography addiction in the life of a religious person. The use of Internet pornography is on the rise within the Christian population (White & Kimball, 2009). Most people with an Internet pornography addiction face feelings of guilt, shame, anxiety and depression at some point during their

treatment and this is no less true for people of faith (Gardner, 2001). In addition to the rejection and disdain an individual suffers from work, home, family and friends, religious Internet pornography addicts can face feelings of being personally rejected by their God (Abell et al., 2006). Counselors who work to reduce feelings of shame and guilt, normalize the issue, respect cultural norms, are aware of their own values related to sexuality, and who do not underestimate the power of an addiction on the individual seem to be important themes identified in the literature (Haney, 2006; Levert, 2007). Religious clients may prefer to join a 12-step group that matches their worldview or may seek out a counselor who specializes in religious counseling (Laaser & Gregoire, 2003).

**Conjoint couple/family counseling.** Internet pornography addiction is a relatively new area in the range of problems facing couples and families today (Landau et al., 2008). A biopsychosocial therapeutic model is sometimes used for assessment, treatment, and relapse prevention of Internet pornography addiction (McCarthy & McDonald, 2009). A combination of several counseling modalities tends to increase effectiveness and recovery (Swisher, 1995). Areas to work on within the counseling setting include emotional reactions, commitment, accountability, and trust (Fife et al., 2008; Turner, 2009; Zitzman & Butler, 2005). With a topic as emotionally loaded as Internet pornography addiction by one member of a family, the power and complexity of verbal commendations are important where the strengths of the individual, couple, and family are spoken about along with the consequences of the addiction (Limacher & Wright, 2006). Counselors can also use solution-focused or future-oriented treatment approaches that emphasize the specific strengths the client brings with them to session that they have already used to solve other problems in their life (Oravec, 2000). In a

study in which 99 members of AAMFT were given a case study and asked how they would approach the client's problems in actual clinical practice, only 47% reported that they would assess pornography use even when the use of pornography was included in the vignette (Ayers & Haddock, 2009). When couples are seen together for issues related to pornography use by one or both members, it is helpful to think of their treatment as divided into three distinct stages in which the couple moves through: (a) dealing with the initial impact of the discovery of pornography use, (b) examining the context of the pornography use, and (c) moving on either together or separately (Fife et al., 2008; Snyder et al., 2008). The first stage, dealing with the initial impact, would include sharing of intense negative emotions and some disruption of both individual and relationship functioning. This crisis management and assessment phase involves boundary setting, self-care techniques, venting, emotional expressiveness and learning how to deal with flashbacks (Snyder et al., 2008). Even experienced therapists can become overwhelmed in this stage and great care must be taken to remain neutral, continue to be ethical, and maintain a non-judgmental attitude (Ayres & Haddock, 2009; Fife et al., 2008; Snyder et al., 2008). A significant portion of the first few sessions will involve some powerful emotional expression by both individuals and the counselor needs to maintain a safe environment in which both clients can comfortably share and be heard (Maltz, 2009). The use of pornography by one member of the coupled relationship, typically combined with deception and secrecy, produces a monumental negative impact greater than any one of the injuries alone (Zitzman & Butler, 2009).

The second stage, examining the context, begins once the couple has progressed beyond sharing their initial experiences. This stage will involve exploring the reasons

behind pornography use and will examine past and present family relationships as well as familial influences (Fife et al., 2008). This stage will lay the groundwork for recovering the trust and intimacy that the user's partner feels is lost and will probably be the lengthiest stage of the three (Kort, 2009). Hopefully this stage will also help the pornography addict to learn to fulfill the needs that viewing pornography satisfies in a more mutually agreed upon fashion so as to begin to rebuild the couple's relationship. Carefully manufactured reframes by the counselor is especially useful during this stage to help both parties see how they can share responsibility for the quality of their relationship (Kort, 2009). Counselors who have used interventions specific to relationships where infidelity has occurred have had some effectiveness with relationships where Internet pornography addiction is present (Snyder et al., 2008). Poor affect regulation, inability to process interpersonal phenomena, persistent externalization of responsibility, or excessive guilt can all detract from the healthy progression through stage two and the counselor needs to be cognizant of these pitfalls (Snyder et al., 2008). If the counselor is uncomfortable or unable to productively examine the context of pornography use, recommending an appropriate 12-step group such as Sex Addicts Anonymous, or Recovering Couples Anonymous may be helpful in conjunction with couple or personal counseling (Maltz, 2009).

The third stage, moving on, is essential to the resolution of a relationship. Either partner can become stuck in the past or become indecisive about the future of the relationship. This stage is designed to help facilitate a decision, whether it be ending or rebuilding the relationship. During this stage both partners are able to regain a balanced view of the other person, commit to not let hurt or anger rule their thoughts, voluntarily

give up the right to continue punishing the offending partner, and decide whether to continue in the relationship (Snyder et al., 2008). The challenge here is how each partner can maintain a sense of individuality while simultaneously exploring how close they want to feel as part of an intimate partnership (McCarthy & McDonald, 2009). As couples increase their empathy and humility, the therapist can help them move forward by increasing their relationship commitment and hope for the future. This three-stage model of a treatment plan can easily be incorporated into CBT by using couple's therapy. All three stages involve both parties changing their thinking about how they interact with each other and with pornography so as to change the behavior. The couple will also be given the opportunity in all three stages to learn how cognitive inferences can evoke emotions in the partner, which produce behaviors, and emotions and behaviors can influence cognitions (Epstein & Baucom, 2002).

### **Mental Health Professionals' Attitudes Toward Internet Sexual Activity**

Miller and Byers (2008) sent an email to the training directors of all 17 accredited clinical psychology programs in Canada and to 32 randomly selected accredited programs in the United States and found that many students do not appear to be receiving adequate education or training related to sexuality issues in psychology training programs (Miller & Byers, 2008). In another study the same authors surveyed 105 clinical and counseling psychologists trained in Canada or the United States who were licensed and found that the vast majority of the respondents would be interested in obtaining additional training related to sexuality and thought it was very important for psychologists to receive sex education and training to increase their comfort in discussing this issue with clients (Miller & Byers, 2009). Many mental health practitioners, in a

variety of professions, are reporting that they currently are not comfortable discussing Internet sexual issues with clients. This has been reported in social work (Berman, 2006; Maltz, 2009) marriage and family therapy (Harris & Hays, 2008; Hertlein & Piercy, 2008) and in counseling psychology (Ng, 2006). Counselor comfort with sexual issues has a direct correlation to client comfort with discussing this topic with the practitioner; a more significant impact than training and clinical experience (Ayers & Haddock, 2009; Berman, 1996).

Research has shown that it is important for psychologists and marriage and family therapists to ask clients about their sexual concerns comfortably and openly and not wait for the client to bring sexual issues up in session (Harris & Hays, 2008). A correlation has been established between sexual education in graduate school and therapist comfort in discussing this topic with clients (Fife, Weeks, & Gambescia, 2008; Miller & Byers, 2008, Miller & Byers, 2009). Counselors who are embarrassed or uncomfortable discussing sexual topics may inadvertently harm clients who are dealing with sexual issues (Harris & Hays, 2008; McCarthy & McDonald, 2009). Didactic education relating to sexuality and addictions, supervision while counseling clients with these presenting issues, and experience observing a clinician conducting sexual interventions are the best predictors of graduate psychology students' self-efficacy in addressing clients' sexual concerns and problems (Miller & Byers, 2008). In a separate study by the same authors, it was found that therapists who have less sex education and training also have less confidence in their ability to discuss presenting issues of a sexual nature and are also more likely to refer (Miller & Byers, 2009). Therapists need to be comfortable and competent in responding to clients' sexual concerns as sexuality is an integral part of

humanity and comfort with this topic is critical to the success of all mental health practitioners (Maltz, 2009).

Training programs in social work and psychology are not necessarily including sexuality training for students, which can lead to problems in the interaction between the client and counselor, including ethical violations (Berman, 1996; Wiederman & Sansone, 1999). If future clinicians receive any type of addictions training it is often voluntary and has to be sought out during professional conferences or by accessing scholarly literature online, perhaps while seeing a client who has presented with an addiction to online sexual activity. Clients are regularly disclosing pornography use in therapy, but clinicians have received very little, if any, training to prepare them to assist clients with the consequences of compulsive Internet pornography use according to a study involving 99 clinical members of AAMFT (Ayres & Haddock, 2009). Therapists often question their ability to work with sexual issues in a couple relationship and can approach the cases cautiously which may not be in clients' best interest (Fife et al., 2008). The amount of sexual education training offered to psychologists in graduate school is quite limited and is not related to how long clinicians have been practicing (Miller & Byers, 2010). Therapists should be well trained in the many presentations of sex addiction in order to avoid missing its presentation in session, or discovering it too late or after damage has already occurred (Turner, 2009). Unfortunately, neither the clients nor the counselors are adequately prepared to deal with Internet pornography addiction as a topic in counseling (Young et al., 2000).

Issues relating to Internet pornography are presenting themselves quite often to mental health professionals in clinical practice (Mitchell et al., 2005). There is simply



not enough specific training in place during graduate programs for students to address clients' sexual concerns (Nasserzadeh, 2009). In a qualitative study involving ten psychotherapists as part of his dissertation research Ng (2006) found that "sexual addictions/compulsivity, erotic/sexual transferences, transgenderism, paraphilias, infidelity in couples' treatment, sexual offending, sexual abuse, and sexual fantasies were identified as especially difficult to work with, particularly when they involve minors" (page iii). These difficulties were attributed to a lack of training, a lack of experience dealing with these issues in practicum and internships, and personal ethical dilemmas of encountering individuals with these issues (Ng, 2006).

In a study that involved 350 mailed surveys to AAMFT members, Harris and Hays (2008) found that sexuality education and supervision experience addressing sexuality issues are the best predictors of therapists' comfort and willingness to initiate discussions about sexuality with their clients. In an Internet survey of 508 practicing marriage and family therapists, Hertlein and Piercy (2008) found that, when given a fictitious client scenario, there were "differences in how therapists assessed and treated clients based on client gender, the therapists' age, and gender, how religious the therapists reported they were, and the extent of therapists' personal experience with infidelity" (p. 481). Because of the fact that there is no consensus on the treatment of Internet infidelity and addiction, and because the prevalence of this problem is increasing, therapists tend to rely on other factors such as their own attitudes, beliefs, values and biases to treat these clients, which would then put the clients at risk for inconsistent and inappropriate treatment (Hertlein & Piercy, 2008; Yarris & Allgeier, 1988). The dramatic rise in clients who are addicted to Internet pornography presenting for

counseling has caught many practitioners unprepared and the counselors may not understand the extent of the problems online sexual activity can cause, or how deeply harmful it can be to individuals, couples and families (Maltz, 2009).

### **Counselors' Need for Training**

Due to the lack of training in counselor education programs and the lack of diagnostic criteria, treatment interventions, and even a lack of counselor comfort in discussing sexual issues, many potential clients turn to self-help groups, church seminars, and friends who serve as accountability partners (Abell et al., 2006; Hagedorn & Juhnke, 2005). Many of these resources do not have licensed mental health practitioners present, and are not governed by an agreed upon ethical standard or empirically-based treatment protocols so the potential for unintended harm to the client with online sexual activity issues increases (Hagedorn & Juhnke, 2005; Haugh, 1999). If counselors-in-training were given opportunities to discuss sexual issues in general, and online sexual activity addiction in particular during their program, then the comfort level of these counselors might increase, thus allowing the counselor to feel better prepared to handle sexual issues in counseling better. As it stands now, counselors are reporting that they currently are not comfortable discussing sexual issues with clients (Hagedorn & Juhnke, 2005; Lerza & Delmonico, 2002). This is remaining true, in spite of the fact that at least two decades ago a call was made in the counseling literature regarding the need for sexuality training to help counselors be proficient in the area of client sexuality (Gray & House, 1991). This research topic has remained virtually untouched in the counselor education literature to this day (Hagedorn, 2009a).

The counselor should not simply wait for the client to bring up sexual issues and Internet pornography activity if it is an issue because of the shame, secrecy and guilt associated with these behaviors (Haney, 2006). Counselors who have not received training surrounding Internet pornography addiction may feel hesitant to address this issue, and may inadvertently harm clients who are dealing with sexual issues, by denying, avoiding or minimizing the issues (Gray & House, 1991; Hagedorn, 2009a; Hagedorn, 2009b; Hagedorn & Juhnke, 2005). Clients have a right to have access to mental health counselors who are well prepared and have addressed their own comfort in the area of sexuality and addictions (Gray & House, 1991). Without proper training in counselor education programs to help counselors be more comfortable addressing client sexual concerns, the likely outcome will be that neither the client nor the counselor are currently equipped to work through the issue of Internet sexual activity addiction (Young et al., 2000).

Hagedorn (2009a) conducted a thorough search of scholarly and Internet-based search engines and found that more and more mental health practitioners are facing clients with Internet pornography and other sexual addictions and that there is a lack of standardization within and between programs that address these counseling issues. The results of his online questionnaire revealed that just over half of the 174 addictions counselors and certified sex addiction therapists had encountered discussions of sex addiction in their graduate studies and that over 98% of the respondents desired additional training in sexual addictions (Hagedorn, 2009a). Unfortunately, there continues to be a deficit between what is identified as a need in the profession and what is being included in the training programs of graduate students (Hagedorn, 2009b). This

deficit continues to affect practitioners negatively and is associated with feelings of being unprepared to assist clients who are sexually addicted (Hagedorn & Juhnke, 2005).

### **Rationale for the Study**

From a developmental and training perspective, it is imperative that counselors recognize, understand, examine, and constantly be aware of how facets of the counselors' and clients' personalities, backgrounds, beliefs and values shape the counseling process. As demonstrated by the above review of the literature surrounding the national and international prevalence in all age groups and strata of societies that Internet pornography addiction encompasses, it becomes apparent how numerous aspects of counselors' and clients' culture, training, and experiences can contribute to the processing of sexual material during the course of counseling. However, in spite of the realization that counselor and client subjectivities both play a role in how Internet pornography addiction is brought up and addressed in counseling, there has been very little research and literature on this topic from the perspective of counselor educators. This study addresses this omission in the field, and this researcher hopes to contribute to the development of useful information and tools to begin effectively assess, diagnose, and treat Internet pornography addiction and recognize its effect on families and couples, as well as on the individual in many aspects of life. Additionally, this study addresses the reality that many counseling training programs virtually ignore sexual issues, and that clients frequently perceive mental health care providers as being uncomfortable with sexual issues and lacking clinical skills when discussing sexual issues, including Internet pornography addiction. By identifying and exploring the aspects of Internet pornography that are especially challenging for counselors to address clinically, ethically,

professionally, and/or personally, this study affirms the Surgeon General's (2001) statement that:

Health care providers typically do not receive adequate training in sexual aspects of health and disease and in taking sexual histories. Ideally, curriculum content should seek to decrease anxiety and personal difficulty with the sexual aspects of health care, increase knowledge, increase awareness of personal biases, and increase tolerance and understanding of the diversity of sexual expression. (p. 9).

Continued research in the field of counselor education is needed to maintain accountability, foster excellence, and create distinction from other fields of mental health practitioners. Counselor educators are in the unique position to be most able to affect change in multiple professions such as clinical mental health counselors, marriage and family therapists, school counselors and counseling psychologists (Hagedorn, 2009a; Hagedorn, 2009b). These professions are also likely to encounter clients who are addicted to Internet pornography (Ayres & Haddock, 2009; Carnes, 2003; Cooper, et al., 2000; Cooper, et al., 1999; DelMonico & Carnes; Flood, 2009; Gray & House, 1991; Haney, 2006; Ng, 2006). This study is timely in light of CACREP's 2009 Accreditation Standards which mandate that the training of all counselors include the prevention, intervention and treatment of addicted clients. This study is significant because the information gained will provide guidance to CACREP-accredited programs through the use of "expert testimony" to help identify areas where counselor education programs could improve process addiction education and training.

### **CHAPTER III**

#### **METHODOLOGY**

This chapter provides a detailed description of the methodology that was employed in this study. This chapter is divided into two sections. The first section explains the methods and reasoning used for obtaining the quantitative data, and the second section describes the methods and reasoning used for obtaining the qualitative data. Within each of these sections, the details about the design, sampling, data collection, and data analysis are provided. The nature of this research study lent itself nicely to a quantitative analysis since the researcher was interested in assessing the opinions of counselors with regard to their attitudes toward pornography and the addiction counseling self-efficacy of these same counselors. The Internet offers unprecedented opportunity for individuals to have anonymous, cost-effective, and unrestricted access to an essentially unlimited range of sexually explicit text, pictures, videos, and audio materials (Haney, 2006). While researching this topic for a class and while collecting anecdotal responses from counselors in discussions of this dissertation topic, a need for further, deeper, analysis became apparent. This research study was designed to help understand if counselors were comfortable with this topic, if they thought more training in this area would be helpful and what the current assessment was of their training in the area of Internet pornography addiction in clients.

The following research questions guided this study and were the basis for the quantitative and qualitative research methods to be employed. The first research question

and its subquestions were about counselor competence and were answered through the use of descriptive statistics. The second research question and its subquestions test the relationships among key variables, and were examined through statistical methods which are identified in parentheses after each research question. The third research question and its subquestions have to do with interviews that were conducted with experts that will be analyzed qualitatively.

- 1) What is the perceived sense of competence counselors have in regards to treating the process addiction of Internet pornography?
  - i) How satisfied are counselors with the amount of training they have received in regards to the process addiction of Internet pornography addiction?
  - ii) How effective do counselors believe they are in counseling clients who are addicted to Internet pornography?
  - iii) How comfortable are counselors in discussing Internet pornography addiction issues with clients?
- 2) What are the relationships between counselor demographic variables (ethnicity, age, gender, program emphasis, comfort discussing sexual issues, and experience and training) and counselors' self-assessed attitudes and skills?
  - i) What are the relationships between counselor demographic variables and counselor self-efficacy with treating addictions? (Multiple Linear Regression Analysis)

- ii) What are the relationships between counselor demographic variables and counselor attitude toward pornography?  
(Multiple Linear Regression Analysis)
  - iii) What is the relationship between counselor attitude toward pornography and counselor addiction counseling self-efficacy? (Bivariate Correlation Analysis )
- 3) What do counselor educators with expertise in process addictions related to sexuality view as best practice in the education of counselors regarding sexual addictions?
  - i) What are these experts' current assessments of the training counselors receive in regards to sexual addiction in general and Internet pornography addiction in particular?
  - ii) What do these experts view as best practice in the training and continuing education of counselors regarding process addictions related to sexuality?
    - a) What are recommended by experts as the preferred ways to develop adequate knowledge and competency in this area?
    - b) Should a class in sexual addictions in general be required in counselor education training programs?
    - c) Should counselors be required to receive continuing education units involving the



assessment and treatment of Internet  
pornography addiction?

According to Creswell (2006) mixed methods research involves both collecting and analyzing quantitative and qualitative data. The primary research questions for this study lent themselves well to both quantitative and qualitative methods, thus a mixed methods design was deemed to be appropriate. There are advantages and disadvantages to using a mixed-method design that have been widely discussed in the literature (Creswell, Goodchild, & Turner, 1996). Some of the advantages are that a mixed methods design is easy to implement for a single researcher, as it can flow smoothly from one stage to another, the mixed methods design is useful for exploring quantitative results in more detail, and that this design can be particularly useful when unexpected results arise from quantitative data. The disadvantages to a mixed methods design is that it can take longer to complete, it requires knowledge of both types of design to facilitate collecting and analyzing the data, and that the quantitative results might show no significant differences which could weaken the qualitative data (Cresswell, 2006). After careful examination of the advantages and disadvantages inherent in conducting a mixed methods experimental design, along with consideration of the research questions, this researcher decided to proceed with a mixed methods design.

In a mixed methods approach, the researcher builds the knowledge of the subject matter by linking practice and theory (Creswell, 2003). This approach lends itself well for a researcher to assert that truth is “what works” (Howe, 1988). The researcher chooses approaches, variables, and units of analysis which would assist in finding an answer to the research questions (Tashakkori & Teddlie, 1998). A starting assumption of

linking practice and theory is that quantitative and qualitative research methods are compatible within research studies. Put another way, a researcher who uses a mixed methods design is making an assumption that the measurable data along with the observable and descriptive data are both needed to help better understand the research problem. When looking at counselors' perceptions of clients who are addicted to Internet pornography and their training related to this, it became obvious that this study would be incomplete without a qualitative piece where experts were consulted on the best practices they would recommend in regards to training counselors to be able to effectively deal with the issue of Internet pornography addiction with clients.

The research on mixed methods recommends consideration of three issues during the design process: priority, implementation, and integration (Creswell, Plano Clark, Guttman, & Hanson, 2003). *Priority* is used to help determine whether quantitative or qualitative research is given more emphasis in the study. *Implementation* refers to how the researcher will combine the two types of methods within the study; whether quantitative and qualitative data collection and analysis will be done in a certain sequence, or whether both types of research will be completed at the same time. *Integration* helps determine the phase in the research process where the mixing of quantitative and qualitative data occurs. This study used one of the most popular mixed methods design in educational research: sequential explanatory mixed methods design, consisting of two distinct phases (Creswell, 2006; Creswell, 2003; Creswell et al., 2003).

In the first phase, the quantitative, numeric, data were collected first, using a web-based survey. The goal of the quantitative phase was to identify the attitudes and beliefs of counselors regarding Internet pornography addiction. The literature review for this

study allowed for purposefully selecting expert informants for the second phase which established best practice goals for the training of mental health practitioners. In the second phase, a qualitative interview process was used to collect narrative data through the use of individual, semi-structured interviews to help explain why certain counselor external and internal factors may have come about through specific training techniques, or the lack of specific training. The rationale for this approach is that it was expected that the quantitative data and results would provide a general picture of the research problem, insofar as what the counselors' attitudes are about clients with Internet pornography addiction, while the qualitative data and its analysis refined and explained where the profession currently stands and compare that with where it should be by exploring experts' views in more depth. The use of interviewing experts in qualitative research is not new, but it is not without its debate, either. Talking to experts can be a more efficient and focused method of gathering data because it can serve to shorten the data-gathering process, especially in instances where a taboo subject matter might make a field more closed to study (Bogner, Littig, & Menz, 2009)

The priority in this design was given to the quantitative method, and came first in the sequence, because the quantitative research represented the major aspect of data collection and analysis in the study, focusing on in-depth explanations of quantitative results by exploring counselors' attitudes toward, and competence in, dealing with clients who are addicted to Internet pornography. The smaller qualitative component will be used to reveal the best standard of practice as it relates to counselor training and preparation in the training of counselors and in treating clients facing this issue in the counseling setting. Therefore, this study used a mixed methods design where the

researcher was attempting to ascertain the best practice in the training of counselors while also looking at what is the current state of training, attitudes and beliefs of counselors surrounding clients with an addiction to Internet pornography (Creswell, Shope, Clark, & Green, 2006). It was determined that, for the purposes of this study, it was not enough to simply report the current state of counselors' perceptions and self-assessed competence with treating clients with Internet pornography addiction. This researcher also wanted to paint a broader picture of what experts in this field think the training and actions of counselors should be in relation to this topic. The quantitative results and qualitative findings are explained during the presentation of the outcomes of the whole study.

### **Quantitative Methodology**

#### **Research Design and Instrumentation**

This study included a descriptive design because that type of design is generally used to gather more information about a specific trait or occurrence within a particular field of study. A descriptive study may be used to develop theory, identify problems with current practice, justify current practice, make judgments or identify what others in similar situations may be doing. There is no manipulation of variables and no attempt to establish causality (Allbutt, Becker, Tidd, & Haigh, 2008). Two of the three research questions for this study were fully addressed through the use of the survey questionnaire. These questions are: (1) What is the perceived sense of competence counselors have in regards to treating the process addiction of Internet pornography? (2) What are the relationships between counselor demographic variables (ethnicity, age, gender, program emphasis, comfort discussing sexual issues, and experience and training) and counselors' self-assessed attitudes and skills? The third research question is: What do experts in the

mental health field who have experience in this area view as best practice in the education of counselors with regards to sexual addictions? Counselor self-efficacy refers to individuals' beliefs in their ability to accomplish a certain task, in this case effectively counsel clients who present with issues related to Internet pornography addiction.

According to Bandura (1997) self-efficacy beliefs have great influence on self-regulation and the quality of human functioning. According to social cognitive theory, self-efficacy can be bolstered by performance of a task and experience success or failure, observational learning or imitation, receiving feedback that convinces the receiver to take action, and positive affect resulting from believing in oneself (Bandura, 1977). The first two research questions and their subquestions deal specifically with counselor self-efficacy toward clients who are addicted to Internet pornography since they ask about the knowledge, experience, training and comfort of counselors surrounding this topic. These four areas are important parts of counselor self-efficacy with regard to addiction and they are included in both the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (1998) and the Addiction Counseling Self-Efficacy Scale (Murdock, Wendler, & Nilsson, 2005; Wendler, 2007).

### **Survey Instrument**

The author determined that the survey questions were best measured by the use of already developed questionnaires regarding attitudes and beliefs about pornography, but it was necessary to adapt the questionnaires to measure counselors' attitudes and beliefs about pornography in general and the people who use pornography. Permissions to adapt the questionnaires were granted from the original authors of the instruments (Berman, 1996; Katzander, 2009; Wendler, 2007). A 90-item questionnaire (Appendix A) was

developed based on a review of previous research. The targeted sample for this study was counselors who are members of the American Counseling Association and who have seen clients in a counseling setting after graduation from a counselor preparation program. There are several survey questions specifically asking participants for demographic information which will be used to help determine if any of these factors affect the efficacy of discussing pornography addiction with clients. The first survey question served as screener question to ascertain whether the potential participant qualified to take part in the study by asking if the respondent had seen clients in a counseling setting after graduation. This stipulation was also presented in the consent form that potential participants read and acknowledged before the survey was begun. The next question asked whether the individual graduated from a master's-level, CACREP-accredited counselor education program. All counselors were potentially able to participate in this study, and those that were trained in a CACREP-accredited program were compared to those that were not. The third question asked the participant to identify her/his gender in order to help determine if there was a gender difference in the self-efficacy to treat Internet pornography addiction and in the counselors' attitude toward individuals who are addicted to pornography. The fourth question asked the age of the respondent so as to help determine if there might be a correlation between age, attitudes toward pornography and self-efficacy toward problematic Internet sexual issues. Question five was used to determine if race or ethnicity had an effect on participants' attitudes toward pornography and self-efficacy in treating problematic Internet sexual issues. Question six asked the participant to rate the importance of religious values and morality to the therapeutic relationship with clients and will help determine if there was a

correlation between self-efficacy, attitudes toward Internet pornography and the importance of religious values and morality to the counselor. Questions seven through 15 asked participants about their training and experiences regarding problematic Internet sexual activities with clients.

Questions 16 through 26 represent the Sexual Comfort Scale (SCS) which was used, with permission, from Laura Berman's dissertation which was published in 1996 in which she researched social workers' willingness to address client sexual concerns. Berman adapted the SCS from The Sexual Comfort Instrument which she attributed to Hedgepeth and cited that the SCS was originally published in 1988 to measure the comfort of school counselors in discussing sexual issues with students. Berman's SCS dealt with the sexual comfort of social workers and this researcher modified the scale slightly to include asking the participants about their comfort discussing Internet pornography with clients. In addition to the slight modification of the wording of those questions, one question was added by this researcher to specifically ask about participants' increasing their comfort discussing sexuality. Berman (1996) found that this scale had an Alpha Reliability Coefficient of 0.63 and though she and this researcher had wished it were higher, "this is considered adequate for attitude scales" (p. 60).

Questions 27 through 31 asked participants about their satisfaction with their training in the areas of sexuality and process addictions. This information was used to determine if there was a correlation between satisfaction with training and the self-efficacy of counselors when working with clients who have an addiction.

Questions 32 through 61 comprise the Attitudes Toward Pornography Questionnaire which was used with permission from Nina Katzander who included it in

her dissertation published in 2009. Katzander created this questionnaire from information contained in the book *Pornified* (Paul, 2005). This researcher used the 30-item questionnaire in its entirety, altering the focus from individuals who use pornography to the counselor who has a client who uses pornography. Katzander found that this scale had an Alpha Reliability Coefficient of 0.88.

Questions 62 through 90 contained the Addiction Counseling Self-Efficacy Scale (ACSES) which was also used with permission, developed by Alicia Wendler, and published in her dissertation in 2007. This 35-item scale asks counselors about their self-efficacy in treating clients who are addicted to substances. Wendler's dissertation is entirely on the validation of this scale and examining the psychometric properties of its items. The test-retest reliability coefficients of this scale were determined to be between 0.88 and 0.98 and the alpha coefficient (internal consistency) was determined to be 0.95. This researcher modified 13 of the 35 items in this scale to include Internet pornography and problematic Internet sexual activities as addictions. Six of the original 35 questions were eliminated, four of which had to do with forming groups to help clients who are addicted, one of the eliminated questions pertained to careers, and one asked about helping clients with finances. The version of the ACSES that appears in this study has 29 items.

Based on a pilot study where seven people participated, it was estimated by this researcher that this survey would take approximately 15 minutes to complete and consideration was given to pilot participants' comments to improve the survey. Because it is an easily accessed site, and it is convenient for most people to use a computer, the online survey program QuestionPro was used for this investigation. Participation in this



study (or access to the survey) was voluntary and was granted only if the potential participants electronically indicated that they had read the consent document (Appendix B) and were willing to complete the survey. The consent document explained confidentiality, the purposes of the research, and how the data will be used. The electronic indication of consent was obtained when the potential participant clicked the “Continue” button on the consent page of the website.

### **Sampling, Subjects, Access, and Setting**

A simple random sampling of 1,000 individuals from the entire population of the American Counseling Association (ACA) was used to estimate the characteristics of the whole population. The entire population as of February, 2012 was 49,600 members (Sites, 2012 personal communication). Participants for this study were chosen by purchasing a postal mailing list of 1,000 random names from the American Counseling Association. The ACA had recently stopped providing email addresses with the purchase of names and contact information from their Member Programs Coordinator, just before data collection for this study began. The ACA was asked to pull a sample of professional members only, to include all genders, as well as various ethnic groups. They were asked to exclude members with non-U.S. addresses and those who have specifically requested no soliciting. They were also asked to exclude known bad addresses (i.e., occupants moved, left no forwarding address). The contact list was used to mail a greeting card (Appendix C) to the potential participants asking them to log on to a website containing an electronic survey. Sampling the members of the ACA was preferred because of an increased likelihood that these people might be interested in participating and because the results were more meaningful for counselor educators so as to effect change and provide

information for the profession. An electronic survey was the chosen method because it is assumed that most counseling professionals have access to the Internet, and feel comfortable using it as a communication medium.

The use of online surveys has grown in popularity and the results of studies indicate that the online method may result in higher return (Dixon & Turner, 2007). However, the additional benefits of speed, convenience, and cost make the online method even more appealing (Kaplowitz, Hadlock, & Levine, 2004). Having respondents submit their surveys online had the potential to increase response rate because participants did not have to mail a packet back to the researcher. Researchers have recommended several strategies to improve the quality and response rates of online surveys such as personalized greetings, including statements which ask for the respondents' help, informing participants they are part of a small, selected group, and the use of advance letters (Fan & Yan, 2010). This researcher employed all of these methods to improve the response rate, with the greeting card serving as an advance letter which asked that the respondent go online to complete the survey. An individually addressed envelope sent to their address served as a personalized greeting.

Response rates can vary dramatically by discipline and survey to survey, but response rates are generally declining in Western societies (Van Horn, Green, & Martinussen, 2006). Declining response rates make using response facilitation techniques increasingly important. Studies examining the use of monetary incentives have consistently reported increased response rates over those studies with no incentive, and the increase is greater when the incentive is received with the survey rather than sending one out after the survey is returned. In order to attempt to increase response rate

a \$1 incentive was included in the initial mailing of the card containing instructions for the survey. This researcher hoped that the incentive would reduce the necessity for multiple reminder mailings, thus saving money over the course of this project. Using the United States Postal Service to send a card enabled the researcher to use multiple strategies to improve response rate, in addition to the \$1 incentive. This investigation sought a 25% response rate from the individuals contacted which would equal 250 participants.

### **Data Collection Methods**

When the invitation cards and the incentive were ready to be mailed through the postal service, the survey was loaded into QuestionPro and tested for accuracy by this researcher. The first of three reminder postcards (Appendix D) were sent to the potential participants ten days after the initial invitation was sent out. The last two reminder postcards were also sent ten days apart. The postcards were mailed within a security envelope so as not to expose the survey link to individuals other than the intended recipients. It was projected that the data collection process for the survey would take approximately six weeks. The survey was closed exactly six weeks after the initial mailing with just under 30% participation.

### **Data Analysis**

All questionnaire responses were entered directly into QuestionPro by respondents. The program allowed the researcher to run a series of analyses in order to find descriptive statistics (e.g., mean, range) for each of the survey questions and subscales. Because the literature has not thus far adequately addressed the issue of counselor competence and comfort surrounding the use of Internet pornography by their

clients, this study was interested in simply exploring the current status of competence and comfort and providing a summary of the existing phenomenon by using descriptive statistics to characterize the group of counselors selected for participation in this study. This study assessed the nature of existing competencies within individuals graduating from CACREP accredited programs. With research questions one and two addressing the current state of counselors, research question number three addressed what experts in the field believed would be the best practices of the profession and thus provide a benchmark standard with which to compare what is with what should be.

Because this study deals with descriptive statistics, the analyses performed on the data were relatively simple, but they gave a picture of the current status of competence and attitudes of counselors toward both clients and their Internet sexual activities. Demographic data were best represented by use of histograms so as to visually get a picture of the respondents' identified ethnicity, age distribution, gender, graduate program, comfort discussing sexual issues and years of experience and training. Representation of this data through the use of histograms also allowed readers to visualize quickly and easily how the different demographic variables represent the total sample. The first research question was tested by running a series of analyses in order to find descriptive statistics (e.g., mean, total number) for each of the subquestions. The first two subquestions of the second research question were tested by employing Multiple Linear Regression Analysis. The third subquestion to the second research question was tested using Bivariate Correlation Analysis to determine if the addiction counseling self-efficacy of counselors had an effect on counselors' attitudes toward pornography and vice versa, or whether there was no correlation at all between the two dependent variables. A

weakness of these statistical techniques is that if the two dependent variables do have a correlation, it can then be assumed that any correlation that appears in the first two research questions may be affected by one or both of the dependent variables and it is impossible to determine whether a correlation between the independent and dependent variables would have existed apart from the correlation between the two dependent variables.

In summary, the survey method is the best approach to employ in an effort to answer two of the three research questions. The data will determine (a) the sense of competence counselors have in regards to treating the process addiction of Internet pornography and (b) how counselors rate their attitudes toward pornography and clients who present issues with their Internet pornography activities (c) a mean score of counselors' attitudes toward pornography and (d) a mean score of counselors sense of efficacy and competence in treating online sexual activity addiction. The survey also provided the data necessary to ascertain if counselors believe the training they receive from counselor education programs is adequate to prepare them to counsel clients addicted to Internet pornography. Last, an online survey is the most cost effective and time efficient research method. The next section will provide an overview of the qualitative methodology of this mixed-method research design.

### **Qualitative Methodology**

In the past, the perceptions of scholars who are knowledgeable about topics relating to mental health have been obtained primarily by quantitative measures. No study was found where experts were interviewed to ascertain their perception of best practice regarding how to conceptualize and treat individuals, couples and families where

an Internet pornography addiction is presented as an issue in counseling. Since so few studies have been done regarding Internet pornography addiction, information obtained by interviewing experts who have valuable experience, specifically those who are experts in the area of addiction and addictive behaviors, is crucial in the attempt to determine best practices. Marshall and Rossman (2006) point out that often when researchers only use quantitative methodology, decision makers are sometimes not able to find the meaning in the statistical data and the findings can be made more useful by employing qualitative methodology.

### **Research Design**

Creswell (2007) describes a method of qualitative research called “purposeful maximal sampling” where the researcher chooses which cases to study based on “the problem, process, or event” that is intended to be portrayed (p. 75). Marshall and Rossman (2006) point out that, “The participant’s perspective on the phenomenon of interest should unfold as the participant views it (the emic perspective), not as the researcher views it (the etic perspective)” (p. 101). The research design for this study was constructed based on elite interviewing of counselor educators who are also experts in the addiction field. Therefore, the most important aspect of this interviewer’s approach was to convey that the experts’ views were valuable and useful to this study. The primary data for this portion of the study were interviews. This study employed within-case and cross-case analysis, as well as assertions to make an interpretation of the experts’ answers to research question 3: What do experts in the mental health field who have experience in this area view as best practice in the education of counselors with regards to sexual addictions? The responses of the interviewees provided data to be

analyzed in order to identify key themes and recommendations regarding best practices for the counselor education profession.

Including a qualitative piece to this study served two purposes: to gain an assessment of the training counselors receive in regards to process addictions in general and Internet pornography addiction in particular, and ascertaining what the best practices are in the training and continuing education of counselors in regards to the process addiction of Internet sexual activities. Internet sexual activity is not a recognized addiction by the DSM-5. This researcher was interested to discover whether experts in this field had similar or dissimilar perspectives on addictions training in the counselor education program in general and the process addiction of Internet pornography addiction in particular. Using qualitative research interviews in order to obtain data for thematic analysis was the most likely way to obtain those perspectives. The responses of the experts provided information that was used for thematic analysis in order to examine and compare their opinions and to create thematic networks. Thematic Analysis is a widely used and adaptable method of qualitative research in which the data is systematically analyzed for recurring themes which are then used to inform the researcher of the “experiences, meanings and the reality of participants” (Braun & Clarke, 2006, p. 81). Further elaboration of this process is provided in the Data Analysis section below.

### **Sampling, Participants, Access, and Setting**

Although random sampling is employed for the quantitative portion of this study, in the selection of experts for the qualitative portion, nonrandom sampling was employed. Because this research is interested in interviewing experts who met predetermined criteria, purposive sampling was used to identify specific individuals from the population

(Minke & Haynes, 2011). Purposive sampling is not uncommon in qualitative research. Once several experts are identified, snowball sampling was also employed whereby each of the respondents was asked to identify others who might be willing to participate in this project until at least five experts who were willing to participate were identified. Two experts recommended other experts to be invited to participate in the study and through that process three experts were recommended that were already in the study. Two additional experts were recommended by participants and they subsequently agreed to participate. The participants for the qualitative part of the study were to be considered an “expert” in the field of addictions, and they were selected based on meeting at least four of the following eight criteria developed for a similar study (Lee, 2011):

- 1) Employed full-time as a counselor educator at a CACREP-accredited program at the time of the interview.
- 2) Published one or more journal articles related to the process addiction of online sexual activities.
- 3) Conducted research related to the process addiction of online sexual activities.
- 4) Presented information on the process addiction of online sexual activities at a conference.
- 5) Provided five or more years of counseling.
- 6) Obtained credentials in the sexual addictions or sex therapy arena (e.g., AASECT)
- 7) Taught at least one sex therapy or addictions course.



- 8) Provided professional service in the areas of sexual addictions or sex therapy for a year or longer (e.g., committee or board member, editor, etc.).

The researcher ascertained the participants' opinions on best practices related to the education of sexual issues and sexual addictions in the training of counselors. In addition, these experts were asked for their perception regarding the best method for counseling students to be exposed to the delivery of this content.

The sample of nine experts was selected from the researcher's compilation of a list of specific counselor educators who have published on the topic of sexual addictions and/or Internet pornography addiction, taught coursework in the area, and presented addiction information at conferences, as well as from suggestions by other experts. Five experts was considered sufficient to obtain a sampling of the opinions of those knowledgeable in this field, however this method of sampling resulted in seven experts completing the interview process. Their ages ranged from the youngest being in his 30s to the oldest being in his 50s. Two experts interviewed met at least six of the eight criteria and the other five experts met seven of the eight criteria (see Table 1). Two potential participants never responded to the initial invitation. These opinions were used to establish a best practice standard for this study. The counselor educators were contacted by the researcher via telephone or email, or both, to determine if they qualified as experts for the purposes of this study and if they were willing to participate in the research interview. The protocol used for the screener telephone call or email is outlined in Appendix E. So as to maintain the confidentiality of the participants the researcher assigned each one a case number identifier in order to protect the experts' identity and to

encourage more open and free responses from the interviewees. These case number identifiers were used for the purposes of data keeping and analyses (Spicer, 2008). Part of the risk inherent in being an expert is the risk of being identified by the experiences, opinions and standards being discussed. Once the interviews were conducted the results are reported here in general terms so as not to divulge the identity of the experts.

Table 1

*Expert Criteria*

Criteria	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7
1) Full Time Counselor Educator	X	X	X	X	X	X	X
2) Published one or more journal articles on online sexual activities		X	X	X	X		X
3) Research related to online sexual activities		X	X	X	X	X	
4) Presented on online sexual activities at a professional conference	X	X	X	X	X	X	X
5) Five or more years of counseling experience	X	X	X	X	X	X	X
6) Credentials in the sexual addictions or sex therapy arena	X					X	
7) Taught at least one sex therapy or addictions course	X	X	X	X	X	X	X
8) Provided professional service in this area for a year or longer	X	X	X	X	X	X	X
<b>MEAN AGE = 43 years</b>	Early 30s	Mid 40s	Mid 40s	Mid 40s	Mid 40s	Mid 30s	Mid 50s

### Data Collection Methods

Once a pool of potential participants was created, initial contact was made by phone, by email or both asking (Appendix E) if they would like to participate in a qualitative piece of this researcher's dissertation research. There was an explanation as to

what the research hopes to accomplish as well as an explanation that the results will be used to further the counselor education profession. In addition, the potential participants were asked the criteria questions to see if they met the standard of “expert.” Once a participant met enough criteria and agreed to have them sent, two copies of the consent document (Appendix F) were mailed to that person, so that one copy was signed and returned via an enclosed self-addressed stamped envelope and the other was kept. Once the consent document was returned via postal mail and received by the researcher a mutually convenient time was scheduled for the interview to be conducted. All interviewees were asked verbally, as well as on the consent form, for permission to record the interview for accuracy, analysis and data collection purposes. All data collected were stored in a locked file cabinet in the researcher’s office. In order to maintain organization and some structure to the interview process, Interview Guide Questions (Appendix G) were developed and used by the interviewer throughout the process to keep the interview flowing and to ensure the coverage of important topics. These questions served as a useful guide to the in-depth interviewing process as a research approach, and helped establish context to the qualitative inquiry (Holstein & Gubrium, 1995). This researcher followed the recommendation to keep the first few questions broad so as to allow the participants to share their unbiased opinion of counselor preparation and education with regards to Internet pornography addiction and then use subsequent questions to obtain more specific information and to fill in gaps left from earlier questions (Denzin & Lincoln, 1998). Because of the emergent nature of this research, it was expected that there would most likely be questions generated from the interview process that were not on the Interview Guide, but rather emanated from the

interview process. This researcher, however, maintained an unbiased, neutral stance during the interview process and did not express approval or disapproval of the responses by the interviewees. Since the purpose of these interviews was to gain information-rich, best practice opinions, the interviews were structured much like a conversation with open-ended questions and probing, but with careful thought so as not to lead the interview by probing some answers and leaving other answers unclear (Holstein & Gubrium, 1995). It was estimated that each interview should last about one hour; they actually ranged from 37 minutes to 56 minutes, with the average interview taking 46.5 minutes and 33 seconds. The interviews were recorded on separate audio files on the computer which were stored in a password protected file on a computer in this researcher's office and were erased once the interviews are transcribed and the transcripts verified.

### **Data Analysis**

Thematic analysis is a method for identifying, analyzing and reporting patterns within the data and was used to analyze the qualitative data collected for this research study. Analysis of active interviews occurs to show the “dynamic interrelatedness of the *what* and the *how*” (Holstein & Gubrium, 1995, p. 79). What this means is that the interview data are analyzed to report not only what the respondent said but also how they arrived at this conclusion, descriptions of experience, groupings of descriptions, organizing frameworks, as well as the subjective meanings that will be conveyed. Themes or patterns within data are often identified by inductive analysis. Inductive analysis allows these themes to emerge from the data collected, rather than be imposed by the researcher's preconceived expectations (Braun & Clarke, 2006). For these

reasons, this researcher chose to use inductive thematic analysis to analyze the interview data to answer research question 3 regarding the views of expert participants. Braun and Clarke (2006) point out the following six phases of inductive thematic analysis:

- 1) Getting familiar with the data: transcribing, reading and re-reading the data.
- 2) Generating initial codes: coding across the data, collating data relevant to codes.
- 3) Searching for themes: collating codes into themes, fully exploring each theme.
- 4) Reviewing themes: checking to see if the themes match the coding, creating a map.
- 5) Defining and naming themes: refine the specifics of each theme, find the story.
- 6) Producing the report: selection of extract examples, relate back to research questions.

### **Credibility Procedures**

Although qualitative inquiry avoids many of the threats to natural validity that are introduced by quantitative experimental interventions with researcher contrived data-gathering instruments, qualitative inquiry does not avoid all forms of artificiality (Kennedy, 1984). Kennedy (1984) outlines the existence of four threats to validity that will be discussed here. The inquiry itself is one of the threats to validity in qualitative research. The very presence of a researcher asking questions about a particular topic can affect the participants and heighten their awareness of a problem or a concern where this

concern may have been minimal before. This can cause participants to alter their testimony to what they feel is a more socially acceptable position based on what they think the researcher wants to hear. Kennedy goes on to point out that a second threat to validity in qualitative research is that researchers are depending more on the testimony of participants rather than on observing the natural behavior themselves. Consequently, the quality of the investigator's data depends on the quality of the testimony the researcher receives, which, as has already been stated, is shaped not only by the participants' concern for social desirability, but also by things such as their ability to have good insights, to be articulate, and to be open. The third threat to the validity of qualitative research, according to Kennedy, is that the researcher is essentially depending on hearsay evidence, which must be accepted at face value, to describe events and people that could not be directly observed by the researcher. The danger in relying too heavily on someone else's interpretation of events is that the summary and interpretation of these events may or may not be the same way the researcher would summarize and interpret the same events. A fourth threat to natural validity is the inherent ambiguity of the language used by participants. Natural language is full of ambiguities, metaphors, and innuendos. Participants may use words that have meaning for them, but might not mean the same for the profession or for the interviewer, and therefore misinterpretations of the testimony might follow.

Validity in the quantitative arena has a set of technical parameters that are well known to most researchers. Since this study contains a qualitative component, this researcher will employ a number of measures to ensure the validity of the data.

According to Denzin and Lincoln (1998), "validity in qualitative research has to do with

description and explanation, and whether or not a given explanation fits a given description” (p. 50). The description of people, events, and things has always been integral to qualitative research. To counter challenges to the validity of a study, the researcher can refer to a solid review of the literature and also to the original theoretical framework created by the researcher to show how data collection and analysis will be guided by concepts and models (Marshall & Rossman, 2006). There will be more discussion of the credibility of the researcher in the next section. Often, researchers also depend on cross-checking, member checks, triangulation of data, and audit trails to ensure that their explanation fits a given description and that the explanation is credible. Of the aforementioned credibility techniques, this researcher employed member checks through sending summaries of the interviews back to the respondents to have them check for accuracy and the appropriateness of the themes. Only two of the experts provided any feedback. One person focused on their use of a word that was “too strong” and replaced it with another phrase. The other expert who provided feedback was interested more in providing more context to a couple of his comments for fear the comments could be taken out of context. The other experts replied that the summary provided was a good and accurate summary of their interviews. This study also employed cross-checking through the use of a devil’s advocate to make sure the analysis of the responses of the experts was accurate and encompasses the major themes that emerged.

Rather than use the term “validity” in qualitative research, Eisner (1991) discussed the “credibility” of qualitative research. As Eisner (1991) stated, “We seek a confluence of evidence that breeds credibility, that allows us to feel confident about our observations, interpretations, and conclusions” (p. 110). In order to most fully answer

questions of validity and credibility, it is important to understand the lens of the researcher so as to understand the assumptions being made.

**The lens of the researcher.** Creswell (2007) spoke of the researcher in qualitative inquiry as being “the key instrument” in their own studies (p. 38). The researcher should explicitly and implicitly demonstrate competence and should clarify the researcher’s assumptions, preconceived notions, and biases from the onset of the study (Denzin & Lincoln, 1998; Marshall & Rossman, 2006). This section will define and explain this researcher as an instrument in this study.

My interest in counseling began while I was a Student Financial Advisor for a small, private university in southwest Michigan beginning in 2003. As an advisor, it was necessary for me to be privy to the personal financial matters of all of the families within my purview, which was one quarter of the entire student population. As I would meet with families seeking my help in getting their children enrolled in our school they would often share other personal struggles with me that they were experiencing as a family, such as divorce, remarriage, infidelity, step families, illegal immigration, custody battles, loss of income, incarceration, and many other problems experienced by families. Not only were families communicating with me about the problems they were experiencing as a family, but they were seeking input and advice as to what the solutions might be for these and a host of other problems. I quickly realized that my degree in secondary education was not sufficient background to assist these families in the way they desired. The university I was employed at offered full time staff one free class per semester so I decided to take a class in counseling to help me learn the proper way to give feedback to



families. During my first class I realized I was hooked and I decided to pursue a degree in community counseling (now called clinical mental health counseling).

During my program I discovered that several of the professors that I most respected for their clinical experience and knowledge had private counseling practices in addition to their full time faculty position. This provided stability of income against the unpredictability of income of counseling full time. I became fascinated by the concept of combining my first career love (teaching) with my second career love (counseling) into a new career for me in Counselor Education and Supervision. At the same time, several professors in my master's program approached me with the idea of pursuing a PhD. Throughout my contact with clients beginning with my master's practicum experience and beyond I encountered individuals with compulsive Internet pornography problems both professionally and personally.

While going through the Counselor Education and Supervision doctoral program I decided to seek licensure as a marriage and family therapist through the State of Michigan. It was during a marriage and family therapy course which had as a requirement to present on a technique or intervention to help couples or families deal with an issue that I had the idea of researching pornography addiction and find interventions to help these families. I found a glaring lack of interventions and techniques available to counselors to use with clients who have pornography addiction as a presenting problem in counseling. After this presentation my desire to do this as a topic of my dissertation was born. This experience has affected my opinion on the level of importance of specific addiction-related curricular components, especially in light of the implementation of the addiction-related competencies listed in the 2009 CACREP

standards for the Clinical Mental Health Counseling program. I believe that requiring an addictions course for all CACREP-accredited degree programs would be the most efficient and effective way to ensure the implementation of these competencies into the curriculum. I also believe that process addictions should be required to be addressed in this required addictions class. It is my opinion that not all counselors will be comfortable or qualified in the pharmacology, diagnosis, and treatment all types of addictions, but a basic, common understanding of the etiology, assessment, and treatment options for addictions is necessary so that an intelligent referral can be made if the counselor does not feel qualified. I believe that if screening for addictions is not done, then irreparable harm can result since treatment will be based on erroneous information.

I have now returned to teach full time as a tenure-track professor at the university where I completed my master's degree and I am responsible for teaching the Therapies for Addictions class for our master's students. When I arrived at this university as a faculty member this class was not required of any program. Since my arrival, it is now required of both of our CACREP-accredited programs: Clinical Mental Health Counseling, and School Counseling. I was integral to this change and it is a direct result of my research and the resulting lack of training counselors receive in how to treat addicted individuals in counseling.

I have had close family members addicted to substances and have had both personal and professional experiences with people with process addictions, including Internet pornography addiction. I have seen firsthand individuals suffer from seeing counselors who have not been trained in how to handle this addiction and who have fallen back on their personal values and morals. I have presented on this subject nine

times to state, regional and national audiences in three different professional organizations' conferences and each time I ask the attendees, "Who in the audience has seen clients or supervised counselors who have clients dealing with compulsive Internet sexual activities" and every time the majority of hands are raised. These experiences have undoubtedly had an effect on my lens as a researcher, and on my beliefs about addictions, process addictions, and mental health. Our profession should be a leader in assisting individuals in getting help for this and other mental health issues and instead we are lagging behind other nonprofessional organizations such as churches and 12-step groups who are struggling to make up for a lack of professional research to provide proven diagnoses, etiology, prevalence, interventions and treatment plans. This lack of research is especially glaring in light of the fact that there have been calls for more research in this area since the dawn of the Internet decades ago (Swisher, 1995).

Qualitative researchers have long accepted the fact that research is ideologically driven (Denzin & Lincoln, 1998) and this researcher accepts the fact that there is no value-free or bias-free design for qualitative research. However, I have identified my biases early on and have no problem articulating this conceptual framework within this study, and have taken great care throughout the study to make sure that the biases that I have which have affected the lens with which I do research will not have an effect on the credibility of this project. One of the ways I will do this is that because I care about the outcome of this project, and because I care about this profession and I am interested in the people being studied, I must remain neutral about what is revealed to me so as not to damage their opinions or the credibility of this study.

**The lens of the participants.** The credibility of the researcher is a unique concept in qualitative research. In an attempt to maintain the lens of the participants, one of the main means of achieving credibility is by performing a member check of the interviews once the transcript and the initial themes are identified (Buchbinder, 2010; Creswell, 2007). In this member check process, the researcher asks participants to evaluate and provide feedback about the accuracy of the researcher's understanding about what they shared. With this in mind, each participant was sent a one to two page summary of the interview with that person. The researcher asked the participants to provide written and/or verbal feedback regarding their impression of this researcher's interpretation of the interview. All of the experts responded, but only two had suggestions. One wanted a phrase that he had used that might be misinterpreted changed, and the other was adjusting the coherence of what was stated. The other five experts approved the summary as it was presented to them. Through the use of member checking, the interviewees were able to confirm the credibility and authenticity of the information provided in the qualitative portion of this study and the lens of the participants were understood and maintained.

**The lens of the reviewer.** In a continuing effort to maintain the credibility of the research and protect against bias in the interpretation of the qualitative data, this researcher used an individual who is external to the study to make sure there was agreement regarding the analysis of the responses of the experts (Creswell, 2007). This "devil's advocate" process ensured that the preliminary codes and themes were representative of the responses of the experts and were not unduly influenced by the researcher's bias or familiarity with the topic. The use of a devil's advocate is a fairly

common practice in qualitative research. This researcher's devil's advocate also served as the graduate assistant at Andrews University in Berrien Springs, Michigan to review and challenge the preliminary themes and draft of the written analysis of the qualitative data. The devil's advocate became familiar with the interview transcripts and identified his own major themes, organizing themes, and basic themes. The reviewer was then provided with the list of codes, the emerging themes and the thematic networks developed by this researcher, and was asked to provide thoughtful challenges to the researcher's identification and analysis of the themes. In essence, the reviewer was asked to question whether the analysis of the data was in line with what the reviewer found, why certain themes were labeled and developed, how certain themes were different from others, which ones could be combined, and to look for and challenge possible bias in the interpretations (Creswell, 2007; Creswell, Goodchild & Turner, 1996). The reviewer provided verbal and written feedback for this researcher so that changes could be implemented accordingly. A discussion ensued with the reviewer and researcher reaching compromises on what the global, organizing and basic themes were for the qualitative interviews.

### **Summary**

This chapter provided a detailed description of the methodology that was employed in this study. This chapter was divided into two sections. The first section explained the methods and reasoning used for obtaining the quantitative data, and the second section described the methods and reasoning used for obtaining the qualitative data. Within each of these sections, the details about the design, sampling, data collection, and data analysis were provided. The nature of this research study lent itself

nicely to a quantitative analysis since the researcher is interested in assessing the opinions of counselors with regard to their attitudes toward pornography and their addiction counseling self-efficacy. This study also lent itself nicely to including a qualitative component to ascertain what experts view as best practice for the counseling profession and whether the profession is measuring up to those practices.

Continued research in the field of counselor education is needed to maintain accountability, foster excellence, and create distinction from other fields of mental health practitioners. Counselor educators are in the unique position to be most able to affect change in multiple professions such as clinical mental health counselors, marriage and family therapists, school counselors and counseling psychologists (Hagedorn, 2009a; Hagedorn, 2009b). These professions are also likely to encounter clients who are addicted to Internet pornography (Ayres & Haddock, 2009; Carnes, 2003; Cooper, et al., 2000; Cooper, et al., 1999; DelMonico & Carnes, 1999; Flood, 2009; Gray & House, 1991; Haney, 2006; Ng, 2006). This study is timely in light of CACREP's 2009 Accreditation Standards which mandate that the training of all counselors include the prevention, intervention and treatment of addicted clients (CACREP, 2009). This study is significant because the information gained will provide guidance to CACREP-accredited programs through the use of "expert testimony" to help identify areas where counselor education programs could improve process addiction education and training. Next, Chapter IV presents the quantitative results and qualitative findings of the study.

## **CHAPTER IV**

### **RESULTS AND FINDINGS**

This chapter answers the three research questions that were outlined in chapter one. The results will be organized within this chapter by first reporting the quantitative data collected from the survey portion of the study which answers the first two research questions. Next, the qualitative data collected from the seven expert interviews will be presented which answer the third research question.

#### **Quantitative Results**

The quantitative data collected answered the first two research questions and the results are reported here in three sections. The first section contains a breakdown of the demographic variables and descriptive statistics regarding the survey participants. The second section of this part of the chapter describes the study variables such as counselor comfort with sexual topics, counselor satisfaction with training, counselor attitudes toward pornography, and counselor addiction counseling self-efficacy, and contains statistical descriptions of these variables. The third section of this part of chapter four includes the results of the testing of the research questions and an analysis of the data for each question. This section is divided into six subsections corresponding to the subquestions contained within the first two research questions.

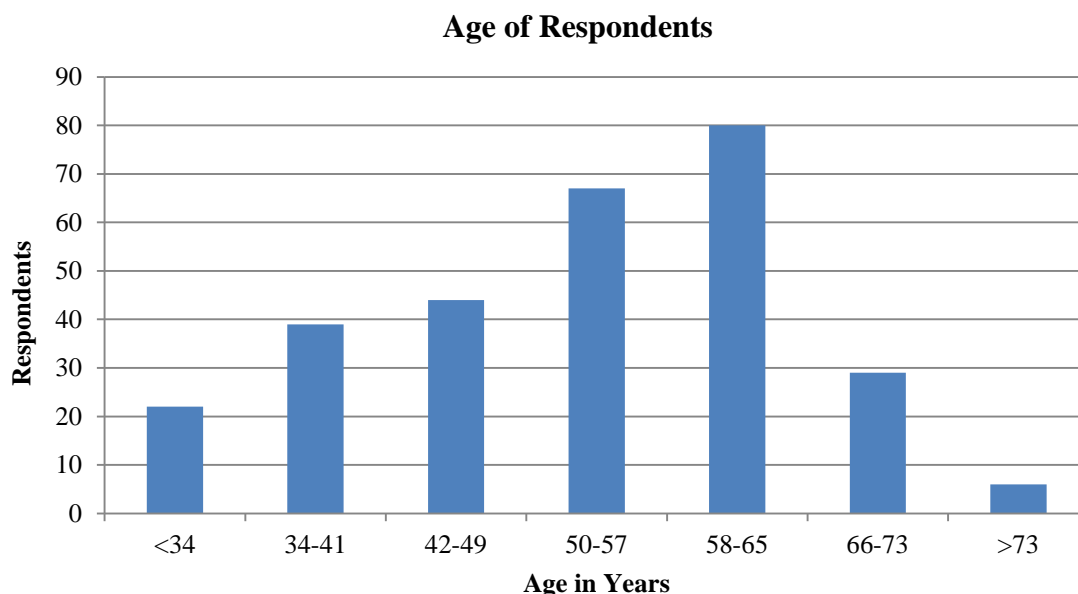
## **Survey Participants**

The 90-item questionnaire was loaded onto the online platform QuestionPro and a U. S. postal mailing directing potential participants to the online survey was sent to 1,000 professional members of the American Counseling Association, with three subsequent reminder mailings. Of those 1,000 individuals, 317 people started the survey. Almost all of those people (298) finished the survey for a completion rate of 94%. Five of the 317 people who started the survey did not finish because they had either not seen clients in a counseling setting after graduation, or they had not finished their master's program yet. Among the 298 participants who finished the survey, 11 of them had significant sections of the survey left blank and were eliminated from the results because their unanswered questions made it difficult to tabulate a score on one or more of the study variables. One respondent was eliminated from the results because a trend was discovered in that respondent's answers, thus making this researcher suspicious about the quality of the information obtained from the answers. Taking all of this into account, there were 286 usable surveys, for a final response rate for the quantitative portion of this study of 28.6% which is better than the desired 25% response rate.

Participants were asked if they graduated from a graduate level, CACREP-accredited counselor education program and 78% answered that they had. Of the 286 participants, 70.8% (199) were female and 29.2% (82) were male. Five respondents did not identify their gender. A place was provided in the questionnaire for respondents to identify their current age and those numbers were divided into categories for ease of reporting and for use of statistical procedures. The youngest respondent was 25 and the oldest was 84 years old. The age categories were broken down for ease of reporting as



25-33 years old (N=22, 7.7%), 34-41 years old (N=39, 13.6%), 42-49 years old (N=44, 15.3%), 50-57 years old (N=66, 23.3%), 58-65 years old (N=80, 27.9%), 66-73 years old (N=29, 10.1%), and over 74-84 years old (N=6, 2.1%) (See Figure 1).

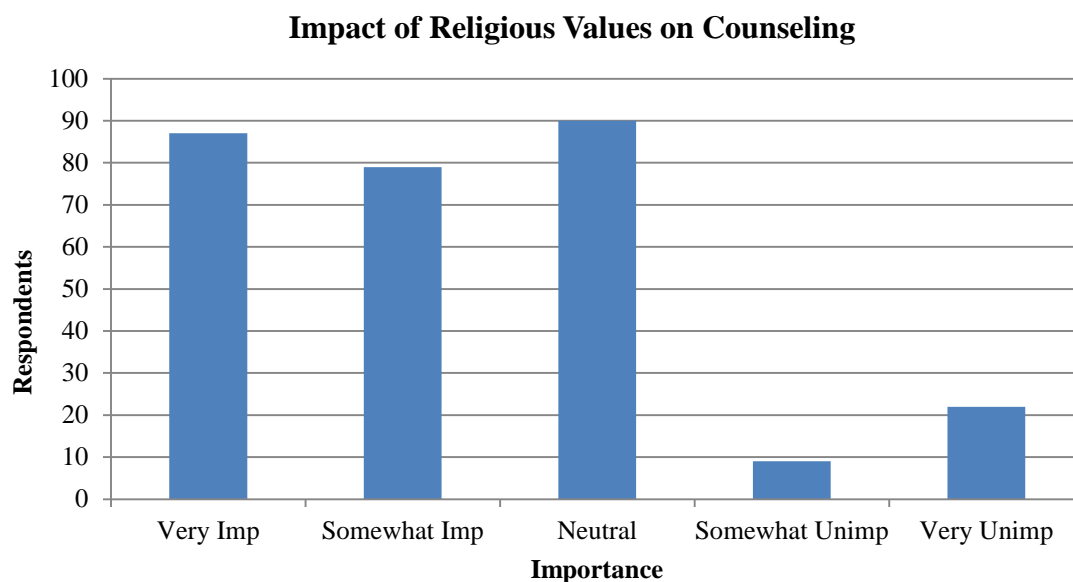


*Figure 1.* Categories of the age of each respondent. This figure illustrates the frequency of the age of the respondents as reported in the survey.

Respondents were asked to choose a racial or ethnic category with which they could identify and over 83% (N=239) identified as white. The next most populous category was Black or African American with 6.3% (N=17), Mixed Race/Ethnicity with 3.5% (N=10), Hispanic or Latino with 2.8% (N=8), Asian, Native Hawaiian, or Other Pacific Islander with 2.1% (N=6), and Other or No Answer with 2.1% (N=6). Originally the survey instrument offered separate categories of “Asian” and “Native Hawaiian, or Other Pacific Islander” but these categories were combined to make the comparison of the means as a statistical procedure a viable option.

Answers to the question, “How would you rate the impact of your religious values, spiritual beliefs and morality to the clinical work you do with your clients?” are

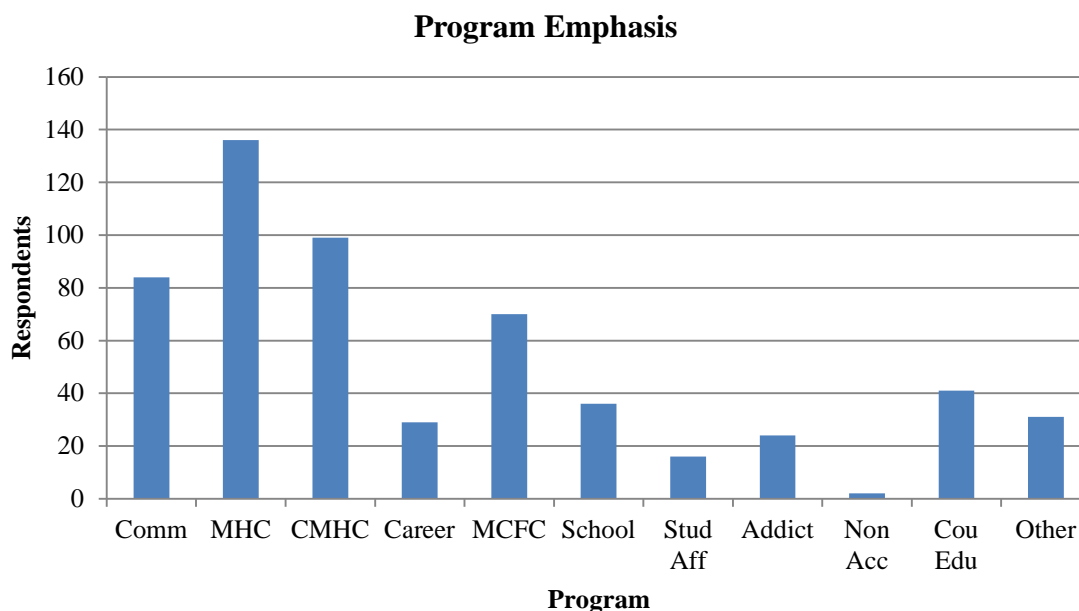
illustrated in Figure 2 below, and show that the most frequent (N=90, 31.4%) choice of participants identified the impact as Neutral, followed quite closely (N=87, 30.3%) by Very Important, and then Somewhat Important (N=78, 27.5%). In other words, nearly 60% of respondents identified their religious values, spiritual beliefs and morality as having a *very* or *somewhat important* impact on the clinical work they do with their clients (See Figure 2).



*Figure 2.* Categories of the impact of religious values, spiritual beliefs, and morality to the clinical work of counselors. This figure illustrates the frequency of the importance respondents reported in the survey.

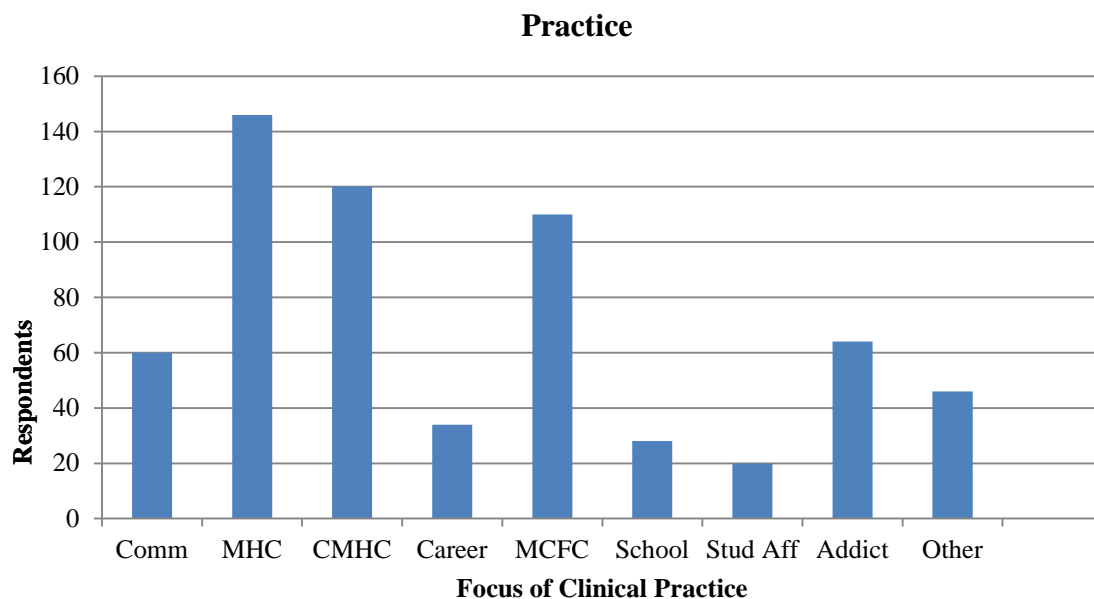
Respondents were asked to choose as many descriptions of the program emphases provided as they felt applied to them during their education and training. The most frequent choice was Mental Health Counseling (N=136, 47.6%) followed by Clinical Mental Health Counseling (N=99, 34.6%) and then Community Counseling (N=84, 29.4%). The following is a list of the rest of the choices given along with their frequency, in order of prevalence after the first three listed previously: Marriage, Couples and Family Counseling (N=70, 24.5%), Counselor Education and Supervision

(N=41, 14.3%), School Counseling (N=36, 12.6%), Other (N=31, 10.8%), Career (N=29, 10.1%), Addiction (N=24, 8.4%), Student Affairs (N=16, 5.6%), and Non-Accredited (N=2, 0.7%) (See Figure 3).



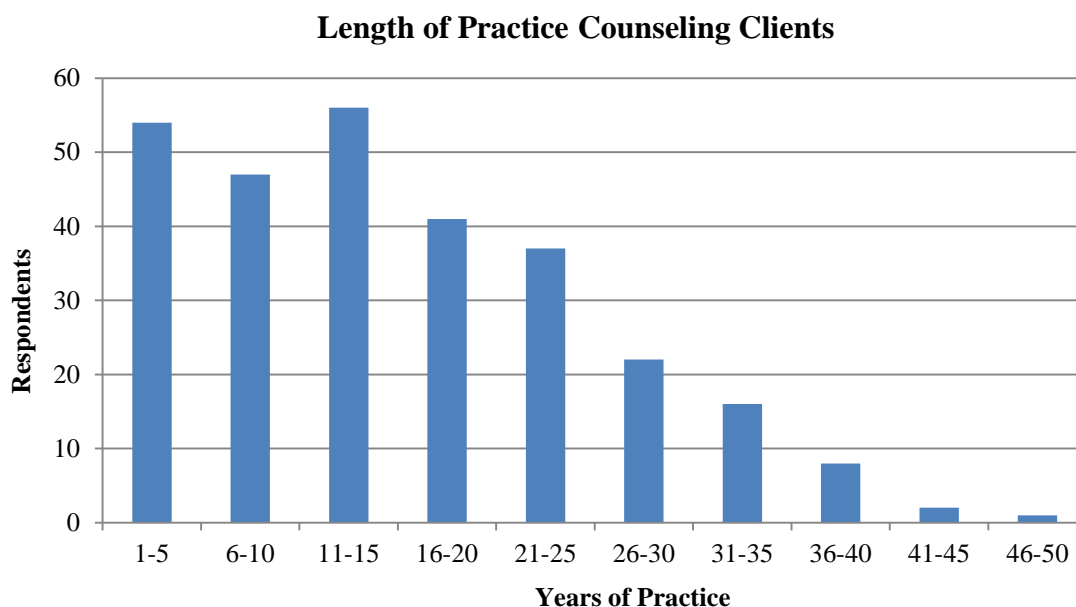
*Figure 3.* Prevalence of program emphasis and training received by respondents. The survey allowed respondents to choose as many as applied to them. This figure illustrates the frequency of the answers provided representing respondents' education and training programs.

Respondents were also asked to choose as many descriptions of their clinical practice as they felt applied to them. The most frequent choice was Mental Health Counseling (N=146, 50.9%), followed by Clinical Mental Health Counseling (N=120, 41.8%), and then Marriage, Couple, and Family Counseling (N=110, 38.3%). The rest of the choices were less popular but are listed here, in order of their prevalence: Addiction Counseling (N=64, 22.3%), Community Counseling (N=60, 20.9%), Other (N=46, 16%), Career (N=34, 11.8%), School (N=28, 9.8%), and Student Affairs (N=20, 7%) (See Figure 4).



*Figure 4.* Respondents' identification of the focus of their clinical practice. Respondents could choose more than one description. This figure illustrates the frequency of the answers provided representing respondents' clinical practice focus.

Since this survey was only sent to professional members, and not to student members, of the American Counseling Association, a question was included that asked respondents to identify how many years they had been practicing counseling. The open ended responses were then tabulated within ranges so as to help organize and report the responses. The most common answer (N=56, 19.5%) identified 11-15 years of experience, followed by 1-5 years (N=54, 18.8%), and then 6-10 years (N=47, 16.4%). In other words, over 54% of the respondents had 15 years of experience or less counseling clients. The breakdown of the remaining categories, in order of prevalence, follows: 16-20 years (N=41, 14.3%), 21-25 years (N=37, 12.5%), 26-30 years (N=22, 7.7%), 31-35 years (N=16, 5.6%), 36-40 years (N=8, 2.8%), 41-45 years (N=2, 0.7%), 46-50 years (N=1, 0.3%) (See Figure 5). Two people did not answer this question.



*Figure 5.* Length of counseling practice in years. This figure illustrates the years of experience the respondents have providing counseling.

A question was included that asked respondents to think about when they conduct an intake or assessment for clients and if there were typically any questions or items on these forms or in these procedures that allow the counselor to address the Internet sexual activities that their clients may be engaged in. The overwhelming majority (N=231, 80.5%) said they do not screen for Internet sexual activity problems during the intake.

### **Results of the Scales**

This researcher determined that the survey questions were best measured by the use of already developed questionnaires regarding attitudes and beliefs about pornography, but it was necessary to adapt the questionnaires to measure counselors' attitudes and beliefs about pornography in general and the people who use pornography. Three different scales were used in the survey instrument to assess counselors' attitudes, beliefs and competence in regards to counseling an individual who self-reports an

addiction to Internet pornography. Permissions to adapt the questionnaires were granted from the original authors of the instruments (Berman, 1996; Katzander, 2009; Wendler, 2007).

**Comfort with sexual topics.** The Sexual Comfort Scale (SCS) which was used, with permission, from Laura Berman's dissertation which was published in 1996 in which she researched social workers' willingness to address client sexual concerns. This scale was adapted to fit counselors' comfort and willingness to address client sexual concerns, especially as those concerns relate to Internet pornography use. Respondents were asked a series of 11 questions, indicating their answer by choosing one from a Likert scale that ranged on a scale from 1 to 5, where 1 was Strongly Disagree and 5 was Strongly Agree. The mean score for the scale as a measure of each respondent's comfort was calculated based on their answers. The mean score on this scale for each respondent in this study ranged from a low of 2.36 to a high of 4.64 with an overall mean of 3.3797 and a Standard Deviation of 0.33400.

Two descriptive statistics, skewness and kurtosis, were used to determine how the distributions for this study compare with a normal distribution. Skewness refers to the symmetry of the distribution of the data as compared to a normal bell-shaped curve (McMillan & Schumacher, 2006). The Sexual Comfort Scale in this current study has a skewness of 0.122 and a standard error for skewness of 0.144. The skewness is considered not seriously violated (McMillan & Schumacher, 2006; Shavelson, 1996). Even though the overall mean of this scale is 3.3797, which indicates a slightly more positive than neutral comfort, the skewness tells us that the bulk of the respondents feel

slightly less comfortable discussing sexual topics with clients than we might originally have thought from the overall mean.

Another descriptive statistic that can be derived to describe the significance of a distribution is called kurtosis. This refers to the relative concentration of scores in the center, the upper and lower ends. Kurtosis that is normal involves a distribution that is bell-shaped and not too peaked or flat. The kurtosis of the means for the Sexual Comfort Scale was 0.682 with a standard error of 0.286. This distribution is significantly non-normal in terms of Kurtosis (leptokurtic), which means the bell curve is more peaked than what should be expected if it were a normal distribution (Shavelson, 1996). Leptokurtic also means that the distribution is symmetrical in shape, similar to a normal distribution but the center peak is higher. This simply means that more respondents answered a neutral category, and less answered positively or negatively than expected. Since many statistical techniques have assumptions in regards to the normal distribution of the data before proceeding with the analysis, decisions need to be made in regards to the need of variable transformation. A determination was made, based on what is acceptable research in this profession, that this particular variable does not require transformation since it does not affect the outcome.

In summary, when considering the distribution of the answers for the Sexual Comfort Scale, taking into account the skewness and kurtosis, we find that the distribution is slightly to the right of what we would consider normal, meaning overall the respondents seem to be slightly more comfortable than expected with sexual issues, but the kurtosis tells us more respondents than expected land squarely in the center of the

distribution, making the distribution more peaked than expected. This is reinforced by the overall mean of 3.3797 when a “normal” distribution would have been 3.0.

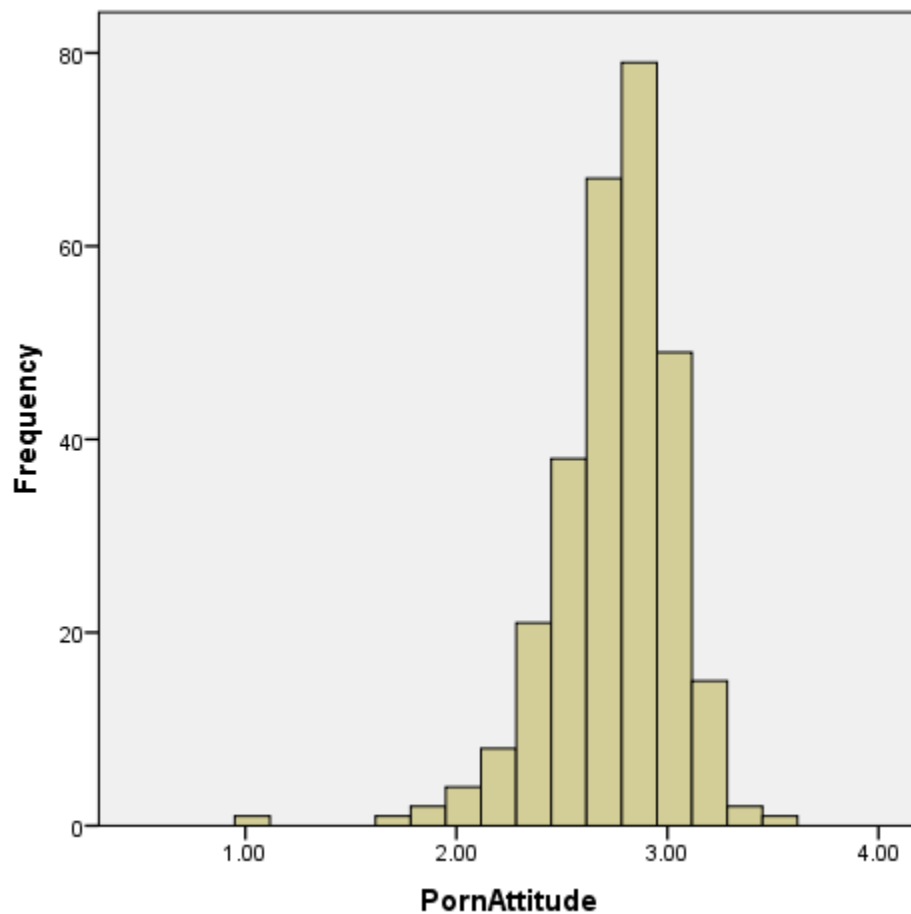
**Attitudes about pornography.** The Attitudes Toward Pornography Questionnaire was used with permission from Nina Katzander who included it in her dissertation published in 2009. This current study used the 30-item questionnaire in its entirety, altering the focus from individuals who use pornography to the counselor who has a client who uses pornography. Katzander and her research partner Lawrence Josephs found that this instrument had an Alpha Reliability Coefficient of 0.88. Respondents were asked a series of 30 questions, indicating their answer by choosing one from a Likert scale that ranged on a scale from 1 to 5, where 1 was Strongly Disagree and 5 was Strongly Agree. The mean score for the scale as a measure of each respondent's attitude was calculated based on their answers. The mean score on this scale for each respondent ranged from a low of 1.77 to a high of 3.50 with an overall mean of 2.7630 and a Standard Deviation of 0.27065.

The Attitudes Toward Pornography Questionnaire has a skewness of -0.629 and a standard error for skewness of 0.144. The skewness for The Attitudes Toward Pornography Questionnaire is significantly non-normal. Since skewness involves the symmetry of the distribution, and the data for this scale is significantly non-normal, this tells us that this scale does not have a perfectly symmetric distribution. The value of -0.629 is well within acceptable standards for statistical procedures and does not warrant adjustment. Please refer to Figure 6, below.

Kurtosis, as noted above, involves the peakedness of the distribution. The kurtosis of the means for the Attitudes Toward Pornography Scale was 1.126 with a



standard error of 0.287. Since the value is 1.126, which is outside the range, this distribution is also significantly non-normal in terms of Kurtosis (leptokurtic), which means the bell curve is more peaked than usual. This kurtosis is not of a value that would warrant transformation, however, so analysis continued. Please refer to Figure 6, below.



*Figure 6.* Histogram suggesting that the distribution of the means of the Attitude Toward Pornography Scale is not a normal bell-shaped curve. This figure illustrates both the negative skewness and the leptokurtic distribution of the kurtosis.

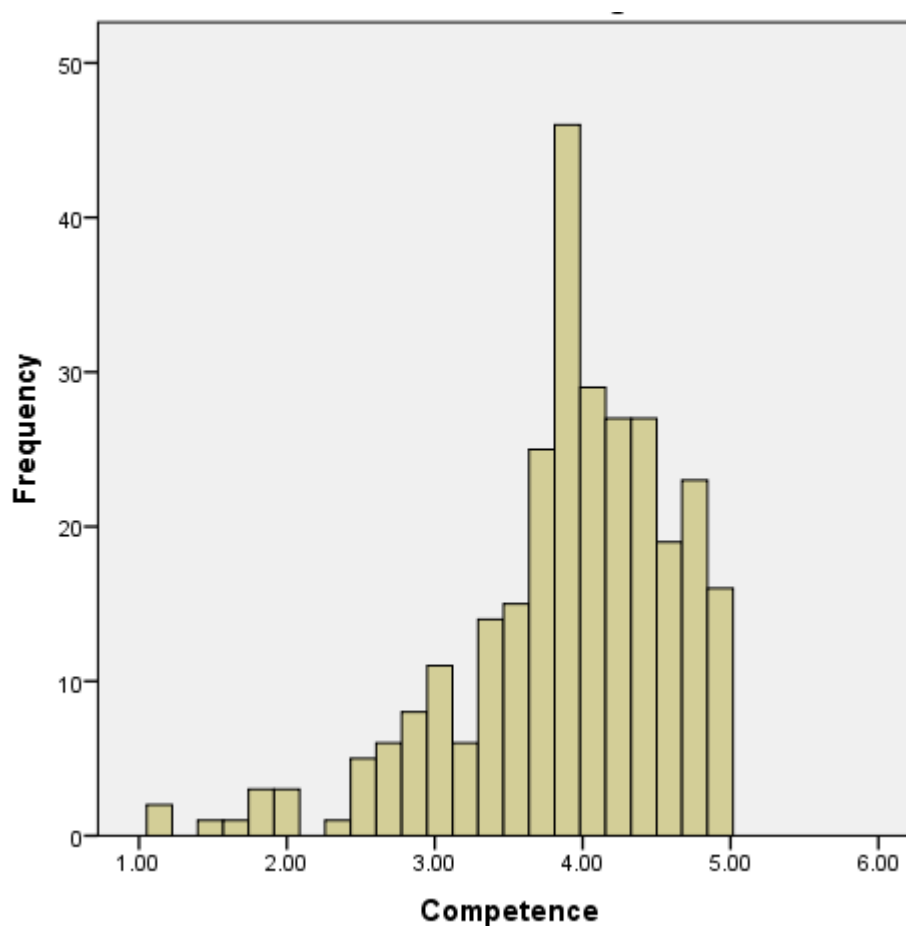
In summary, when considering the distribution of the answers for the Attitudes Toward Pornography Questionnaire, taking into account the skewness and kurtosis, we find that the distribution is slightly to the left of what we would consider normal, meaning overall the respondents seem to have a slightly more negative attitude toward

pornography than expected, but the kurtosis tells us more respondents than expected land squarely in the center of the distribution, making the distribution more peaked than expected. This is reinforced by the overall mean of 2.7630 when a normal distribution would have been 3.0.

**Counselor self-efficacy with clients' Internet pornography addiction.** The Addiction Counseling Self-Efficacy Scale (ACSES) which was also used with permission, developed by Alicia Wendler, and published in her dissertation in 2007. The scale used in this study was adapted to ask counselors about their self-efficacy in treating clients who are addicted to pornography. Respondents were asked a series of 29 questions, indicating their answer by choosing one from a Likert scale that ranged on a scale from 1 to 5, where 1 was No Confidence and 5 was Absolute Confidence. The mean score as a measure of their confidence in being able to counsel an individual with an addiction was calculated based on their answers. The mean score on the scale in this study ranged from a low of 1.14 to a high of 5.00 with an overall mean of 3.9093 and a Standard Deviation of 0.71299.

The ACSES has a skewness of -1.085 and a standard error for skewness of 0.144. This means that when looking for a bell shaped curve with this scale we find that the majority of the respondents are falling slightly right of the middle of the scale. The skewness for Addiction Counseling Self-Efficacy Scale is significantly non-normal. This tells us that the respondents answered in a way other than what would be predicted. The value of -1.085 is well within acceptable standards for statistical procedures and does not warrant adjustment. Please refer to Figure 7, below.

Kurtosis involves the peakedness of the distribution. The kurtosis of the means for the ACSES was 1.643 with a standard error of 0.287. A value of 1.643 indicates that this distribution is significantly non-normal in terms of Kurtosis (leptokurtic), which means the bell curve is more peaked than usual. This tells us that more people than would be predicted by a normal distribution answered in the range of a four (somewhat confident) than would be expected. In spite of the skewness and the kurtosis being significantly non-normal, they are still within acceptable parameters to use the data analysis for this study.



*Figure 7.* Histogram suggesting that the distribution of the means of the Addition Counseling Self-Efficacy Scale is not a normal bell-shaped curve. This figure illustrates both the negative skewness and the leptokurtic distribution of the kurtosis.

## Results for Research Questions

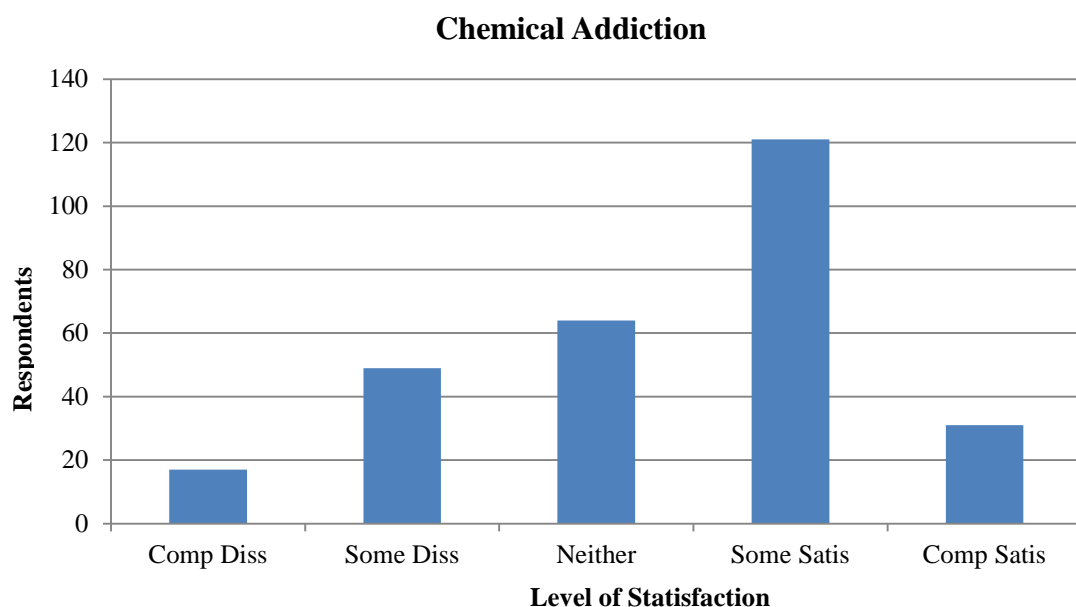
**Research question 1: Counselor competency.** The first research question was regarding the present state of addiction training and was as follows:

- 1) What is the perceived sense of competence counselors have in regards to treating the process addiction of Internet pornography?
  - i) How satisfied are counselors with the amount of training they have received in regards to the process addiction of Internet pornography addiction?
  - ii) How competent do counselors believe they are in counseling clients who are addicted to Internet pornography?
  - iii) How comfortable are counselors in discussing Internet pornography addiction issues with clients?

***Subquestion 1.1: Training satisfaction of counselors.*** The first subquestion above asks about the satisfaction of counselors with the training they have received. Five questions in the survey instrument dealt with counselor satisfaction with one's training and experiences in regards to addictions in general and Internet pornography addiction training specifically. Each of the questions will be dealt with here individually, each with its own chart and subheading.

***Chemical addiction training satisfaction.*** The first of the five questions asked about the respondent's satisfaction with chemical addiction training. Respondents could choose a number between one (completely dissatisfied) and five (completely satisfied) when rating their satisfaction. By far the most commonly selected answer was *satisfied*

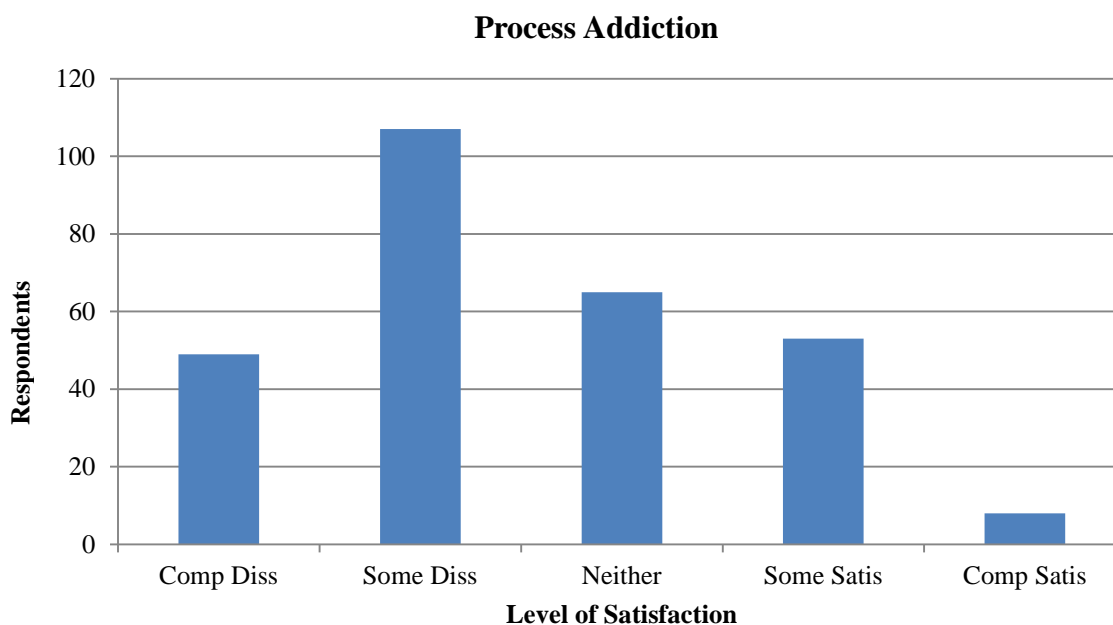
(N=121, 42.2%), followed by *neither satisfied nor dissatisfied* (N=64, 22.3%). The third most commonly chosen answer was *not very satisfied* (N=49, 17.1%), making the fourth most commonly selected answer *completely satisfied* (N=31, 10.8%). The least common answer was *completely dissatisfied* (N=17, 5.9%). Four respondents did not answer this question. This tells us that slightly more than half or 53% (N=152) of the respondents are either *completely or somewhat satisfied* with their chemical addiction training, leading us to conclude that respondents are *generally satisfied* with their chemical addiction training. For the purposes of this study, those respondents who are completely or somewhat satisfied will be compared with those who are completely or somewhat dissatisfied with their training. Please refer to Figure 8, below.



*Figure 8.* Satisfaction respondents have with chemical addiction training. Suggests that the majority of respondents are somewhat or completely satisfied with their chemical addiction training, as compared with those who are somewhat or completely dissatisfied with their chemical addiction training.

*Process addiction training satisfaction.* The next question in the survey asked respondents to rate their satisfaction with process addiction training. Respondents could

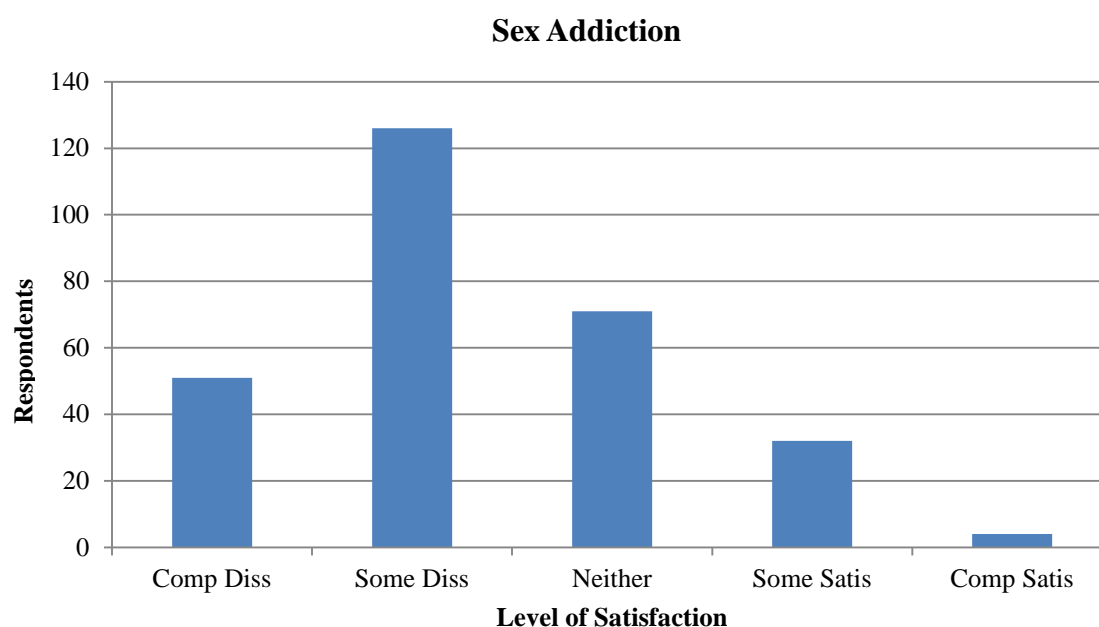
choose any number between one (completely dissatisfied) and five (completely satisfied) when rating their satisfaction. By far the most commonly selected answer was *somewhat dissatisfied* (N=107, 37.3%), followed by *neither satisfied nor dissatisfied* (N=65, 22.6%). The third most commonly chosen answer was *somewhat satisfied* (N=53, 18.5%), making the fourth most commonly selected answer *completely dissatisfied* (N=49, 17.1%). The least common answer was *completely satisfied* (N=8, 2.8%). Four respondents did not answer this question. This tells us that 54.4% (N=156) of the respondents are either *completely or somewhat dissatisfied* with their process addiction training, leading us to conclude that respondents are *generally dissatisfied* with their process addiction training. Please refer to Figure 9, below.



*Figure 9.* Satisfaction respondents have with process addiction training. Suggests that the majority of respondents are somewhat or completely dissatisfied with their process addiction training.

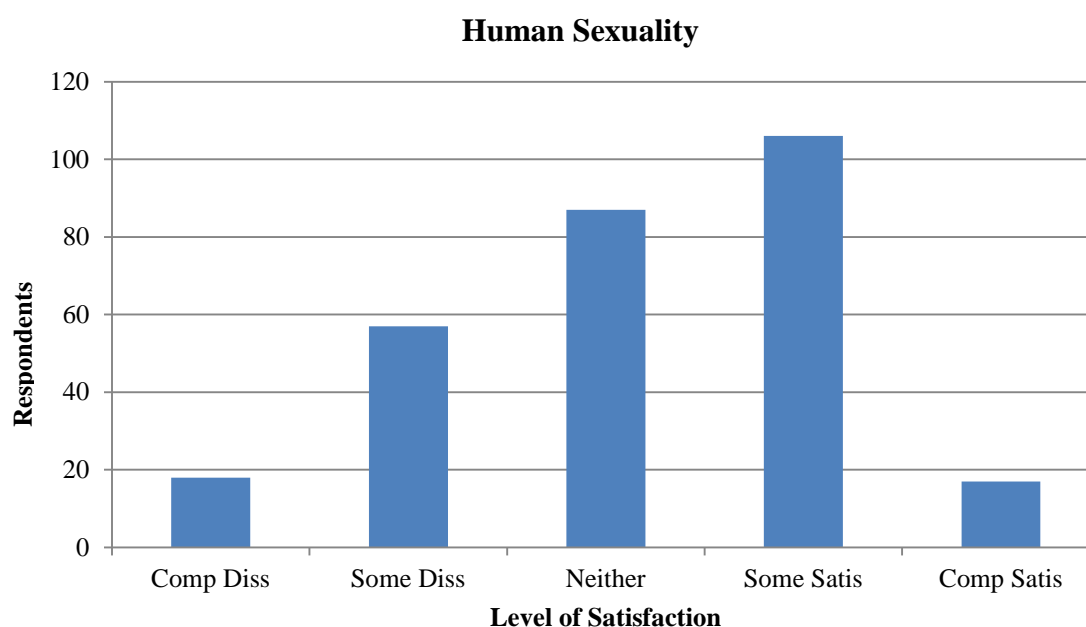
*Sexual addiction training satisfaction.* A question was also included in the survey which asked respondents to rate their satisfaction with sexual addiction training.

Respondents could choose a number between one (completely dissatisfied) and five (completely satisfied) when rating their satisfaction with their training. By far the most commonly selected answer was *somewhat dissatisfied* (N=126, 43.9%), which was followed by *neither satisfied nor dissatisfied* (N=71, 24.7%). The third most commonly chosen answer was *completely dissatisfied* (N=51, 17.8%), making the fourth most commonly selected answer *somewhat satisfied* (N=32, 11.1%). The least common answer was *completely satisfied* (N=4, 1.4%). Two respondents did not answer this question. This tells us that 61.7% (N=177) of the respondents are either *completely or somewhat dissatisfied* with their sexual addiction training, leading us to conclude that respondents are *generally dissatisfied* with their sexual addiction training. Please refer to Figure 10, below.



*Figure 10.* Satisfaction respondents have with sexual addiction training. Suggests that the majority of respondents are somewhat or completely dissatisfied with their sexual addiction training.

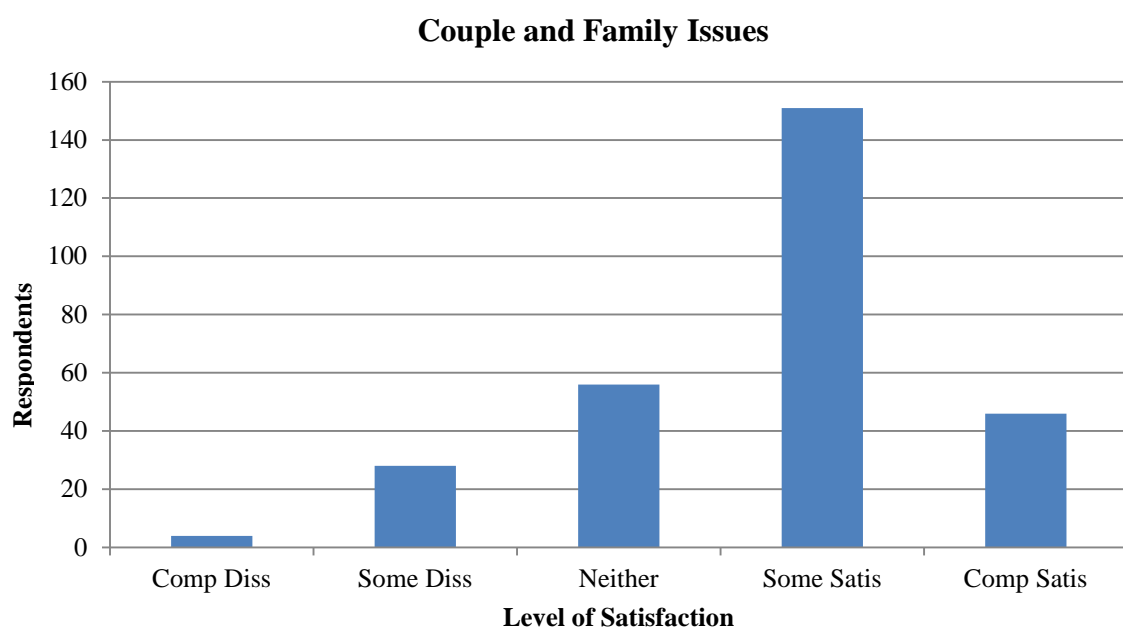
*Human sexuality training satisfaction.* A question was also included in the survey which asked respondents to rate their satisfaction with their training in human sexuality using the same 1-5 scale as above. By far the most commonly selected answer was *somewhat satisfied* (N=106, 36.9%), which was followed by *neither satisfied nor dissatisfied* (N=87, 30.3%). The third most commonly chosen answer was *somewhat dissatisfied* (N=57, 19.9%), making the fourth most commonly selected answer *completely dissatisfied* (N=18, 6.3%). The least common answer was *completely satisfied* (N=17, 5.9%). One respondent did not answer this question. This tells us that 42.8% (N=123) of the respondents are either *completely or somewhat satisfied* with their human sexuality training, leading us to conclude that *less than half the respondents are generally satisfied* with their human sexuality training. Please refer to Figure 11, below.



*Figure 11.* Satisfaction respondents have with their human sexuality training. Suggests that the majority of respondents are somewhat or completely satisfied with their human sexuality training.



*Couple and family issues training.* The final question that measured participant satisfaction with training asked respondents to rate their satisfaction with their training in couple and family issues using the same 1-5 scale. By far the most commonly selected answer was *somewhat satisfied* (N=151, 52.6%), which was followed by *neither satisfied nor dissatisfied* (N=56, 19.5%). The third most commonly chosen answer was *completely satisfied* (N=46, 16%), making the fourth most commonly selected answer *somewhat dissatisfied* (N=28, 9.8%). The least common answer was *completely dissatisfied* (N=4, 1.4%). One respondent did not answer this question. This tells us that 68.6% (N=197) of the respondents are either *completely or somewhat satisfied* with their training in couple and family issues, leading us to conclude that respondents are *generally satisfied* with their couple and family issues training. Please refer to Figure 12, below.



*Figure 12.* Satisfaction respondents have with their couple and family issues training. Suggests that more than two-thirds of the respondents are somewhat or completely satisfied with their couple and family issues training.

*Other training experiences.* There were also questions included in the survey that were related to training experiences the respondents may have had. One question asked respondents to identify topics or courses addressed during graduate education. See Table 2 for a description of each topic respondents could choose and the percentage of total respondents each choice received. Respondents could choose more than one answer, so the total may be more than 100%.

Table 2

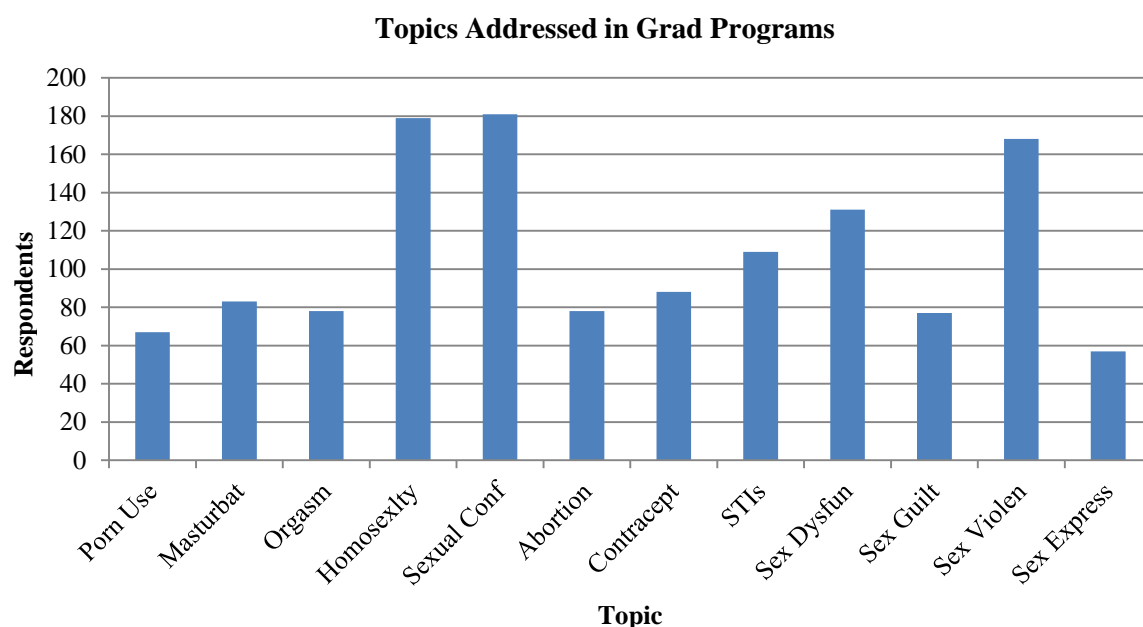
*Other Training Experiences Offered by Graduate Programs in Counseling*

<b>Topics or Courses Addressed During Graduate Education</b>	<b>Percentage of Respondents Who Chose This Response</b>
Addictions class that included process addictions such as pornography.	19.5%
Addictions class that did <i>not</i> include process addictions such as pornography.	47.4%
Human sexuality	64.8%
Reproductive biology	14.3%
Sex roles	39.4%
Sexual therapy or education	26.5%
Cross-cultural aspects of sexual behavior	26.8%
Psychological aspects of sexual behavior	38.3%
Sexuality development	42.9%
Sexual ethics and values	24.4%
Marriage therapy or relationships	78.0%
Sexual variations	24.7%

Also of importance is that respondents are not necessarily indicating that they have taken these courses or participated in these topics, but rather that these topics or courses were “addressed during their graduate education.” Only two of the listed topics were chosen by the majority of respondents: Marriage therapy or relationships with 78% choosing this option, and Human sexuality with 64.8% of respondents identifying this as an option in their program. Perhaps most striking is that an addictions class that includes process addictions such as pornography was only chosen by 19.5% of respondents, which is the second least common topic of those listed. Almost as infrequent is that only 24.4% of respondents remembered their program offering a course or topic that covered sexual ethics and values, which could include counseling sexual minorities and those with fetishes and sexual compulsions.

*Topics addressed during training.* Another question included in the survey asked about sexually related topics that had been addressed during the respondents’ graduate program (including supervision). The survey allowed multiple responses to this question. The topics included, along with the number of respondents choosing that option and the percentage of the sample, were: pornography use and addiction (N=67, 23.3%), masturbation (N=83, 28.9%),orgasm (N=78, 27.2%), homosexuality (N=179, 62.4%) , personal conflicts in sexual relationships (N=181, 63.1%), abortion (N=78, 27.2%), contraception/safer sexual practices (N=88, 30.7%), sexually transmitted infections (N=109, 38%), sexual dysfunction (N= 131, 45.6%), sexual guilt (N=77, 26.8), sexual violence (abuse or rape) (N=168, 58.5%), and finally, frequency and intensity of sexual expression (N=57, 19.9%). Please refer to Figure 13 below.

Survey participants were asked if they had ever attended a continuing education course, or an educational session at a professional conference that was specifically pertaining to Internet pornography addiction and 70.7% (N=203) said they had not. However, when asked if ever a client had discussed their Internet sexual activities with the respondent, 71.8% (N=206) said they had. Additionally, 54% (N=155) of respondents identified that they had at least one client discuss being addicted to Internet pornography.



*Figure 13.* Prevalence of identified topics addressed during counselor education programs including during supervision. This figure illustrates that sexual conflicts, homosexuality, and sexual violence are covered most frequently in graduate programs. This figure also illustrates that sexual expression, and pornography use and addiction are covered the least frequently.

*Training satisfaction.* The survey asked respondents to identify their satisfaction with the training they have received in regards to clients with addictions. When comparing training satisfaction with gender, through the use of an Independent Samples T-test the data show that Levene's test is not significant ( $F .043, p = .835$ ), therefore,

equal variances are assumed. When looking at the results, men were statistically significantly more likely to be more satisfied with their addiction training than female counselors are ( $t\ 3.11$ ,  $df\ 272$ ,  $p = .002$ ).

Levene's Test was also not significant when comparing whether respondents graduated from a CACREP accredited program or not with satisfaction with training ( $F\ .040$ ,  $p = .842$ ), therefore equal variances are assumed when looking at the results of the significance (2-tailed) and the data show that those who did *not* graduate from a CACREP accredited program are statistically significantly more likely to be satisfied with their addictions training ( $t\ -3.305$ ,  $df\ 277$ ,  $p = .001$ ). When comparing satisfaction with training and demographic variables such as respondent age, racial or ethnic identification, and the importance of religion to their work with clients using a One Way ANOVA, there were no significant differences between groups in training satisfaction ( $F\ (5, 274) = .531$ ,  $p = .713$ ).

In summary, for subquestion 1.1: Training satisfaction of counselors, respondents seem to be generally satisfied with their training in regards to chemical addictions, human sexuality, and couple and family issues. Respondents seem generally dissatisfied with their training regarding process addictions, and sexual addictions, with respondents being more dissatisfied with sexual addiction training than process addiction training. Overall, men are statistically significantly more likely to be more satisfied with their addiction training than female counselors are. There were no other significant differences between demographic groups and training satisfaction.

Also, homosexuality, and sexual violence are covered most frequently in graduate programs, but sexual expression, and pornography use and addiction are covered the

least frequently. The majority of respondents have had clients discuss their Internet sexual activities, but the majority of respondents have not attended a continuing education course, or an educational session at a professional conference that specifically pertained to Internet pornography addiction.

***Subquestion 1.2: Counselor competence.*** The second subquestion asks about counselor competence in regards to counseling individuals addicted to Internet pornography. In order to measure counselor competence The Addiction Counseling Self-Efficacy Scale (ACSES) was used which was described earlier. There were 29 questions in this scale. Respondents were asked to rate how confident they were in their ability to perform specific skills as they related to clients who identify as being addicted to Internet pornography. By doing so, the survey endeavored to identify their level of competence and confidence in counseling clients who are addicted to Internet Pornography. The scale provided ranged from one (no confidence) to five (absolute confidence). As was mentioned before, the mean score for study respondents was 3.9093 and a Standard Deviation of 0.71299, indicating that generally the sample seemed confident in their ability to counsel individuals with an Internet pornography addiction (See Table 2).

When looking at the questions individually, the results show clearly there are some aspects of counseling clients who are addicted to Internet pornography that counselors feel much more competent in carrying out than others. See Table 3 below for the mean responses on each item, on a scale from 1 (no confidence) to 5 (absolute confidence). The ten areas in which counselors felt the most competent, in order, were: Maintain a respectful and nonjudgmental atmosphere with a client (4.533), Refer a client when I cannot treat her/his co-occurring mental illness (4.521), Establish a warm,

respectful relationship with a client (4.517), Convey an attitude of care and concern for the client (4.440), Use active listening techniques when working with a client who has problematic Internet sexual activity (4.420), Include a client in the referral decision-making process (4.325), Develop trust with a client who has an Internet pornography addiction (4.224), Help a client determine who is available to support her/his recovery (4.206), Create a therapeutic environment where the client will feel that I understand them (4.203), and Show empathy towards a client who is addicted to Internet pornography (4.202). All 10 of these mean scores show that counselors surveyed are at least somewhat confident in their ability to address these items in counseling with someone who self-identifies as being addicted to Internet pornography.

Table 3

*Mean Item Response on the Addiction Counseling Self-Efficacy Scale (Wendler, 2007) in Descending Order*

Question with original item number	Mean Score
29. Maintain a respectful and nonjudgmental atmosphere with a client.	4.533
27. Refer a client when I cannot treat her/his co-occurring mental illness.	4.521
22. Establish a warm, respectful relationship with a client.	4.517
4. Convey an attitude of care and concern for the client.	4.440
28. Use active listening techniques when working with a client who has problematic Internet sexual activity.	4.420
6. Include a client in the referral decision-making process.	4.325
7. Develop trust with a client who has an Internet pornography addiction.	4.224
9. Help a client determine who is available to support her/his recovery.	4.206
3. Create a therapeutic environment where the client will feel that I understand them.	4.203
2. Show empathy towards a client who is addicted to Internet pornography.	4.202

Table 3—Continued

Question with original item number	Mean Score
8. Screen clients for co-occurring mental health disorders.	4.181
23. Gather information about a client's prior experiences with problematic Internet sexual activity treatment.	4.056
24. Challenge behaviors that interfere with a client's recovery.	4.000
19. Help a client recognize what triggers her/his use of Internet sexual activity.	3.955
18. Help a client figure out what behaviors will support recovery.	3.875
25. Select high quality referral sources for a client if needed.	3.874
17. Teach a client about self-help support networks and related self-help literature.	3.846
21. Summarize a client's treatment and recovery information for other professionals.	3.815
12. Responsibly challenge a client with problematic Internet sexual activity.	3.775
11. Use assessment data to develop a treatment plan.	3.672
14. Assess a client's readiness to change problematic Internet sexual activity.	3.659
20. Write accurate and concise assessment reports.	3.654
15. Help a client develop realistic expectations about recovery.	3.644
26. Work effectively with a client who has both problematic Internet sexual activity and a mood disorder (e. g., depression).	3.581
16. Work effectively with a client who has both problematic Internet sexual activity and trauma-related issues.	3.481
1. Assess a client's previous experience with self-help groups like Sex Addicts Anonymous, Sexual Compulsives Anonymous, S-ANON, etc.	3.449
5. Work effectively with a client who has an Internet pornography addiction.	3.350
13. Work effectively with a client who has problematic Internet sexual activity and a personality disorder.	2.986
10. Work effectively with a client who has an Internet pornography addiction and a psychotic disorder (e. g., schizophrenia).	2.678

*Note.* Table 3 represents the questions in the Addiction Counseling Self-Efficacy Scale (Wendler, 2007) in descending order of means, showing the competence respondents felt toward each question. Scale ranges from 1 (No Confidence) to 5 (Absolute Confidence).



The 10 areas in which counselors felt the least confident, in descending order of confidence, were: Use assessment data to develop a treatment plan (3.672), Assess a client's readiness to change problematic Internet sexual activity (3.659), Write accurate and concise assessment reports (3.654), Help a client develop realistic expectations about recovery (3.644), Work effectively with a client who has both problematic Internet sexual activity and a mood disorder (e.g., depression) (3.581), Work effectively with a client who has both problematic Internet sexual activity and trauma-related issues (3.481), Assess a client's previous experience with self-help groups like Sex Addicts Anonymous, Sexual Compulsives Anonymous, S-ANON, etc. (3.449), Work effectively with a client who has an Internet pornography addiction (3.350), Work effectively with a client who has problematic Internet sexual activity and a personality disorder (2.986), Work effectively with a client who has an Internet pornography addiction and a psychotic disorder (e.g., schizophrenia) (2.678).

In summary, for subquestion 1.2: Counselor competence, it seems that generally, respondents feel the most competent in areas that deal directly with general counseling relational skills such as establishing a trusting, therapeutic relationship with the client, being empathetic, and expressing care and concern. Overall, since 27 of the 29 items have a mean above 3.0, it seems that counselors generally feel competent to work with clients who say they are addicted to Internet pornography. It is important to note, however, that "Work effectively with a client who has an Internet pornography addiction" has the third lowest mean score. Respondents shared that they generally do not feel as competent with areas that deal with specific skills related to Internet porn addiction such as assessing for specific problems, writing reports, developing treatment

plans, and working with clients who have co-occurring disorders along with Internet pornography addiction.

***Subquestion 1.3: Counselor comfort discussing sexual issues.*** The third subquestion asks about the comfort of counselors in discussing sexuality, sexual issues and pornography with clients. As was stated above, The Sexual Comfort Scale (SCS) measured counselors' willingness to address client sexual concerns especially as those concerns relate to Internet pornography use. Respondents were asked a series of 11 questions and provided possible answer choices that ranged from one (strongly disagree) to five (strongly agree), and the mean score of their comfort was calculated based on their answers. The mean score on this scale ranged from a low of 2.36 to a high of 4.64 with an overall mean of 3.3797 and a Standard Deviation of 0.33400. A mean of 3.3797 would indicate slightly more comfort than ambivalence (neutral comfort) in discussing sexual issues with clients (See Table 4).

When looking at the questions individually, the results show that there are some distinct differences in comfort among counselors discussing sexually related issues with clients. For example, the four statements that yielded the highest mean scores, in order of their comfort level were: I consider the expression of sexuality to be an integral part of the total human personality (4.528), Internet pornography is a topic worthy of academic study (4.435), I am tolerant of sexual beliefs and lifestyles that are different to my own (4.350), and When confronted with sexual values different from my own, I feel tolerant (4.199). However, there was one statement which indicated less comfort among participants. The statement, "I believe that Internet pornography in general is positive and adds zest to living" yielded the least positive result (2.125). Also worth noting was

the statement, “In my opinion, the expression of sexuality is an acceptable topic for everyday conversations” which was rated favorably by only 55.1% of participants (N=158).

Table 4

*Mean Item Response on the Sexual Comfort Scale (Berman, 1996) in Descending Order*

Question with original number order	Mean Score
24. I consider the expression of sexuality to be an integral part of the total human personality.	4.528
26. Internet pornography is a topic worthy of academic study.	4.435
23. I am tolerant of sexual beliefs and lifestyles that are different to my own.	4.350
29. When confronted with sexual values different from my own, I feel tolerant.	4.199
30. I avail myself of opportunities to increase my comfort with sexuality.	3.768
22. I have a foundation of support for my own values, knowledge, and beliefs about Internet pornography.	3.746
31. I avail myself of opportunities to increase my comfort with discussing Internet pornography.	3.615
25. In my opinion, the expression of sexuality is an acceptable topic for everyday conversations.	3.540
21. I believe that Internet pornography in general is positive and adds zest to living.	2.125
28. I feel anxious about my own sexual standards and behavior.	1.488
27. I feel in turmoil about my sexuality.	1.378

*Note.* Table 4 represents the questions in the Sexual Comfort Scale (Berman, 1996) in descending order of agreement, by way of the overall mean score of each question. Scale ranges from 1 (Strongly Disagree) to 5 (Strongly Agree).

*Counselor attitude toward pornography.* This researcher thought it was not only necessary to look at counselor comfort discussing sexual issues with clients, but also counselor attitude toward pornography itself. The Attitudes Toward Pornography Questionnaire asked a series of 30 questions, and had respondents indicate their answers by choosing from a Likert scale that ranged on a scale from one (Strongly Disagree) to

five (Strongly Agree). The mean score as a measure of their attitude was calculated based on their answers. The mean score on this scale ranged from a low of 1.77 to a high of 3.50 with an overall mean of 2.7630 and a Standard Deviation of 0.27065. Since a choice of three on the Likert Scale indicated a neutral attitude, a mean of 2.7630 would seem to indicate a slight disagreement with the purported benefits of pornography (See Table 5).

Table 5

*Mean Item Response on the Attitudes Toward Pornography Questionnaire (Katzander & Josephs, 2009) in Descending Order of Agreement*

Question with original number order	Mean Score
47. It is not good when clients hide from their partners how much they use pornography.	3.976
50. Pornography is not just for guys: women have the right to access the same kind of empowerment that comes from discovering and owning their sexual desires.	3.811
57. More girls than is commonly thought look at pornography – it's just more secret and less overtly acceptable among women.	3.470
54. Pornography fundamentally exploits women because it degrades them.	3.390
60. Occasional pornography use is okay, but if a client has to view it every day, they have a problem.	3.355
58. One of the benefits of pornography is that it can open a person up to fantasies, sexual acts or positions that once were thought of as taboo.	3.267
34. Looking at pornographic material can make clients' sex life more exciting.	3.265
41. Pornography devalues human sexuality by presenting sex in an impersonal and tasteless way.	3.238
43. People use pornography to avoid intimacy or avoid having a real relationship.	3.101
32. Looking at pornography can be educational.	3.098
49. One problem with watching too much pornography is that real live sex becomes boring.	3.070
59. There's a difference between erotica and pornography. Erotica is a turn-on for me; pornography is not.	2.951
46. If clients are in a relationship, it is better for them to use pornography than cheat on their partner.	2.847

Table 5—Continued

Question with original number order	Mean Score
33. It's important for a couple to share the same taste in pornography.	2.842
40. It is not a good thing for clients to want to watch other people having sex on a video when they are with a partner.	2.745
36. Using pornography to masturbate is like scratching an itch.	2.720
51. Pornography is a healthy outlet.	2.704
39. Pornography lets people indulge the harmless fantasy of an endless variety of partners, whether in a relationship or not.	2.608
45. I feel it is over controlling for one partner to tell the other to stop watching pornography.	2.479
35. When a person is sexually frustrated it is good to have ready access to pornography to relieve the tension.	2.425
61. Any pornography use is a problem.	2.339
48. The problem with pornography is that it makes users want to cheat on their partner.	2.267
42. Many times I feel that pornography is something clients may indulge in when they are younger, but by the time clients settle down they should outgrow it.	2.230
38. All men look at pornography, and there is nothing wrong with that.	2.154
53. Pornography is good because it shows images of strong independent sexually confident women.	2.129
44. Pornography is just another kind of harmless entertainment when clients are bored-like watching TV.	2.115
37. Only really religious people are morally against pornography.	1.826
56. Knowing about stuff like landing strips and thongs is key to a girl having a full and satisfying sex life.	1.818
55. There would be nothing wrong with a student club at college publishing a magazine with pictures of naked students and other sexual content.	1.753

*Note.* This table represents the questions in the Attitudes Toward Pornography Questionnaire (Katzander & Josephs, 2009) in descending order of agreement, according to the overall mean score of each question. Scale ranges from 1 (Strongly Disagree) to 5 (Strongly Agree).

When looking at the questions individually, there were five questions that seem to have a notable disagreement. If both strongly disagree and disagree are taken into account, the five statements that had the most disagreement were as follows: Only really religious people are morally against pornography (N=261, 90.9%), There would be

nothing wrong with a student club at college publishing a magazine with pictures of naked students and other sexual content (N=245, 85.4%), Knowing about stuff like "landing strips" and thongs is key to a girl having a full and satisfying sex life (N=238, 82.9%), Pornography is just another kind of harmless entertainment when clients are bored-like watching TV (N=214, 74.6%), All men look at pornography, and there is nothing wrong with that (N=203, 70.8%).

Continuing to look at the answers to the questions assessing the attitudes of counselors toward pornography, the five statements that yielded the least amount of disagreement, based on both the strongly disagree and disagree answer choices into account were as follows: Looking at pornographic material can make a client's sex life more exciting (N=53, 18.5%), One of the benefits of pornography is that it can open a person up to fantasies, sexual acts or positions that once were thought of as taboo (N=53, 18.5%), More girls than is commonly thought look at pornography – it's just more secret and less overtly acceptable among women (N=31, 10.8%), It is not good when clients hide from their partners how much they use pornography (N=17, 5.9%), and Pornography is not just for guys: women have the right to access the same kind of empowerment that comes from discovering and owning their sexual desires (N=14, 4.8%).

In summary, when looking at the comfort of respondents surrounding sexual issues and topics, it seems counselors have the most comfort with sexual expression and tolerance toward sexual expressions different than their own. Interestingly, the topics that yielded less comfort seemed to be around actually talking about pornography, and finding something positive in pornography use. When looking at attitudes toward pornography it seems that respondents have a more positive, or less negative, rather,

attitude regarding pornography when it is used as a relationship aid, when women can look at it too, and when it is used for fantasy. Those topics that respondents had the most negative attitude toward included those topics that dealt specifically with pornography and topics addressed in pornography, which, at least theoretically, will be what clients will need to discuss.

**Research question 2: Relationship between variables.** The second research question was regarding the present state of addiction training and was as follows:

- 2) What are the relationships between counselor demographic variables (ethnicity, age, gender, program emphasis, and religiosity) and counselors' self-assessed attitudes and skills?
  - i) What are the relationships between counselor demographic variables and counselor self-efficacy with treating addictions?
  - ii) What are the relationships between counselor demographic variables and counselor attitude toward pornography?
  - iii) What are the relationships between counselor demographic variables and counselor comfort discussing sexual issues with clients?

Question 2 compared the study variables (such as pornography addiction counseling self-efficacy, attitudes toward pornography, satisfaction with addictions training, and comfort discussing sexual issues) and the demographic variables (such as respondent ethnicity, age, gender, program emphasis, and religiosity).

***Subquestion 2.1: Self-efficacy and demographic variables.*** The first subquestion addressed the relationship between counselor addiction training self-efficacy and the demographic variables listed above. The results of the Addiction Counseling Self-Efficacy Scale (ACSES) were reported above. When comparing the mean of the ACSES and whether the respondent graduated from a CACREP accredited program the research shows that there is not a statistically significant difference. A One-Way ANOVA was conducted to compare the mean of the respondents' ACSES and their gender Levene's Test of Equal Variances shows that equal variances are assumed ( $F = .869, p = .352$ ). The results show that males are statistically significantly more likely to self-assess as feeling somewhat or very competent with their ability to counsel individuals with an addiction ( $t = 1.997, df = 279, p = .047$ ). Even though this difference is significant, the effect size of this difference is small (Cohen's  $d = 0.26$ ), which means this difference is of limited importance. There was not a statistically significant difference between the ACSES and age, racial identification, or the stated importance of religiosity of the respondents ( $F(78, 207) = 1.311, p = .067$ ).

***Subquestion 2.2: Attitude toward porn and demographic variables.*** The second subquestion examines the relationship between counselor demographic variables and counselor attitude toward pornography. As stated above, the mean score on the Attitude toward Pornography Scale ranged from a low of 1.77 to a high of 3.50 with an overall mean of 2.7630 and a Standard Deviation of 0.27065. This mean was compared to respondent demographic variables to see if there were significant relationships. Upon conducting an Independent Samples T Test comparing the type of program (CACREP or not) with the respondent's attitude toward pornography no significant relationship was



found. Upon conducting an Independent Samples T Test comparing the respondent's gender with the respondent's attitude toward pornography no significant relationship was found.

A One-Way ANOVA was conducted to compare the mean of the respondent's attitude toward pornography and the respondent's age, race, and the importance the respondent felt that their religion and morals had to their practice of counseling. The age of the counselor did not have a significant effect on the respondent's attitude toward pornography. A statistically significant relationship was found between the counselor's identified racial/ethnic category and their attitude toward pornography ( $F(42, 243) = 1.471, p = .039$ ). Upon further examination of the Post Hoc comparisons, there were not any significant differences between groups to support the earlier findings. Although a significant relationship was found when originally comparing all racial/ethnic categories with the attitudes toward pornography, the Post Hoc comparison, which looked at each racial/ethnic category and their particular attitudes toward pornography, found no significant relationship between each category and their attitudes toward pornography. Post-hoc examination is used to strengthen induction by limiting the probability that significant effects seem to have been discovered between subgroups of a population when none actually exist (McMillan & Schumacher, 2006). This may have been due to the low numbers of ethnic/racial minorities in the sample. In order to further examine the ethnic/racial minorities' attitudes toward pornography, those respondents that chose White ( $N=239$ ) were compared with all of the rest of the categories as a whole (Non-White,  $N=47$ ) and no significant difference was found in that Independent Samples T-test.

A statistically significant relationship was found between the counselor's identified religiosity and their attitude toward pornography ( $F(4, 282) = 4.335, p = .002$ ). Upon further examination of the Post Hoc comparisons this statistically significant difference was supported in that group one (counselors whose religious values, spiritual beliefs and morality are *very important* to the clinical work done with clients) is significantly different than group two (*somewhat important*), three (*neutral*), and five (those whose values, beliefs and morality are *not important at all* to the clinical work done with clients). Group four (those whose values, beliefs and morality are *somewhat not important* to the clinical work done with clients) was not significant compared to any other group. The Ryan-Einot-Gabriel-Welsch F Post Hoc test showed that group one had a significantly lower attitude toward pornography as compared to group two, three, and five. When comparing group one with group two the Cohen's  $d$  is 0.49, when comparing group one with group three the Cohen's  $d$  is 0.56 and when comparing group one and group five the Cohen's  $d$  is 0.53. All three effect sizes are considered medium which means the estimated magnitude of the relationship between groups is reasonably strong and it accounts for much of the variance between groups in the study and that these variances are not just due to chance (Kinnear & Gray, 2010).

***Subquestion 2.3: Comfort discussing sexual issues and demographic variables.***

Subquestion 3 addresses the relationships between counselor demographic variables and counselor comfort discussing sexual issues with clients. As was described earlier, The Sexual Comfort Scale (SCS) was adapted to fit counselors' comfort and willingness to address client sexual concerns, especially as those concerns relate to Internet pornography use. Respondents were asked a series of 11 questions, indicating their

answer by choosing one from a Likert scale that ranged on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). The mean score ranged from a low of 2.36 to a high of 4.64 with an overall mean of 3.3797 and a Standard Deviation of 0.334. When this mean was compared to other variables such as whether the respondent's program was CACREP accredited, the respondent's gender, age, identified race, or the importance of religiosity, only the respondent's gender resulted in a statistically significant difference. When comparing sexual comfort mean scores by gender, Levene's test shows that the variance of the groups is equal ( $F .037, p = .849$ ), therefore, equal variances of the standard deviations are assumed. When looking at the Independent Samples T-test the data shows that men are statistically significantly more comfortable discussing client sexual concerns including Internet pornography use than female counselors are ( $t 2.454, df 279, p = .015$ ). The statistically significant difference has a medium effect size (Cohen's  $d .326$ ) which tells us that this significant difference is important and it accounts for a good portion of the variance between gender and counselor comfort discussing client sexual concerns including Internet pornography.

In conclusion, the results for research question 2 show that male counselors are more likely to self-assess as feeling somewhat or very competent with their ability to counsel individuals with an addiction. Counselors whose identified religiosity is very important to their counseling work have a lower attitude toward pornography than do the other groups. Men are more comfortable discussing client sexual concerns including Internet pornography use than are female counselors.

The next section of Chapter IV will outline the qualitative portion of the results and findings. The qualitative data collected from the seven expert interviews will be

presented which address the third research question. Seven global themes were found after completion of the thematic analysis of the expert interviews.

### **Qualitative Findings**

The qualitative data answered the last research question of this mixed-method study. The third and final question was:

- 3) What do counselor educators with expertise in process addictions related to sexuality view as best practice in the education of counselors regarding sexual addictions?
  - i) What are these experts' current assessments of the training counselors receive in regards to sexual addiction in general and Internet pornography addiction in particular?
  - ii) What do these experts view as best practice in the training and continuing education of counselors regarding process addictions related to sexuality?
    - a) What are recommended by experts as the preferred ways to develop adequate knowledge and competency in this area?
    - b) Should a class in sexual addictions in general be required in counselor education training programs?
    - c) Should counselors be required to receive continuing education units involving the

## assessment and treatment of Internet pornography addiction?

The 2009 CACREP standards address addiction training in the CMHC and School Counseling program options, but traditionally, an addiction class, if offered, covers chemical addictions much more heavily than process addictions (Hagedorn, 2009b). The purpose of obtaining expert opinions regarding the current state of process addiction training instruction is three-fold. First, the results of the interviews provide an informal evaluation of process addiction training instruction. Second, the opinions offer some guidance about where the profession should be in regards to training, clinician experience, and especially client needs for counselors handling this issue. Last, it was important to gain the perspectives of experts on the “best practices” in addictions training of master’s-level counselors, such as necessary curriculum components and effective pedagogical methods, so the profession might move forward in how it teaches about process addictions.

The presentation of the qualitative results is as follows. The findings from the thematic analysis are organized by the main, or global, themes. Last, a summary is given which highlights the significant outcomes from the qualitative inquiry.

### **Findings From Thematic Analysis**

Seven global themes were found after completion of the thematic analysis of the expert interviews. Each global theme contains one or more organizing themes. Each organizing theme is made up of basic themes. A global theme, then, is an overarching concept that forms “the basis of repeated patterns across the data set” (Braun & Clarke, 2006). Organizing themes are the pieces of the global theme that support and inform its

importance, and basic themes do the same for the organizing themes. In the following sections, the data will address all three levels of themes. The seven global themes are: (1) Need for Process Addictions Training, (2) Process Addiction Training Critical, (3) CACREP Acknowledgement of Process Addictions/Internet Porn Addictions, (4) Addiction Course Content Delivery, (5) Counselor Education Programs' Inclusion of Process Addiction Training, (6) Qualifications for Teaching Addictions Courses, and (7) Addiction Class Course Design (See Figure 14).



*Figure 14.* Global themes from qualitative thematic analysis of expert interviews.

### **Global Theme One: Need for Process Addictions Training**

Cross-case analysis of the seven expert interviews resulted in certain patterns of meaning related to the necessity for counselors to have training specific to process addictions. The middle-order themes, or organizing themes, represent the cluster of basic themes found in the data. Participants were asked: “In your opinion, how important is process addictions training in counselor education and why?” The key themes that emerged from their responses included these three organizing themes: “Unification Needed,” “Relatively Uncharted Territory,” and “Growing Problem.” Refer to Figure 15 for the Thematic Network of Theme One.

**Unification needed.** Six basic themes were categorized together to create this organizing theme. The experts indicated that the counseling profession has not reached agreement on how to approach process addictions which prevents the profession from establishing a comprehensive training program. The six basic themes comprising this organizing theme follow.

***Narrow definition of addictions.*** The first basic theme identified by participant responses indicated the narrow definition that the profession has for addictions which leads to resistance from some in the field to recognize process addictions as addictions. Additionally, some do not recognize sexual addictions as addictions, and furthermore, there are members of the profession who do not recognize Internet pornography addiction as an addiction. Some think Internet pornography addiction is a subset of sexual addiction, or it is a compulsion, rather than an addiction. One expert said, “Our field in general has a very narrow definition of addiction.” Another expert stated that, “One of the things that makes it so difficult to study is based on what we call it.” Still another expert

further elaborated by adding, “[Counselor training] is far from having the average clinician understand even what process addictions are.”

*Sexual addiction doesn't meet the criteria for addictions.* The second basic theme identified was that there is still considerable debate in the profession of counseling as to whether sexual addictions are really addictions at all. One of the experts interviewed stated that, “Sexual addiction should be called ‘compulsivity’ because there's no physical dependence; it simply doesn't meet the criteria for addictions.” But yet, as was stated earlier, clients are presenting with issues related to pornography addiction, sexual addictions, and other process addictions in greater numbers. One expert stated, “Internet pornography should not be called a compulsive disorder because it's not used primarily as tension relief but for pleasure; compulsive disorders are not usually reported as pleasurable.” When addressing why sexual addictions are not recognized another expert said, “I don't think it has the credibility that other disorders have.” One expert pointed out, “Actually as clinicians, we're rewarded for not looking for process addictions. Because how is it that you are going to document that with your diagnosis, how is it that you are going to get insurance reimbursement for that?”

*All addictions have the same underlying components.* The third basic theme identified was that both process and chemical addictions have the same underlying components or criteria used to describe them. The same diagnostic criteria can be used to identify alcohol addiction as can be used to identify pornography addiction, with very little adjustment to the language. One expert stated that, “With process addictions, there's a chemical dependency component to it, but it's probably much more clearly psychological.” More research is being done regarding the function of the brain in



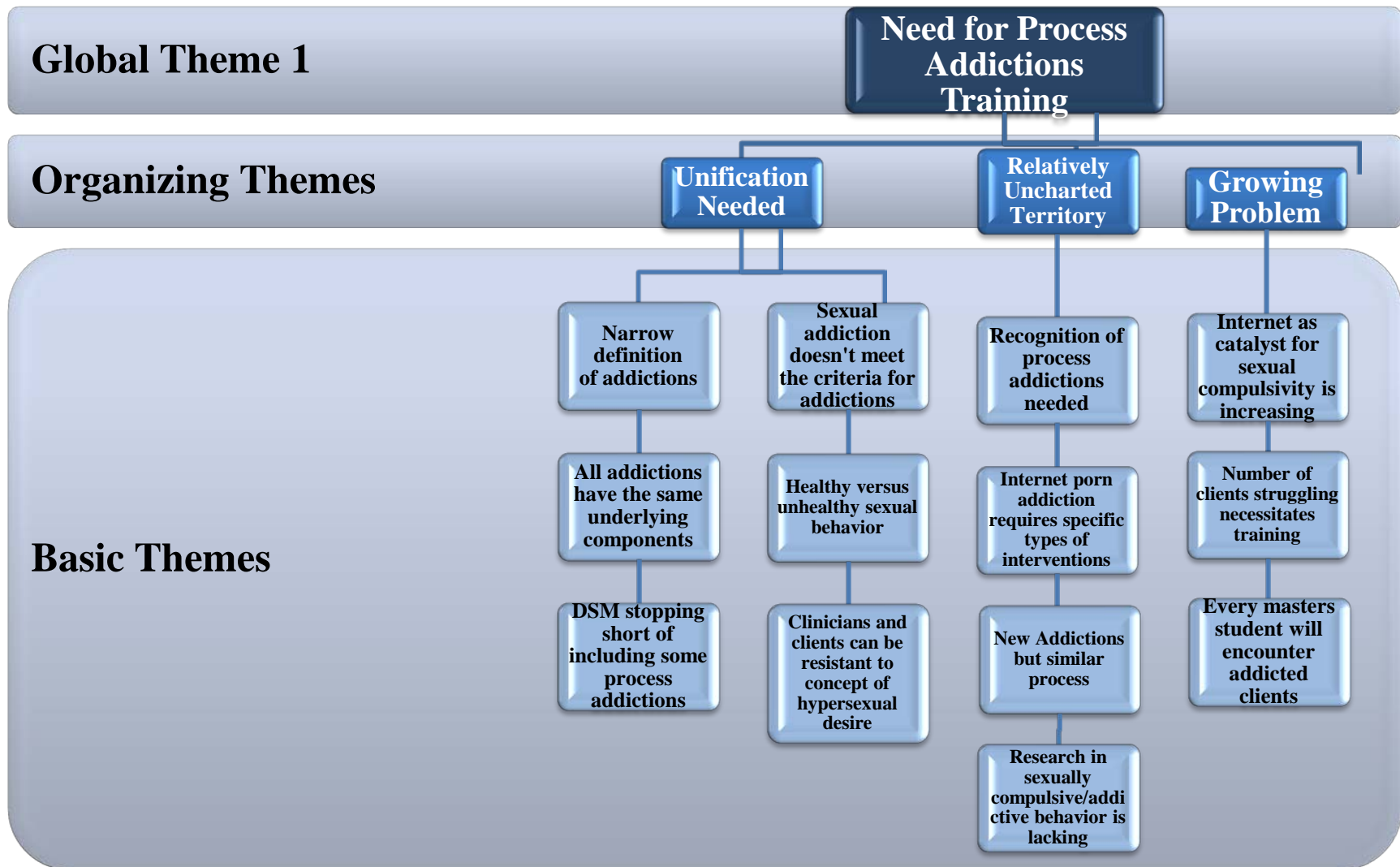


Figure 15. Thematic network for global theme one, "Need for Process Addictions Training."

connection with addiction, and one expert pointed out that, “The neuro-transmitic activity in the brain is not much different between sex, gambling, and drugs.”

***Healthy versus unhealthy sexual behavior.*** The fourth basic theme identified has to do with our society being inundated with sexual images and sexualized behavior. In spite of this, there still seems to be a lack of communication and clarity about healthy sexuality and what healthy sexual behavior looks like. Because this topic is not typically covered in training programs, counselors are no more likely to be comfortable discussing these issues than is society as a whole. As one expert put it, “The field seems to be about 10 years behind in the area of technology, people are under-informed about process addictions, [and this] creates unprepared professionals.” Counselors learn what they are taught about this topic, and this was reinforced by another expert who stated, “Faculty need to be brought up to speed and answer questions from students about what that means. Many faculty cannot answer those questions about healthy or unhealthy sexual behavior.”

***DSM stopping short of including some process addictions.*** The fifth basic theme that arose from expert participant responses indicated that according to the DSM-IV-TR and the DSM-5 proposed changes, sexual addiction is not a recognized addiction. Assessment, diagnosis, and treatment are difficult when this issue is not included in our diagnostic manual. One expert said, “A lot of people struggle, and aren’t treated effectively...because [sexual compulsivity or sexual addiction] is not included [in the DSM].” Yet another expert commented that, “It’s disheartening that the DSM-5 is stopping short in a few areas of process addiction, but including other addictions.” Counselors need to know how to use the DSM, and depend upon this manual, but as yet

these process addictions do not appear in the DSM. One expert asserted that training for process addictions should include use of DSM, and also trends, clinical aspects, defining terms and giving examples. Another respondent reported that “Clients struggling with sexual compulsivity and addiction are not treated effectively due to the absence [of sexual addictions] from the current DSM.

*Clinicians and clients can be resistant to concept of hypersexual desire.* Sexual activity is generally seen as a good thing, and it is difficult, at times, to conceptualize a good thing as having the potential to harm. The sexual revolution of the 1960s and 1970s, combined with the sexual acceptance of the 1980s and 1990s have created the possibility in society of anything goes, as long as the sexual activity is not hurting anyone. A label of “hypersexual desire” is abhorrent to some clinicians. A possible explanation for the resistance of counselors and society to label some sexual behaviors negatively was discussed by one expert as, “to call [hypersexual desire] an addiction ... that almost encroaches on the philosophy that they have lived with for 40 years now.” Another expert said, “This (sexually compulsive/addictive behavior) is not being researched as a profession, and society is uncomfortable and feels shame talking about sex. Society and professional counselors are uncomfortable talking about sex addictions.”

**Relatively uncharted territory.** Continuing with global theme number one, “The Need for Process Addiction Training,” the second organizing theme helps conceptualize that in the history of addictions, Internet pornography addiction is a relatively uncharted territory as far as recognition, interventions, and research. Four basic themes supported this organizing theme.

***Recognition of process addictions is needed.*** The first basic theme identified addresses the fact that process addictions are simply not recognized as “real” addictions by the whole of society, or the counseling profession. This lack of recognition leads to issues with clients being taken seriously, and receiving the best care that they deserve. Many clients may not even recognize the presence of process addictions since this is not being talked about in mainstream society. As one expert put it, “Many people come in with a problem, and they identify the problem as being [their] relationships or anxiety or depression, but they don’t realize that there is an addictions genesis to [their problems].” If the client knows there is a problem, but doesn’t recognize a process addiction may be causing it, then the counselor may not ask about the possibility of addictions. One expert touched on this topic, “The average clinician is far from understanding what they need to do when somebody presents with symptomatology that’s specific, or created by process addictions.” Perhaps because process addictions aren’t recognized as generally as some other addictions, counselors are not reimbursed for this diagnosis.

***Internet porn addiction requires specific types of interventions.*** The second basic theme reveals the experts believed Internet pornography addiction was unique enough from other addictions that it requires special treatments and interventions. For example, people in current American culture find it difficult to completely sever their connection to the Internet. Being connected to the Internet, pornography is easily accessible, far more accessible than many other chemical and process addictions. One expert made this point, “counselors need to know how to do interventions and treat process addictions.” Another expert elaborated more on this topic.

We don't really have treatment models for sexual addiction or sexual compulsivity. We've adapted treatment for chemical addiction, then applied that to sexual behavior. And I think sometimes that can work, but they're two very different issues and I think the treatment needs to be very specific.

Adapting a drug/alcohol addiction recovery model may not be effective with an Internet pornography model because it isn't easy to separate completely from the temptation to use. Not only do we need interventions, but, as another expert stated, "As a profession, we need to be leaning towards evidence-based practice and data-driven interventions."

***New addictions but similar process.*** The third basic theme identified showed that when compared to drugs and alcohol and even some process addictions, Internet pornography addiction is a relatively new addiction. As one expert put it, "This is a growing problem, and it's a relatively new problem." Even though it is a new addiction, some experts asserted that the process of becoming addicted is the same as other addictions and lends to the credibility of Internet pornography being a recognized addiction. One expert added to this concept by saying, "[The Internet] is the new gateway to drugs, early access to pornography, gaming, and the Internet sets up the neural pathways for substance abuse; it has infused itself into society."

***Research in sexually compulsive/addictive behavior is lacking.*** The fourth basic theme that emerged from the data is that research is lacking surrounding this topic. In spite of it being a growing problem, not a lot of research has been done with this topic. The profession needs to strengthen the available research on this topic. One of the experts interviewed said, "More researchers and focus on Internet pornography addiction is needed. We need more training [sessions] at ACA, and more funding for research

would be helpful.” Another researcher touched on the same topic by explaining, “Research in sexually compulsive/addictive behavior is lacking. This is not being researched as a profession. Much left to be learned about sexual addiction, there is room for a lot more research.” Another expert quipped, “Someone should do a dissertation on this topic!”

**Growing problem.** Continuing with global theme number one, “The Need for Process Addiction Training,” the third organizing theme helped conceptualize that Internet pornography addiction is becoming a larger and more common issue. Three basic themes support this organizing theme.

*Internet as catalyst for sexual compulsivity is increasing.* The first basic theme that speaks to Internet pornography being a growing problem explains that just as Internet use is increasing at a rapid rate in this country, the Internet as a catalyst for sexual activity is also increasing. An expert addressed this issue by stating, “Internet use is widespread, and so is the risk for online addictions.” People use the Internet for more things now than they did previously, and acting out sexual fantasies can be one of the uses of the Internet. One expert went on to say, “the Internet is a venue through which sexual addiction manifests itself; it is not an addiction itself.” The counseling profession should be addressing this new avenue for process addictions to develop. Not doing so enables the addictions to flourish and grow.

*Number of clients struggling with this necessitates training.* The second basic theme supporting the concept that Internet pornography addiction is a growing problem is that the Internet has become so common, and pornography so easily accessible from multiple electronic devices that an increasing number of clients are presenting with

problematic Internet pornography use. Counseling students are not being trained on how to effectively assess, diagnose, or treat this presenting problem, leading to frustration for both clients and counselors. One expert simply stated, “More and more clients are coming in with process addictions.” Another expert emphasized, “Process addiction training is critical, undervalued, and underexplored, because of the frequency of process addictions and sex addictions, etc. [in clients’ presenting problems].” Surely the use of the Internet shows no sign of decreasing, so the profession needs to ensure the training of clinicians to effectively treat this issue.

***Every master’s student will encounter addicted clients.*** The final basic theme under this organizing theme explains the concept that it is quite likely that master’s students will encounter addicted clients during their training program, and furthermore, it is quite likely they will encounter clients who are dealing with process addictions. Two experts stated simply that “Every master’s student will encounter addicted clients.” Another expert added to this thought by saying, “All counselors have seen clients with addictions; school counselors are not immune from exposure to this population because of exposure of youth to technology.” Since it is quite likely that master’s students will encounter addicted clients, many of whom will have process addictions, surely training in the assessment, diagnosis and treatment of this issue should be included in their training.

In summary, global theme number one explained the need for process addiction training. The experts indicated a need for unification of the counseling profession in agreeing about the definitions of Internet pornography addiction, sexual addiction, or even process addictions. More research needs to be conducted on Internet pornography addiction. This issue needs to be recognized more consistently by the general public and

the counseling profession, and counselors need assessment and treatment protocols to be developed in order to deal effectively with this presenting issue. Internet pornography addiction is increasing and the majority of counselors are having clients present with this issue. The next global theme addresses the experts' views on the importance of process addiction training in counselor education programs, will elaborate on what is happening now, as well as what areas needs to change.

### **Global Theme Two: Process Addiction Training Critical**

Cross-case analysis of the seven expert interviews further resulted in certain patterns of meaning related to the current critical state of the training specific to process additions in counselor education programs. Participants were asked: "In your opinion, what is the current state of process addictions training in master's-level, CACREP-accredited programs?" The key themes that emerged from their responses included these three organizing themes surrounding the second global theme: "Process Addiction Training is Fundamental," "Process Addiction Training Increases Competence and Confidence," and "Current Training." Refer to Figure 16 for the Thematic Network of Global Theme Two.

**Process addiction training is fundamental.** A recurrent theme among many of the experts was identified and used to create this important organizing theme. The experts indicated that the counseling profession should be training students to assess and treat process addictions and that this training for counselors is fundamental to their competence as counselors. The basic theme comprising this organizing theme follows.

*Process addictions training is undervalued and underexplored.* The experts agreed that process addictions are so frequent that the necessity of training is not



debatable. In fact, the experts expressed that to not train individuals to assess and treat process addictions would be a disservice to counselors and to the clients. One expert expressed that, "Process addictions' training is critically important." Another expert expressed the same sentiment with slightly different words, "Training for process addictions is very important for counselors." Still another expert emphasized that, "Process addiction training is extremely important for counselor education, counseling, and supervision." Six experts mentioned how very important this training is. Process addictions are undervalued and underexplored. The third basic theme reinforces the concept that process addiction training is fundamental to counselor education and the importance of this training seems not to be realized. One expert explained this lack of exploration like this, "The counseling profession is at a very early stage of studying Internet pornography addiction."

Another expert discussed this fact by stating, "A lot more research needs to be done; more funding and a focus on Internet pornography addiction is needed." A third expert pointed out, "Because of the frequency of process addictions and sex addictions, etc. [in clients] this issue should be taken more seriously." One expert expressed this sentiment, "Counselor training is not doing a very good job, but it's a lot better than before. In general, the average counseling graduate is 'lacking' in preparation to counsel for process addictions." The experts consistently expressed that process addictions need more study and clarity.

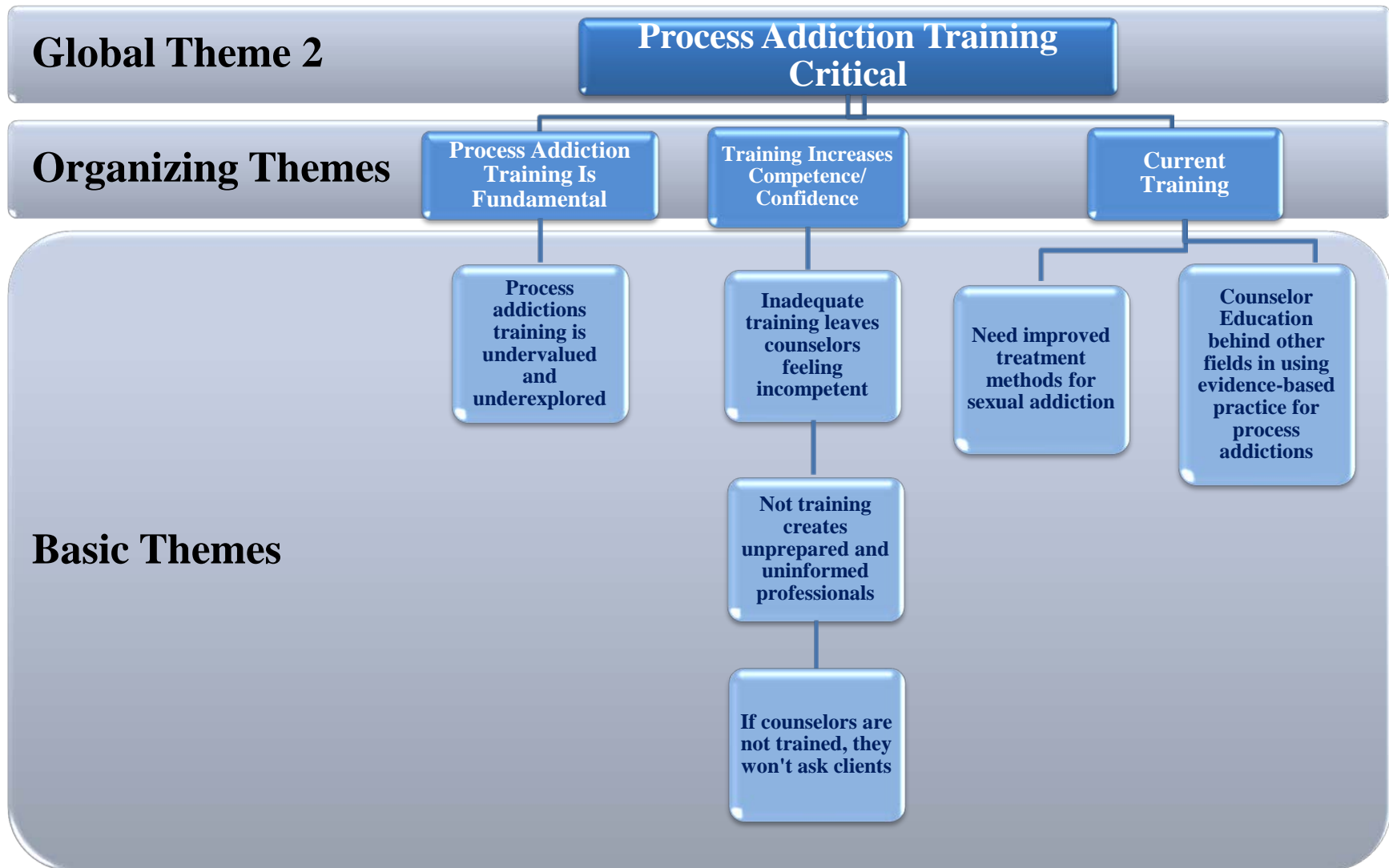


Figure 16. Thematic network for global theme two, "Process Addiction Training Critical."

**Training increases competence/confidence.** The second organizing theme that emerged under the global theme of “Process Addiction Training Critical” was the thought that training in process addictions will create a feeling of competence and confidence in counselors. The participants were asked, “In your opinion, how well prepared is the average counseling graduate to effectively counsel an individual addicted to Internet pornography?” As a result of this question, several basic themes emerged from this discussion. The three basic themes that were categorized together to create this organizing theme follow.

***Inadequate training leaves counselors feeling incompetent.*** The first basic theme centers on the experts’ views that counselors are likely to encounter clients who present with process addictions for treatment, including pornography addiction. They also indicated that many counselors will feel inadequate to address this issue. One expert said, “Most students graduating from counseling programs are ill-prepared to handle Internet pornography addicted individuals.” Another expert further elaborated, “Counseling graduates are not prepared at all to handle pornography addiction; we don’t teach them to ask.” Many counselors feel incompetent to deal with clients’ process addictions because the training seems inadequate in this area.

***Not training creates unprepared and uninformed professionals.*** The second basic theme speaks to a lack of training producing counselors who are not prepared as well as they could be. The experts expressed concern that currently most counselors not only do not ask about process addictions, but the experts believed that most counselors also do not understand the causes of process addictions, nor do they understand how to treat them effectively. As has already been stated, it is likely that counselors will

encounter clients who self-identify as being addicted to Internet pornography. Not including this topic in counselor training programs, sets up counselors to be unprepared to properly handle this issue. One expert said, “We [counselor educators] don’t know much about sexual addiction, the definition, research surrounding it, etc.” so how can we expect clinicians to effectively deal with this issue? Another expert asserted that, “The average counseling graduate is poorly prepared to counsel for Internet pornography or other process addictions.” A third expert went further, “The average counseling graduate is not very well prepared (probably a 2 on a 5 point scale) to counsel Internet porn addiction.” Adequate preparation and training will alleviate our professionals being unprepared.

***If counselors are not trained, they won't ask clients.*** The third and final basic theme that addresses the organizing theme of training competence and counselor confidence is that if we as counselor educators do not train our students to screen for process addictions, they most likely will not. Sexuality and sexual conversations are still awkward and uncomfortable for many in American culture, in spite of being inundated with sexual images. If the counselor does not bring it up and screen for it, the client will likely not bring it up either. One expert pointed out, “People will not usually self-report process addictions (especially sexual addictions).” Another expert agreed, “There is a lot of shame around sexual addiction. People [clients] and clinicians don’t talk about it.” Yet another expert said, “Counselors don't ask about online activity during intake and counseling sessions because they are not informed to do so.”

**Current training.** The third organizing theme that emerged under the global theme of “The Current State of Process Addiction Training” asked what was happening

in the field of counseling right now. All experts mentioned this topic in some form. The two basic themes that were categorized together to create this organizing theme follow.

***Need improved treatment methods for sexual addiction.*** The second basic theme supporting what is happening in the field now is that clinicians tend not to know how to handle sexual addictions, especially Internet pornography addictions, when they are presented by clients, because they have not been trained how to treat them. Improved treatment methods would help give clinicians confidence and knowledge on how to effectively help clients who present with sexual addictions. One expert elaborated this point by saying, “Process addictions and chemical addictions are similar, but process addictions are more psychological. Process addictions are unique.” Another expert understood this point by sharing, “It would be neat if we came up with a certification related to process addictions.” An expert supported this theme by sharing, “In general, the average counseling graduate is "lacking" in preparation to counsel for process addictions. The preparation of the average counseling graduate for process addiction treatment depends on which professors you've had.” A different expert went on to explain that if counselor educators are really concerned about counselor competence as a field, then the training of our counselors should not be based on the experiences of our professors. Another counselor educator put it this way, “I seriously doubt counselors in training are getting detailed training for treatment of online pornography addiction.” Another respondent commented that counselors have a “General framework for understanding process addictions, but not the tools or skills necessary to effectively treat them.”

*Counselor Education needs to use evidence-based practice for process*

**addictions.** The fourth basic theme centers on the notion that counselor education is lagging behind other mental health professions in the area of treating process addictions. Six of the seven experts addressed where the field of counseling is as a profession currently compared to other similar mental health professions, and five of the experts pointed out that counselor education seems to be behind other professions in the willingness and capability to deal with this issue. One respondent indicated, “We need to catch up to social work and psychology regarding evidence and data utilization.” Others recommended specific training components such as, “The counseling field seems to be 10 years behind in the area of technology. Most of my colleagues are not educated about cybersexual behaviors.”

In summary, global theme number two emphasized the importance of including process addiction training in counselor education programs. Process addictions training is fundamental to students’ training, and it would be a disservice to students for them not to be trained in working with clients who have process addictions. By including process addictions training the counseling profession would be preparing better counselors who are more competent to ask the right questions to enable clients to discuss these sensitive issues. Global theme number two also addressed the current state of what is happening in counselor education programs now in terms of process addiction preparation. Currently, most counselors are not being trained in process addictions which places counselor education graduates behind other professions.

### **Global Theme Three: CACREP Acknowledgment of Process Addictions/Internet Porn Addictions**

Cross-case analysis of the seven expert interviews further resulted in certain patterns of meaning related to the current state of CACREP accredited programs, CACREP standards, and their interactions with process addictions and/or Internet pornography addictions. Participants were asked: “In your opinion, what is the current state of process addictions training in master’s-level, CACREP-accredited programs?” A second global theme emerged from this interview question, specifically surrounding CACREP’s handling of process addictions and Internet pornography addiction. The key themes that emerged from their responses included these two organizing themes surrounding the third global theme: “CACREP Standards do not Adequately Address Process Addictions,” and “CACREP’s Place to Ensure Instruction in Process Addictions.” Refer to Figure 17 for the Thematic Network of Global Theme Three.

**CACREP standards do not adequately address process addictions.** Three basic themes were categorized together to create this organizing theme. The experts all generally indicated that CACREP does not address process addictions in the current standards, and because of this, counselor education programs do not seem to place an emphasis on this in training student clinicians. The three basic themes comprising this organizing theme follow.

***Process addictions training in CACREP programs is poor, but gaining momentum.*** The first basic theme indicates that in spite of the fact that process addiction training in CACREP programs is gaining momentum, the experts agreed that the current state of the training preparation for process addictions is still poor. Most of the experts indicated that CACREP is gaining momentum in its coverage of addiction standards,

especially in light of the 2009 standards that some programs are still struggling to implement. In spite of the fact that CACREP is gaining momentum in its attempts to include addictions training for students, the experts pointed out that the current CACREP standards don't adequately address process addictions. One expert reported, "Core skills in CACREP only go so far with process addictions." Another expert stated, "CACREP programs have made a lot of progress in the last 10 years in addressing addictions competencies."

*Add standards, enhance existing ones.* The second basic theme indicated that the experts thought that if CACREP would add process addiction standards as well as enhance the existing addiction related standards, this would strengthen the training programs and help create capable clinicians. Interviewees were asked, "Based on your expertise, can you identify any specific changes that still need to be made in this area? (e.g., related to the profession, the CACREP standards, CACREP-accredited programs, or students and faculty), and the key themes that emerged from their responses follow. One of the participants stated, "Either standards should be added in the specialty area tracks in which process addictions should be taught, or an addictions component could be added in the CACREP core." Likewise, another participant stated a similar sentiment, "We need a process addictions requirement for CACREP--it could be integrated into current standards." One counselor educator stated, "CACREP is not creating an incentive to teach addictions. CACREP needs to add more standards that require programs to teach about process addictions, and be more specific about what that means."



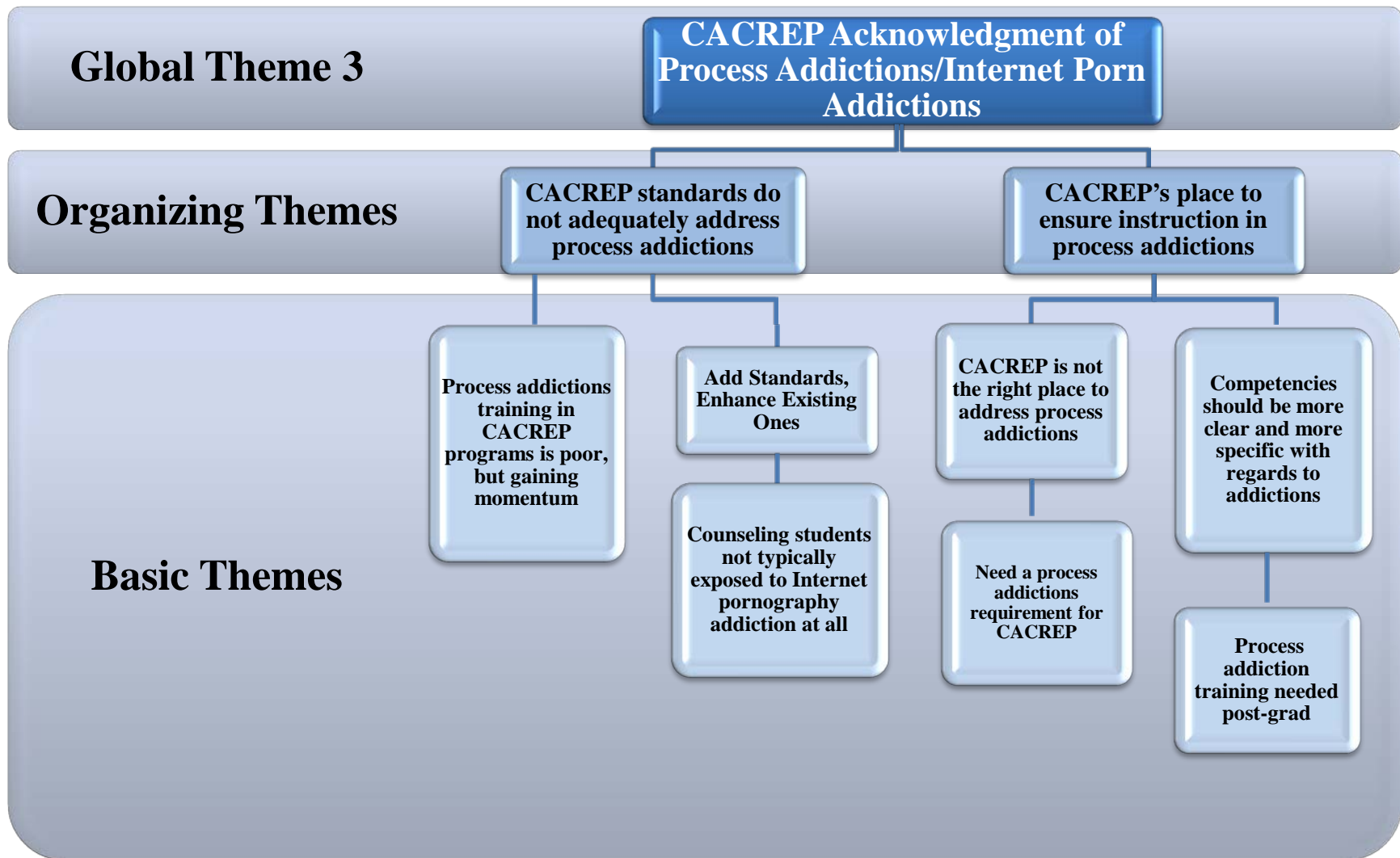


Figure 17. Thematic network for global theme three, “CACREP Acknowledgment of Process Addictions/Internet Porn Addictions.”

***Counseling students not typically exposed to Internet pornography addiction at all.*** The third basic theme identified from the expert interviews illustrated that counseling students in CACREP accredited programs, if they have an addictions class, are probably not exposed to process addictions much, and are typically not exposed to Internet pornography addiction at all. In fact, according to one expert the “Average counseling graduate is poorly prepared to counsel for Internet pornography addiction.” According to one counselor educator, “The Internet as a catalyst for sexual compulsivity is increasing, you would think programs would mention the Internet as an avenue for addiction, but I am not sure they are. I seriously doubt counselors-in-training are getting detailed training for treatment of online pornography addiction.”

**CACREP’s place to ensure instruction in process addictions.** The second organizing theme under the global theme involving CACREP’s acknowledgement of process addictions questioned whether it was even CACREP’s place to involve themselves with something as specific as process addictions. Four basic themes were categorized together to create this organizing theme. Most of the respondents addressed, to some degree, which organizations should have responsibility to ensure clinicians were properly trained in process addictions. All participants indicated that counselors should be trained, but not all believed it was CACREP’s responsibility. The four basic themes comprising this organizing theme follow.

***CACREP not the right place to address process addictions.*** The first basic theme that addresses the idea of whether CACREP can properly ensure clinicians are trained in Internet pornography addiction treatments asserts that it indeed cannot. One expert simply said, “CACREP does not need to provide specialty training in a certain

area.” Another participant stated that, “CACREP is overwhelmed and needs to look at broader issues rather than deeper issues. The best place to make a certification [for pornography addiction] is NBCC, but they won't do it because it's not profitable for them.” This same participant later added, “I don't think CACREP is the right place to address such a narrow, in-depth study as process addictions. An external agency could make requirements for having a process addiction certification.” A third counselor educator addressed the topic this way, “CACREP standards are not expected to include Internet pornography specifically, but should state there are a variety of types of addictions.”

***Need a process addictions requirement for CACREP.*** The second basic theme found was that it is CACREP's responsibility to ensure process addictions are included in every program. The experts who addressed this topic asserted that not enough training was being provided and that the best way to ensure change is to have CACREP require that the programs provide process addiction training. Otherwise, programs will not have the incentive to change training programs. One participant explained, “CACREP needs more specific addictions training requirements.” Another participant indicated, “Introduction to process addiction is a necessary part of a CACREP program. Either standards should be added in the specialty area tracks that process addictions should be taught, or an addictions component could be added in the CACREP core.” Another expert mentioned, “Process addictions training in CACREP programs is lacking. We need a process addictions requirement for CACREP--it could be integrated into current standards.”

***Competencies should be clearer and more specific with regards to addictions.***

The third basic theme found in the examination of the expert interviews called for CACREP to reexamine the competencies surrounding addiction, including process addictions. As they stand now, the competencies are vague and programs struggle to find a good way to comply with the standards and prepare counselors to handle issues specific to process addictions. One participant specifically mentioned, “Competencies should be made more clear, and the importance of addictions training should be made more specific.” One of the experts addressed this issue similarly, “CACREP standards should be more specific regarding process addictions’ training requirements.” One counselor educator stated, “There aren’t many CACREP standards around addictions, there are not even sub-standards. CACREP needs to add more standards that require programs to teach about process addiction. The lack of clear CACREP standards specifically including process addictions makes it difficult to prepare the counselors to handle issues specific to process addictions.

***Process addiction training needed post-grad.*** The fourth basic theme was a call for process addiction training to occur during American Counseling Association conference educational sessions, post-grad certification programs, or even research by counselor educators to be published and read by master’s level practitioners. One expert indicated, “Adequate coverage of process addictions will have to occur post-grad.” Once the profession entertains the idea of counselors getting necessary process addiction training post-grad, or any other voluntary means, not all counselors will receive this training. One expert asserted that the “Such a certification would have to be general

enough so institutions could pick it up easily without having to hire new people or change what they're doing.”

In summary, global theme number three explained CACREP’s role in providing process addiction training. This theme addressed whether it was CACREP’s place to ensure students are trained in this area or whether this training should occur post-grad through workshops, conferences, or other training sessions. If CACREP recognizes that process addiction training in counselor education programs is currently poor, it should add new process addiction training standards, as well as enhance the existing standards to emphasize the need for this training. CACREP drives what courses are offered in counselor education programs so it is likely that not every student will receive the training if CACREP doesn’t require that they do.

#### **Global Theme Four: Addiction Course Content Delivery**

Further cross-case analysis of the seven expert interviews resulted in certain patterns of meaning related to the current state of CACREP accredited programs, CACREP standards, and their interactions with how process addictions and/or Internet pornography addictions are taught in an addictions class. Participants were asked: “How should process addiction instruction be taught? In other words, what would be considered best practice?” Participants were also asked, as a clarifying question, and to get the experts to elaborate: “In regards to best practice, what method should be used to implement competencies into CMHC programs (e.g., infusion, stand-alone, combined)?” The key themes that emerged from their responses included these three organizing themes: “Process Addictions Course Should be a Stand-Alone Course,” “Combined

Methods (Infusion and Stand-Alone Course),” and “Infusion is Best Practice.” Refer to Figure 18 for the Thematic Network of Global Theme Four.

**Process addictions course should be a stand-alone course.** The first organizing theme found through the data analysis process is that some experts thought that process addictions were common enough, different enough, and important enough that they warrant their own course added to CACREP accredited programs. Two basic themes were categorized together to create this organizing theme and their descriptions follow.

*Stand-alone course is the best way to introduce process addictions.* Currently, it seems, counseling students are not receiving training on process addictions consistently. Several experts shared that counselor education needs a stand-alone course to demonstrate that process addiction training is important. These experts believe that there should be a chemical addiction class and a stand-alone process addictions class. The first basic theme that arose suggests process addictions should warrant a stand-alone course as the best way to introduce process addictions and convey its importance to program participants. Several experts simply stated, “Process addictions should be a stand-alone course.” One expert indicated the counseling profession, “Need[s] a stand-alone course (process addictions) without question.” When discussing the option, this participant stated, “I would love to see a stand-alone course that allows you to focus on [process] addictions for a long time.” One of the experts discussed, “Process addictions are a big enough issue to warrant addressing it in depth.” One respondent stated, “A stand-alone course demonstrates that process addictions are an important part of the curriculum.” Another expert added, “Having [separate] stand-alone courses is the best way to

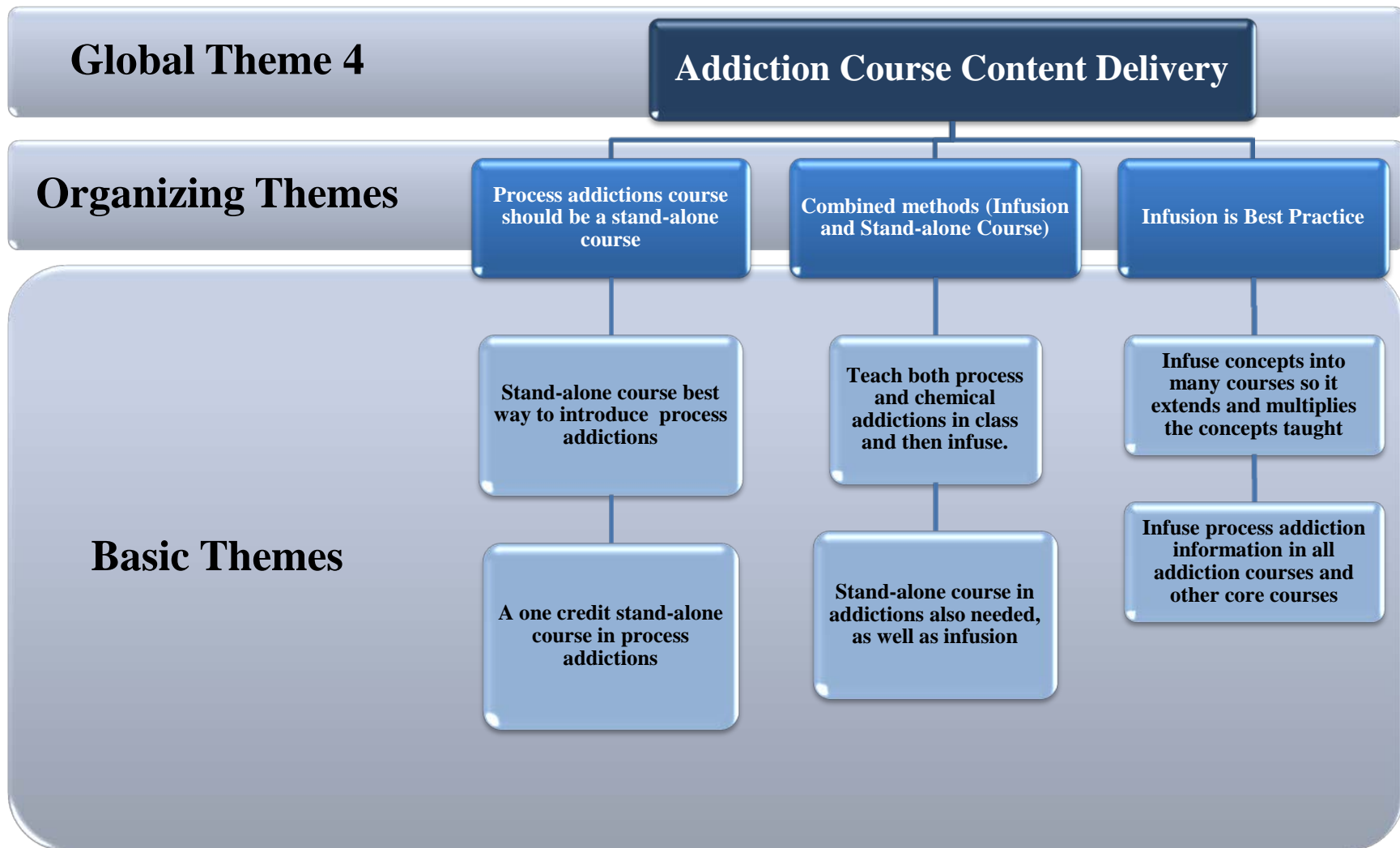


Figure 18. Thematic network for global theme four, “Addiction Course Content Delivery.”

introduce process and chemical addictions to people.” When referencing how to increase the training and acceptance of process addictions, one participant commented that his, “First choice is a stand-alone course.”

***A one credit stand-alone course in process addictions.*** The second basic theme identified surrounding the debate of how to include process addictions in training programs centered on having a one-credit, stand-alone course in process addictions. This, it was thought, would not create undue burden on programs to add a 3-credit class, but would still allow the students to receive process addiction training. One participant asserted that a “Stand-alone process addiction class, supplemental readings, and assignments...” were important for process addiction training. Another counselor educator made reference that it, “Might be good to have a stand-alone, one-credit course in process addictions.”

**Combined methods (infusion and stand-alone course).** The second organizing theme under the global theme of Addiction Course Structure involved experts indicating a need for both a stand-alone course where process addictions are taught, and a need to infuse process addictions into other courses that are taught in the program. Two basic themes were categorized together to create this organizing theme.

***Teach both process and chemical addictions in class and then infuse.*** The first basic theme supporting the concept of combining both a stand-alone course and infusing process addictions throughout the classes in the counseling curriculum involves splitting an addictions class equally between process and chemical addictions, then infusing process addictions as examples in other classes such as practicum, theories and techniques, ethics, and various other courses. One counselor educator summed it up by



saying, “Our program addictions class is half process and half chemical addictions.” One interviewee went on to say, “Chemical and process addictions should be looked at together, not separated.”

*Stand-alone course in addictions also needed, as well as infusion.* The second basic theme outlined the concept that both infusion and a stand-alone course are equally important and training programs would not be complete without one or the other. One participant explained this concept by saying, “We should infuse addictions into lots of courses, yes, but [a stand-alone] addictions class is a must for every program.” Another interviewee stated, “CACREP competencies require a combination of a stand-alone course and infusion across the curriculum.” Another participant discussed his perceptions as to what the best practice would be as, “I prefer to have process addictions infused throughout courses, as well as a stand-alone addiction class, supplemental readings, and assignments that include substances and process addiction.” Another participant indicated, “We need to talk about addictive behaviors and addictions in all courses, but have a dedicated course to show students how important it is as an issue and hit on it in other courses as well.” The participants agreed that in order for counselors to be competent, they really need more than just one course in addictions. One participant indicated, “Many counselors felt incompetent to deal with clients' spirituality; process addictions are as big of an issue as spirituality and should not be trained with just one class.” One counselor educator described his perspective that infused concepts without a base knowledge just tends to water down the concepts. He stated, “Having a stand-alone course is the best way to introduce process and chemical addictions to people. Once we have stand-alone course, we need to infuse the concepts into many courses.” There was a

consensus among the experts that one class in addictions, even if it includes process and chemical addictions, is not going to make an competent addictions practitioner. Students need both a standalone course and for the process addictions component to be infused in other courses as well.

**Infusion is best practice.** The third organizing theme under the global theme of Addiction Course Content Delivery was identified as experts indicating a need for the infusion of process addictions throughout the core classes in the program. The interviewees indicated that infusion was necessary for multiple reasons, which are listed below as basic themes and were categorized together to create this organizing theme. The two basic themes comprising this organizing theme follow.

***Infuse the concepts into many courses so it extends and multiplies the concepts taught.*** The first basic theme reflected a significant amount of discussion surrounding infusing process addictions training throughout the CACREP core courses. Several experts asserted their belief that by infusing these concepts students will get a better sense of their importance. One expert stated, “Process addictions should be infused because it’s infused throughout clients’ lives.” One of the interviewees explained, “We need to infuse the concepts into many courses so it extends and multiplies the concepts taught and students will remember and are better prepared.” The experts explained that infusion must be intentional and is more than a mere mention of something in a class. Infusion should include intentional placement of a concept into a class, applicable to both the topic being presented and the student’s career in order for it to extend and multiply the concepts taught. Another counselor educator described the impact of infusion: “I have seen other concepts infused into courses and sometimes infusion means watered down.”

*Infuse process addiction information in all addiction courses and other core courses.* The second basic theme under the organizing theme of infusion being the best practice conveyed that the experts were clear that not only should process addictions be part of an addictions course, but that also process addictions should be infused in all other core program courses as well. All of the experts expressed the importance of addressing process addictions to students, and many felt it extremely important to address this in the core classes so that its importance is conveyed. One participant stated, “Best practice would be to infuse process addiction information in all addiction courses and other core courses.” Another respondent shared, “Process addiction training should be infused in all addiction courses.”

In summary, global theme number four discussed addiction course content delivery. This theme included discussion of how best to teach process addictions in combination with a “regular” addictions class. This global theme approached this discussion from three directions: 1) process addictions could be its own stand-alone course which would be taught separate from a chemical addictions course, 2) process addictions could be taught in a combined methods format which would include infusion and the use of a stand-alone course, and 3) process addictions could be taught solely through the use of infusing its concepts into the already existing core classes, including the chemical addictions class.

#### **Global Theme Five: Counselor Education Programs' Inclusion of Process Addiction Training**

Further cross-case analysis of the seven expert interviews resulted in certain patterns of meaning related to the current state of CACREP accredited programs, CACREP standards, and their interactions regarding which programs should include

process addictions and/or Internet pornography addictions training. Participants were asked: “Which students should be exposed to addiction training (e.g., Career, CMHC, Marriage, Couple, and Family, School, etc.) and why?” The key themes that emerged from their responses included three organizing themes. The three organizing themes that emerged surrounding the fifth global theme were: “All Program Graduates Should Receive Process Addictions Training,” “Which Counseling Program Graduates will Encounter Sexually-Related Process Addictions Most Often?” and “No Program Should Require Process Addiction Training.” Refer to Figure 19 for the Thematic Network of Global Theme Five.

**All program graduates should receive process addictions training.** Counselors who go on to see clients after their program ends will quite likely encounter clients with process addictions, which is evident by the quantitative data collected for this study. The first organizing theme found through the analysis process is that some experts thought that process addictions were common enough, different enough, and important enough that they warrant their own course added to CACREP accredited programs. Five basic themes were categorized together to create this organizing theme. The five basic themes comprising this organizing theme follow.

***All programs should require an addictions course.*** The first basic theme under the organizing theme of requiring process addictions for all program graduates is the grouping of experts who agreed with CACREP’s requirement that all programs offer an addictions class to their students. The 2009 standards require an addictions class, and the experts expressed that this is a definite need. Most of the participants indicated that all of the programs within CACREP’s purview should include training in process addictions.

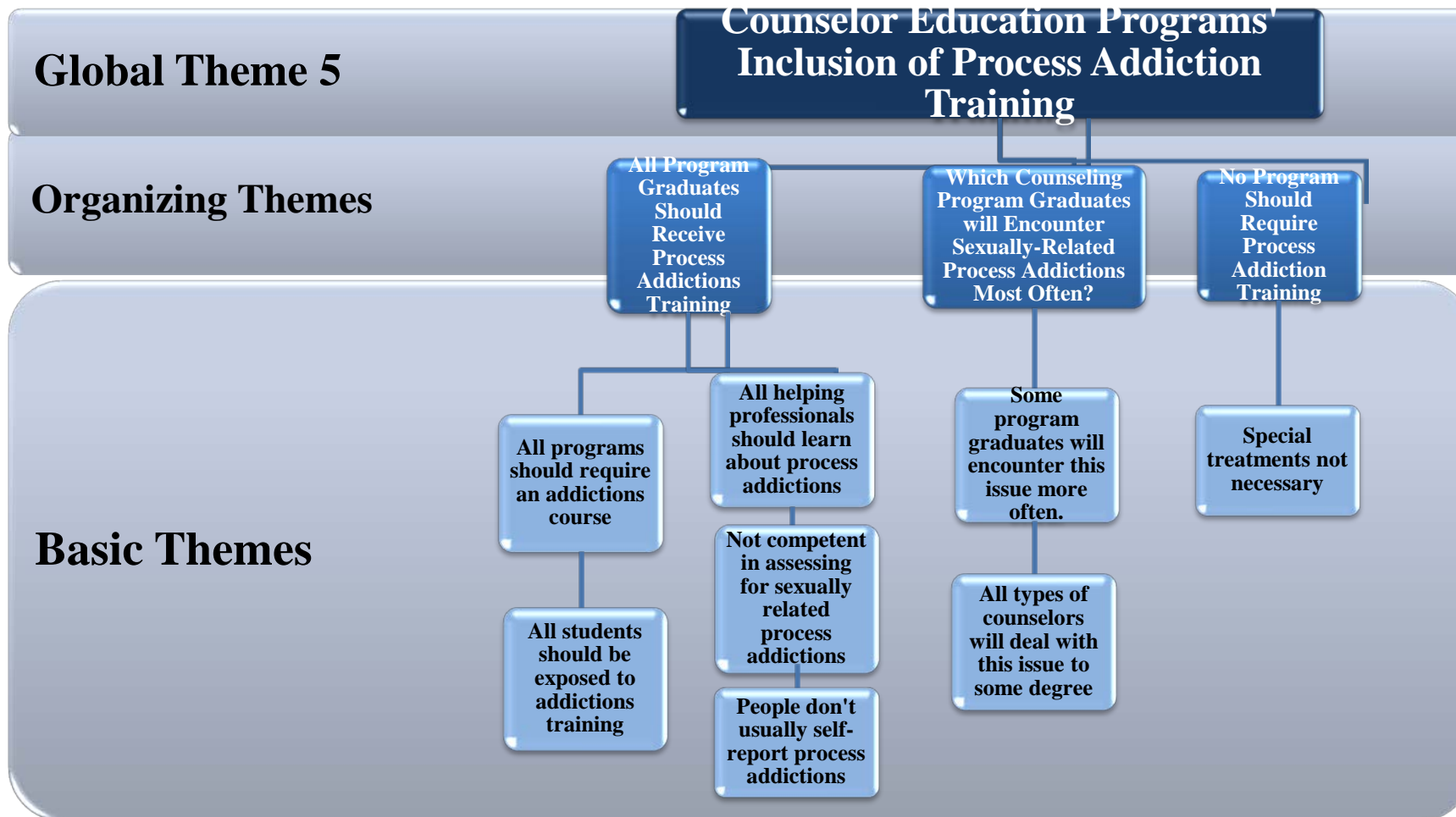


Figure 19. Thematic network for global theme five, “Counselor Education Programs' Inclusion of Process Addiction Training.”

One expert recommended, “An introduction to process addictions is a necessary part of any CACREP program.” Another expert recommended, “School Counselors, College, Career, all counselors need to know how to recognize, assess, and refer addictive disorders. School counselors are sometimes getting the bare minimum training in addictions.” One expert even went so far as to express, “Not requiring a course in addictions is ridiculous.”

*All students should be exposed to addictions/process addictions training.* The second basic theme, similar to the first, describes how some experts thought that all students should at least be exposed to addictions training, even if their program is not specifically geared toward people who may develop addictions. For instance, one expert described, “All students should be exposed to addictions training.” Certainly classes that satisfy a requirement in more than one program could be shared by those programs and have multiple disciplines present in such a class. This expert explained it in this manner, “Students in all programs should be exposed to addictions training, addictions training should cut across all programs.” Another participant expressed that, “Students should have contact with the content of process addictions.” Because all clinicians in all programs will encounter clients with process addictions, it is important for all programs to include this training to some degree.

Every expert that was interviewed mentioned to one degree or another that process addiction training is necessary for students. In fact, one expert stated succinctly, “Every master’s student will encounter process addicted clients.” Process addictions are so prevalent, and their inclusion in the training of counselors is so seldom, that this problem is becoming serious. One counselor educator described it this way, “Process

addiction training for counselors is crucial.” All programs should require process addiction training to show its importance and to guarantee that clinicians will be prepared to handle what clients present.

***All helping professionals should learn about process addictions.*** The third basic theme points out the need for all helping professionals, beyond simply counselors, to learn about process addictions. Many experts pointed out that more clients are presenting with issues related to process addictions in session and counselors and other mental health professionals need to know how to assess and treat these clients. Clinicians in all helping professions will face clients or clients’ loved ones who are dealing with process addictions, including sexual addictions. Students in all sorts of programs will likely have clients who present with process addictions, so all professionals should be trained. According to one respondent, “Most people will run into process addictions in their first week in practice.” The experts expressed that it is quite likely that any practitioner, regardless of setting, will likely encounter clients with process addictions and should know how to treat them. One participant stated, “Any counselor has a good chance of encountering a client with an addiction, clinical mental health and couples counselors need to know how to do interventions and treat.” One expert explained, “So many are struggling with the issue that the necessity of training is not debatable.” Some experts believed that every type of mental health worker is likely to encounter individuals who are facing process addictions. One counselor educator further developed this thought by stating, “All helping professionals should learn about process addictions.”

***Not competent in assessing for sexually related process addictions.*** The fourth basic theme illuminates the concern that many of the experts had that counselors are not

competent to assess for process addictions, particularly sexually related ones, among clients. If all helping professionals will likely encounter clients in need of help with process addictions, and they are not being trained currently, then counselors are not currently competent to assess clients for sexually related process addictions and should be. All of the participants were chosen as experts because of their experiences in researching and publishing about this topic. One of the researchers discussed his research findings in regard to this topic by saying, “Addictions courses are taught from a medical model, around chemicals solely. Eighty percent of addiction clinicians received inadequate graduate-level training related to sexual addiction, and 70% of Master Addiction Counselors felt incompetent to address sexual addiction.” It is important to emphasize the point that the vast majority of even Master Addiction Counselors do not feel competent to assess for process addictions of a sexual nature. Another counselor educator who is well published in the area of sexual addictions stated, “Classroom instruction and reading related to process addictions, the assessment of process addictions, markers to suggest process addictions are occurring in individuals, and intervention techniques that work well for process addictions should all be taught.” Another participant expressed his concern by explaining, “Counselors are not where we need to be in assessing for process addictions, makes it difficult to prevent. Counseling students should be aware of their biases and values surrounding sexuality in general, and sexual behavior specifically.”

***People do not usually self-report process addictions.*** The fifth and final basic theme under the organizing theme of “All program graduates will encounter process addictions” captures the point that clients will probably not share with a counselor



voluntarily that they have a process addiction without the counselor asking the client about it, and knowing how to screen for it. Counselors will not know to ask if they are not trained to ask, so this issue might go unnoticed in counseling. All programs should prepare their students to recognize and ask questions about process addictions since the clients will likely not bring these issues up readily. One participant discussed, “I try and teach the students that clients typically won’t self-report their addictive behaviors, process addictions...because there’s a view that it’s not as dangerous as chemicals and it’s less obvious to see on the person.” Sometimes, according to one expert, the client may not even be aware at first that they have an addiction. He explained it this way, “People don’t know that they have a process addiction. They identify the problem as being the relationships or anxiety or depression, but they don’t realize that there is an addictions genesis to it.”

**Counseling program graduates who encounter sexually-related process addictions most often.** The second organizing theme supporting the global theme of “Counselor Education Programs' Inclusion of Process Addiction Training” explained that some program graduates are more likely to encounter clients who have process addictions than other graduates. Two basic themes were categorized together to create this organizing theme. The experts’ answers to this question seemed to fall into two categories, some clearly need more than basic training, or all counselors need training. The two basic themes comprising this organizing theme follow.

*Some graduates will encounter sexual addictions more often.* Most, but not all, of the experts agreed that at least on a basic level all mental health professionals should be aware of process addictions that are sexual in nature. Some experts mentioned

graduates of specific programs that should have more than a basic knowledge. If we identify which type of counselor is most likely to encounter clients with process addictions of a sexual nature, we can prepare them to know what to do with these clients. One counselor educator stated, “I think the mental health and marriage and family tracks are going to probably have more exposure to it directly within their work.” Another expert continued, “Clinical mental health counselors as well as just the sheer number of couples who are being impacted by some sort of cyber sexual experience, those really jump out in my head as areas where the need [for training] exists.” Another expert agreed, “Mental health and marriage and family need to have a strong foundation in addictive disorders.” One expert emphasized that school counselors should be trained in pornography addiction treatment because of the use of the Internet by young people, and the dangers it contains. He explained, “I think school counselors especially, because of all the technology that these adolescents are exposed to, the social networking...”

***All counselors will deal with sexually-related process addictions to some degree.***

The second basic theme gathered from analyzing the expert interviews revealed that, to a large degree, the experts agreed that all types of counselors will, to some level, have to know how to assess and treat process addictions that involve sexual addiction and pornography addiction. This basic theme conveys that although there may be varying degrees to which some counseling professionals may encounter sexual process addictions more often than another, it seems all mental health professions will deal with this issue to some degree. When one expert was discussing which students need to be exposed to sexual process addiction training, he said,

I think they all need to be. I mean, I think there's some... even with school counselors, even if you're going to work with elementary kids, you are going to be working with their families, and it's possible that their parents or family members, sisters or brothers, whoever, are going to be experiencing issues related to addictions. So, you know, I think it really cuts across all programs.

Another counselor educator was addressing the same topic, and conveyed a slightly differing opinion by saying,

My answer is going to be "all students." But especially anybody who's going to be working or desires a license related to addictions: family, clinical mental health. Now, whether school counselors should have that training—I think they should be knowledgeable about it.

**No program should require process addiction training.** The third organizing theme under the fifth global theme of "Counselor Education Programs' Inclusion of Process Addiction Training" elaborates the idea that really no program should require process addiction training. This organizing theme contained one basic theme and that is the concept that special treatments for process addictions are unnecessary. Only one expert put forth this concept, but it was an important message, one that this researcher felt was an important perspective to be included, although this opinion was a minority one. The basic theme that comprises this organizing theme follows.

***Special treatments for process addictions not necessary.*** The only basic theme under the organizing theme of "No program should require process addiction training" involves the idea that addictions are all basically the same and the treatments should be the same, too. Since addictions all have similar physical, mental, and emotional effects

on the brain and nervous system, the necessary treatments will be provided during an addictions class at the master's level. One expert expressed this thought, "Process addictions are occurring in this individual, or in this family system, or in this coupleship, and we have intervention techniques that seem to be well-suited for process addictions. I don't think you have to have special treatments for that."

### **Global Theme Six: Qualifications for Teaching Addictions Courses**

Further cross-case analysis of the seven expert interviews resulted in certain patterns of meaning related to who should teach an addictions course, what their educational history should be, what experiences they should have, and the training and preparation they should have had to prepare them to teach a course on addictions and adequately prepare students to work effectively with process addictions and/or Internet pornography addictions. Participants were asked: "What should be the qualifications of an instructor who teaches this content?" The key themes that emerged from their responses included three organizing themes. The middle-order, or organizing themes, represent the cluster of basic themes found in the data. The two organizing themes that emerged surrounding the sixth global theme were: "Education of Professors," and "Clinical Experience of Professors." Refer to Figure 20 for the Thematic Network of Global Theme Six.

**Education of professors.** The first organizing theme found through the analysis process involves the education and preparation of professors who might teach addictions courses in a CACREP accredited program. Four basic themes were categorized together to create this organizing theme. The four basic themes comprising this organizing theme follow.

*Certified in treatment strategies for sexual addictions.* The first basic theme found in interviews calls for the professor of an addiction course to know the strategies and techniques available to use with clients who present with this issue, and to be certified in the treatment of sexual addictions. One expert stated, “I think the instructor should be a person who works in the addictions field, and have a concept of an understanding of how people can become out of control with Internet behavior.” The experts agreed that not only should the person who teaches about addicts have an academic knowledge of the process of addictions, but also knowledge in the treatment of addictions. One of the experts recommended, “They need to know how to assess it, how to address it, how to treat it.” As counselor educators, some of an addiction instructor’s knowledge comes from academic study, while some knowledge and experience useful for teaching students will come from experience working with addicted clients. One of the experts shared that the instructor “Needs to understand 12-step programs and needs to understand the different types of treatment available.”

Most of the expert counselor educators discussed the concept of having a special certification dealing with process addictions that people who teach the addictions class should hold. There are several sexual addiction certifications available for people, and the discussion about whether or not the instructor should be required to have this certification was an interesting and valuable conversation. One expert stated the person’s experience should include, “The MAC certification, which means their Master Addiction

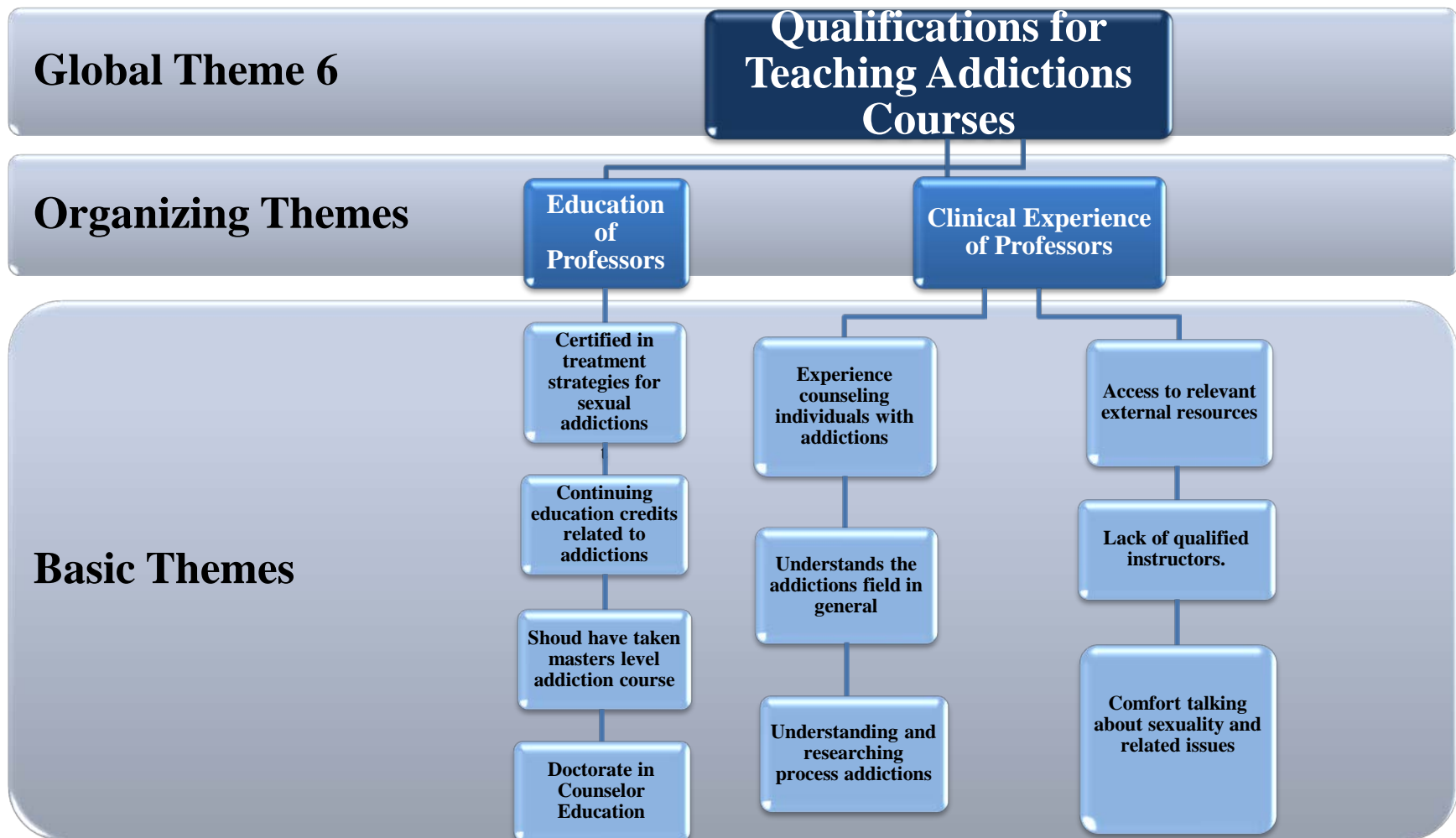


Figure 20. Thematic network for global theme six, “Qualifications for Teaching Addictions Courses.”

Counselor certification.” Another expert also described how the instructor would “preferably be someone who’s certified in treatment of sexual addictions.” One of the interviewees went on to state that, “Anybody who’s been through a certification program—you know, CSAT (Certified Sex Addiction Therapist) or SATP (Sexual Addictions Treatment Provider) or the new one that SASH (Society for the Advancement of Sexual Health) is starting would be a good person to teach an addictions class.” One of the experts described, “It would be really neat if we came up with some kind of certification related to process addictions.” A certification in treatment strategies for sexual addictions would be a great addition to our profession, since we already have a drug and alcohol certification, a sexual addiction certification is needed as part of the CACREP training program and would be a great way to ensure the proper training of counselors to be able to handle this issue when it comes up in session.

***Continuing education credits related to addictions.*** The second basic theme was a summary of the opinions of the experts in regards to an instructor of the addictions class having to attend training beyond the formal degree, such as at conferences, workshops, and training seminars. One expert addressed this issue by stopping short of saying the instructor should be required to attend a certification program, “but at least somebody that’s had 30 hours of CEUs.” Another expert went on to elaborate further, “Faculty should get CEUs in cybersex addiction and translate those concepts for students in the classroom...I think it is not a huge leap for those who have addictions training, having some CEU training around Internet behaviors.”

***Should have taken master’s level addiction course.*** The third basic theme under the organizing theme of the education of professors who teach an addictions course was

that these instructors should have at least taken a master's level addiction course in their counselor education program. One counselor educator who was interviewed emphasized, "So, I mean, I don't want to be power hungry with it but, but if you're going to teach the course you probably should have taken it. I know that hasn't always happened." Another expert went on to compare the competence to teach an addictions course with the competence professional organizations want you to have to counsel someone with an addiction.

We're bound by a code of ethics to practice within our area of competence, and I think that applies to teaching as well. I think we should not be teaching outside of our area of expertise, or our area of competence. So how is that quantified? I'm not quite sure.

Clearly a foundation of academic knowledge is important to the experts for an addictions class instructor.

***Doctorate in counselor education.*** The fourth, and final, basic theme derived from the interviews was that an instructor of an addictions class should have a Ph.D. in counselor education and supervision and other formal training in addictions. Two experts obliquely referenced advanced degrees to teach a specific course such as an addictions course, but one participant went into more elaborate detail about exactly what degree he believed was optimal to train counselors to be competent in this area. He suggested,

Well, first off, if it's a doctoral level course, I strongly believe that they have to have a doctorate in counselor education. If it's a master's course, then it could be somebody just with a master's degree and clinical experience related to process



addictions and addictions. But preferably, it would be somebody with a doctorate in counselor education who has 3 to 5 years' worth of clinical experience.

An interesting observation is that only one expert specifically mentioned a Ph.D. in Counselor Education as a qualification of an instructor who teaches this content, but as mentioned above, two others mentioned advanced degrees. Since all seven experts interviewed had obtained their Ph.D. in Counselor Education, this researcher got the impression the experts assumed an instructor in a CACREP accredited counselor education program would have a Ph.D. The formal training discussed by the experts ranged from having taken the masters level addiction's course themselves, to obtaining a special certification in addictions. One counselor educator stressed the importance of the instructor of an addictions class obtaining formal training, such as, "someone that has training and preparation in addictive disorders." According to one participant, the purpose of making sure the instructor has formal training is to, "Make sure that there's some degree of academic knowledge, some degree of clinical or experiential knowledge, with process addictions."

**Clinical experience of professors.** The second organizing theme under the global theme of the qualifications for teaching addictions courses that was found through the analysis process is the clinical experience of these professors. Not only did the experts focus on academic preparation, but also instructors' clinical experiences will prepare them for teaching this course. Six basic themes were categorized together to create this organizing theme. The six basic themes comprising this organizing theme follow.

*Experience counseling individuals with addictions.* The first basic theme that was found under the organizing theme of the clinical experience of professors was that a valuable experience to prepare a professor to teach an addictions class would be to have experience counseling clients who have been addicted, including having experience working with clients who present with process addictions. This would not only help the professor to know what works and what doesn't, but it will give the counselors-in-training valuable insight into the thinking and reactions of real clients when the professor speaks of these experiences in class. One counselor educator recommended, "I do think that an instructor should have worked with this population at some point in their career." Another participant stated the same concept quite similarly, "I think the instructor should have clinical experience in working with this population." Still another expert iterated, "I think the instructors should be people who work in [the] addictions field, and have a concept of an understanding of how people can become out of control with Internet behavior." Every interviewee mentioned the necessity of the instructor of an addictions class having experience working with addicted clients before instructing the class.

One expert elaborated on the fact that good teachers can teach anything, but are most engaging in courses they feel they are experts. That is, courses that they have experience in. This is how he described it,

I have taught courses that were not in my area of expertise and the interaction with students was just very limited. It was very flat. But when I'm talking about an area that I'm familiar with and that I know really well, the educational process is so much more dynamic. So I guess somebody could teach a course related to

sexual or process addictions if they're not really familiar, but I'm not sure it would be beneficial to students.

Another expert suggested that this experience with process addictions specifically involve cybersex and Internet pornography. This experience is also likely to result from continuing education units, rather than as part of a Ph.D. At any rate, important training and clinical experiences with process addictions remain necessary for an addictions instructor, "They need to be someone who's gone through some formal training on process addictions, and who has experience in working with process addictions." This expert combined not only experience working with process additions, but also formal training on process addictions, which at the present time would be very difficult to find.

***Understands the addictions field in general.*** The second basic theme that was revealed from analyzing the interviews was that these professors should have a working knowledge of the addictions field. Not only should they know about the addictions field, they should understand how addictions work and what they do to people. One expert recommended, "I don't necessarily expect that an instructor would have to be an extreme expert in the field, but they would have to have a fairly good knowledge base, both experientially and through their own training and readings." Several experts pointed out that it is more than knowledge that a professor who teaches addictions must possess. One expert pointed out the necessity for an addictions professor to, "Have a strong foundation in addiction."

***Understanding and researching process addictions.*** The third basic theme involved the experts providing their opinions on the best practices related to an instructor of an addictions course conducting research on process addictions, joining professional

organizations and presenting their research at these professional conferences. Ideally, these instructors would have experience researching process addictions so as to share those valuable experiences with counselors-in-training. Joining professional organizations which allow for the presentation of scholarly research will widen the audience and help train others in the importance of process addictions. One expert simply stated, “The qualifications should be that the individual is familiar with this area, has researched this area.” This same respondent went on to say, “I do think that an instructor should have actively engaged in research related to the content.” Another expert described an additional activity “It would be nice if this faculty member or instructor could do research in the area of addiction, or be professionally involved with the organizations that are focused toward addictions.” Instructors of addictions classes should not only research process and other addictions, but should also present at conferences so that more people can benefit from their research, as said by this participant, “Doing research on their own, and coming back and doing presentations.” One expert stated, “The person should have researched this area... having established him or herself as an expert in the field.” Another counselor educator described the same concept, but elaborated further, “It would be nice if this faculty member or instructor could do research in the area of addiction, or be professionally involved with the organizations that are focused toward addictions.”

***Access to relevant external resources.*** As the fourth basic theme, the counselor educators interviewed discussed that the counseling profession must remain diligent to provide students with cutting edge technology, research, experiences and evidence-based practice in how to assess, diagnose and treat Internet pornography addictions, all process

addictions, and even all addictions. The only way the profession can guarantee that this is being done is by endeavoring to have access to good resources to teach addictions classes. One of the experts indicated, “You know, a good teacher can teach about anything. It’s whether they have the resources to get to that are responsible and rigorous to be able to teach to that.” Not only should the instructors of addictions classes access good resources within the profession, but resources outside of the profession could be tapped as well. One counselor educator stated, “I think the instructor needs to be well-versed on what resources are available in the community, his or her community in the area of addictions.” Resources can enhance the learning experience of students and help them be better prepared to effectively deal with process addictions in the counseling setting.

*Lack of qualified instructors.* Of notable mention as a fifth basic theme was that counselor educators who are qualified to teach addictions, especially ones who satisfy the education and experiences listed in the other basic themes in this section, are scarce indeed. Possibly because of the scarcity, or perhaps it is just the reality of academia, one expert expressed his opinion by saying, “I think they need to have enough understanding, not everyone needs to be an expert, can’t be an expert in everything.” Another participant saw it as just a tough reality that there is a paucity of experts. One participant suggested, “It’s tough because there aren’t a lot of people that have a strong foundation in addiction.” This same expert went on to add, “But I think that as soon as you start putting really specific stipulations [on qualifications to teach] you’re going to work your way out of anybody teaching it.”

*Comfort talking about sexuality and related issues.* As was reported in the quantitative portion of this study, there are areas of sexuality and related issues that counselors are not comfortable discussing with clients. The experts also mentioned, as shown in this basic theme number six, that many faculty members are also not comfortable talking about sexuality and related issues in the classroom. This hesitancy certainly does not make counselors more comfortable discussing this issue with their clients. One of the counselor educators shared that most of society is really hesitant to discuss sexual compulsivity. The following excerpt is how he described the situation:

I also think when you're talking about sexual compulsivity, because of the sexual component, in our society people are still uncomfortable with that, even on a professional level, even on a scientific level. We don't like to talk about sexuality, let alone sexuality that's out of control.

This discomfort, combined with a lack of knowledge and training surrounding sexual compulsivity and process addictions make it far more likely not to address this issue with clients or in the classroom. Another counselor educator explained it this way, "I think at some level it is a lack of understanding of faculty members who don't have training themselves and who don't see it as important. Even the faculty are not comfortable talking about sexuality and sexual related issues."

### **Global Theme Seven: Addictions Class Course Design**

Further cross-case analysis of the seven expert interviews resulted in certain patterns of meaning related to what assignments and experiences should be included in an addictions course, in order to prepare students to work effectively with process addictions and/or Internet pornography addictions training. Participants were asked, "In respect to

course design, what have you found to be the most valuable course assignments or learning experiences that help students gain competence in this area (e.g., testing; reflection papers based on 12-step meetings, interviewing a counselor, or recovery panel; visiting a treatment center)?” The key themes that emerged from their responses included two organizing themes: “Experiential Activities,” and “Increase Awareness.” Refer to Figure 21 for the Thematic Network of Global Theme Seven.

**Experiential activities.** The first organizing theme found through the analysis process involves recommended experiential activities in an addictions class. Experiential activities for students will hopefully allow them to understand, empathize, and get more comfortable with addictions in general, and talking with clients about sensitive subjects. Five basic themes were categorized together to create this organizing theme. The five basic themes comprising this organizing theme follow.

*Students should attend 12-step or other support groups.* The experts interviewed agreed that one of the assignments in an addictions class should be the requirement to attend 12-step (or other recovery type) groups, which became the first basic theme. Students’ intended learning outcomes would include learning accountability and structure, as well as finding out what those groups are like, and finding out if the student would recommend clients attend a recovery type group. The majority of the experts mentioned having students visit recovery groups as part of their addictions classes. One of the experts shared, “Visiting the 12-step groups, they have to speak with someone at the group. They have to write a reaction paper, and then a summary paper.” Some of the experts distribute lists of groups their students can attend, while others have the students find their own groups they would prefer to attend. One

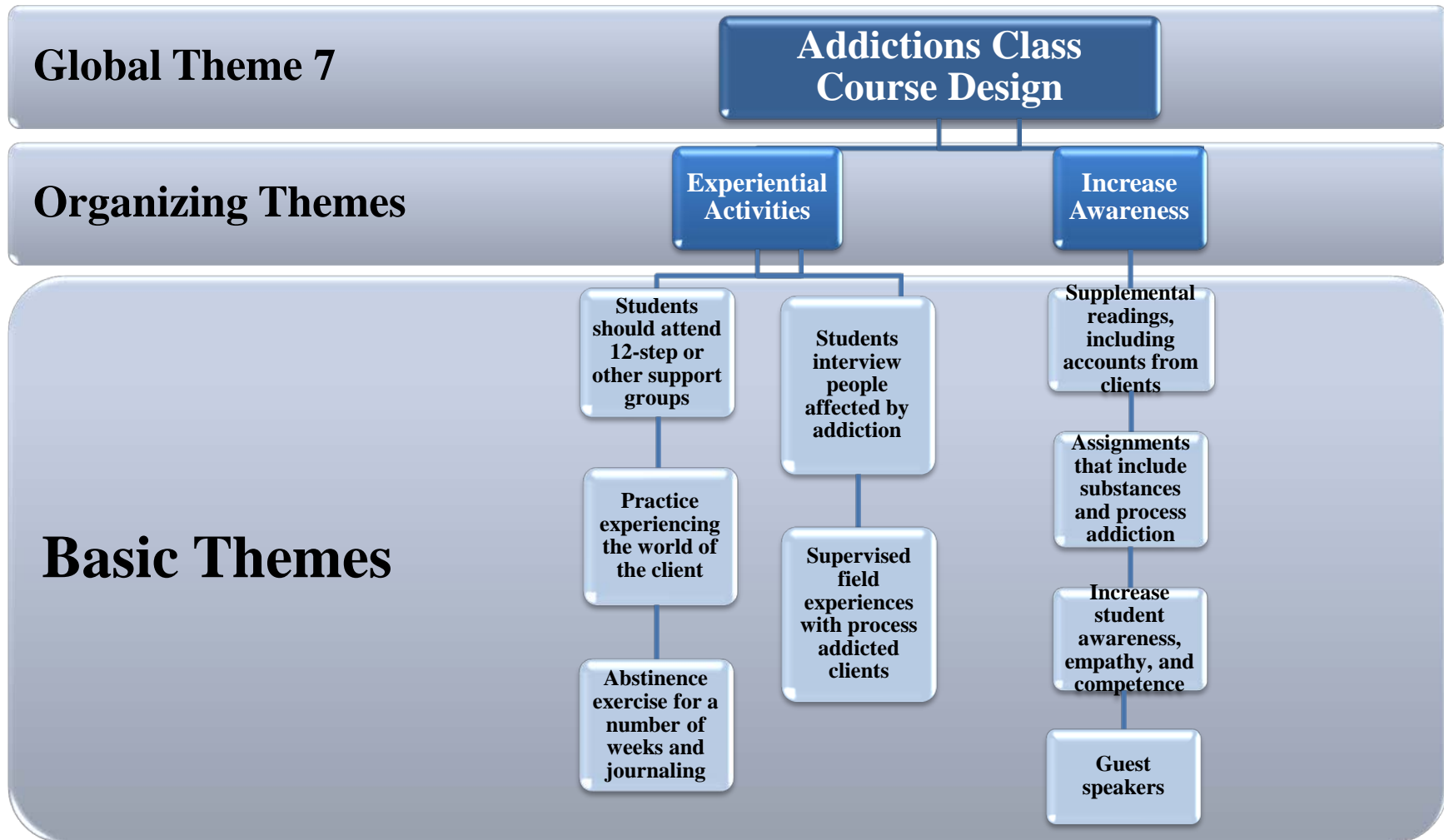


Figure 21. Thematic network for global theme seven, “Addictions Class Course Design.”



counselor educator mentioned, “They have to attend 12-step meetings, and they have to attend an AA meeting, and an NA meeting, an ALANON meeting and then a meeting of their choice. And many of them choose SA (Sexaholics Anonymous) or Love Addicts Anonymous.” Another expert described what he requires, “I like to integrate an experiential component where my students go out to 12-step meetings that are focused on process addictions.” This same expert went on to describe the difficulties with requiring attendance at groups when some groups are closed to visitors, “They’d have a hard time going to a 12-step meeting related to sex addiction or sex and love addiction, I mean, they’d have difficulty getting into these meetings because most of them are closed.”

***Practice experiencing the world of the client.*** The experts agreed that facilitating ways for students to experience the world of the client was important, and this concept became basic theme number two under the organizing theme of experiential activities. There were several ways the experts mentioned for students to have practice experiencing their future clients’ worlds. One expert offered, “Watch movies like “*Intervention*” and bring some practical stuff to make it relevant to students; makes the class more interesting and makes it stick more often and for longer.” Another way for students to experience what being addicted is like in an experiential way is to look at the world of cybersex from the inside. One counselor educator stated, “I think students have really benefited from experiential exercises around this. Something I’ve done when we’re talking about online sexual compulsivity, I’ll post an ad online, a fake ad, seeking sex, on some website that’s known for ‘hooking up’.” He then went on to describe that his class will monitor this fake ad for the number of people and types of comments this ad receives which then illustrates the world of online sexually compulsive people. Another

interesting way to help students become immersed in experiencing the client's world is having the student follow a case study client through the counseling process. One participant asserted,

Students do an extensive treatment plan with a client, and the client always has an interplay of a process and a chemical addictions. So, they have to be able to accurately diagnose, put together objectives, pick the right level of care based on the GAF, based on the number of addictions that are happening.

***Abstinence exercise and journaling.*** Analysis of the interviews revealed that an abstinence exercise is a good experiential assignment for students, which is basic theme number three. Multiple counselor educators mentioned having students “give up something” during an addictions class for a number of weeks to allow the students to experience what that is like, how it makes them feel, and to experience empathy for their clients. Many experts had their students journal about this experience so that they could process it. One counselor educator recommended,

My goal in the addiction class is to increase student awareness, empathy and competence; those are my three goals. So for awareness and empathy, the abstinence exercise is that they are tasked with identifying a substance or behavior from which they're going to abstain for six weeks. And during that time they keep a running diary or abstinence log, where they are recording their thoughts, their feelings, and their experiences.

At least one expert counselor educator does not have his students choose a substance or behavior to abstain from, rather, the students may choose to abstain from all mood altering substances or compulsive behaviors. He said, “They have to do a two-week

abstinence where they refrain from all mood altering substances or compulsive behaviors.” He does give students a choice, though, between that and writing a research paper. He further explained, “No caffeine of any kind, no nicotine, and no alcohol, nothing— for two weeks. And they have an option, they can either do that or write a research paper.”

Another participant has his class also participate in an abstinence exercise. He suggested, “We have students give up something in their life that they consider themselves to be dependent on. And they do that for 30 days in the class, and they journal about their experience.” In discussing this assignment, this expert explained that his students learn empathy, and experience what it’s like to struggle with giving up something that they feel dependent on. He went on to say, “I think that’s a really useful assignment. And we do that in every class. Our students walk away from that assignment feeling like they have a deeper level of understanding around the struggle for the addict to give up something.” This professor went on to explain that having completed this assignment his students more fully understand how to facilitate change with clients.

***Students interview people affected by addiction.*** Basic theme number four deals with having students in an addictions class interview clinicians, family members, former addicts and/or recovery group leaders with experience working with clients who identify as being addicted. This helps students be exposed to real life experiences where people can share what works for them, what does not work and helps the student understand what addictions really look like in full swing in clients. According to one of the experts, “I’ve had students interview, go out into the community and find clinicians working with this population and they had to interview the therapist.” A similar assignment is to have

students interview family members of individuals who are addicted. One of the experts indicated, “One thing that makes the class more interesting and make it stick more often and for longer, is interviewing a family member who is addicted or has been affected by this.” Another way to accomplish the goal of students interviewing people to learn more about addictions is to combine the 12-step assignment with the interviewing assignment. This can be accomplished by requiring students to speak with someone at the 12-step group and write a reaction and summary paper that includes the interview.

*Supervised field experiences with process addicted clients.* The fifth basic theme found under the organizing theme of experiential activities in an addictions class describes the supervised, field experiences of students who have the opportunity to work with process-addicted clients. Specifically, only one expert mentioned this concept, but it is an interesting idea to have students participate in something like this, although it would be complicated to arrange, and could possibly involve some risk. Here is what this participant suggested:

It would be wonderful if people could have actual in-field experiences where they're working, maybe, at a mental health agency, or substance abuse agency, or inpatient hospitalization related to being able to work with somebody with process addictions, run groups. So they would have supervised experiences with people who are in the field doing those kinds of things. You know, places that would have specialized training. The problem is, again, reimbursement for services, identifying people who have expertise, and increasing the number of people presenting with process addictions in that agency or location so that

students would have at least 3 to 5 cases they could track over a 16 week period.

That would be helpful.

Certainly it would be helpful for students to have a chance to work with process addicted clients, receive supervision for that work, and be able to process that experience while in individual and group supervision. Guaranteeing that all students will have the opportunity of supervised field experiences with process addicted clients would be difficult. Although it is likely that students would experience clients with process addictions in practicum and internship, we cannot predict which clients will present with an addiction, since with many clients their addiction, if present, is divulged only after counseling begins. The possibility is there that one student may get several addicted clients while others may not be assigned any.

**Increase awareness.** The second organizing theme under the global theme of addictions class course design that was found through the analysis process involved having the students engage in activities that would increase their awareness of process addictions. By increasing student awareness of process addictions, and Internet pornography addiction specifically, the goal is to create clinicians who are sensitive to these topics, and who will know how to recognize these issues in clients. Four basic themes were categorized together to create this organizing theme. The four basic themes comprising this organizing theme follow.

***Supplemental readings, including accounts from clients.*** One of the ways counselor educators can increase students' knowledge and awareness of process addictions is by having them read about process addictions, especially case studies where client stories are shared. One expert stated, "In respect to course design, at least some

classroom instruction and reading related to process addictions, especially related to the assessment of the potential of having process addictions present.” One counselor educator stressed the importance of this topic by saying, “There should either be a textbook that does a good job at exploring it, or supplemental readings should be assigned and processed with the class.” According to one participant, “doing some reading, we can give them some reading material that covers, maybe a first-hand account, and could get them to understand the complexity of online sexual behavior.”

*Assignments that include substances and process addiction.* Increasing students’ awareness of process addictions that are prevalent for clients is the focus of basic theme number two and makes use of assignments that cover both addiction to substances and processes. As one expert put it, “The assignments that help students translate theories and concepts into being about people are the assignments and activities that are most beneficial.” Another counselor educator worded it this way, “Specific assignments that look at, you know, more than just substances, that look beyond substances.” Combining supplemental readings with role play might result in an even stronger outcome for students by helping them differentiate between process and chemical addictions, as well as how both of them might present clinically. One expert stated, “The best practice for me would be to look at current articles, assign those to your students, have discussion groups related to it, role play how you’d handle somebody who was presenting with issues for assessment.” This same expert went on to say that students could, “Make a determination of whether or not that they have a process addiction difficulty that might be present even though the presenting issues don’t appear related to process addiction—something to rule it out.”

***Increase student awareness, empathy, and competence.*** The experts emphasized the importance of students in an addiction class developing a sense of awareness of process and chemical addictions, empathy toward those with an addiction, and competence in how best to assess and treat these addictions, and this became basic theme number three. Among one expert's reasons were, "If we are not trained, then we don't know to ask clients these questions. If we increase student comfort with sexuality topics, and increase their awareness, then that might encourage them to ask more questions of clients in sessions." Having students give up something for a period during the class (the abstinence activity described earlier) is one activity that teaches empathy and awareness and this activity was cited by several experts while discussing increasing student competence. One of the counselor educators shared,

What is life like without that experience, that process, that substance, whatever, and I really think that that has created some really good insight for the students as far as not recognizing in themselves a capacity for some of the process addictions or other addictions, so it kind of it raises that awareness.

Another related area in which students need to increase awareness and empathy is surrounding society's, and possibly their own, views of healthy and unhealthy behaviors, including sexual behaviors. Students need to think about and challenge their own notions of how they will respond when a client brings up sexually-related process addictions in session, because there are a lot of people who are still very uncomfortable discussing such personal and private matters. One expert reported, "I think a best practice is for instructors to engage in self-awareness exercises with students, for them to be able to identify their biases around this area and their values."

***Guest speakers.*** The fourth and final basic theme identified through examination of the expert interviews revealed that inviting guest speakers would be a beneficial activity for students to increase their awareness of process and chemical addictions. One of the ways to accomplish this would be to have a recovering addict come in to class, along with a family member, and have the class listen to their stories, ask questions, and learn about their personal experiences. This guest could explain to the class either what working with, or being, an addict is like. One participant suggested, “Interviews with family members of persons who were connected with people who had process addictions, to let entry level clinicians understand what that looked like from the outside or persons in recovery from process addictions speaking to classes.”

### **Summary of Qualitative Findings**

Seven global themes were found after completion of the thematic analysis of the expert interviews. Each global theme contained one or more organizing themes. Each organizing theme was made up of basic themes. The seven global themes are: (1) Need for Process Addictions Training, (2) Process Addiction Training Critical, (3) CACREP Acknowledgement of Process Addictions/Internet Porn Addictions,( 4) Addiction Course Content Delivery, (5) Counselor Education Programs' Inclusion of Process Addiction Training, (6) Qualifications for Teaching Addictions Courses, and (7) Addiction Class Course Design. Each global theme is summarized below.

**Need for process addictions training.** The first main theme gathered from the analysis of the seven expert interviews was the expressed need for students to receive process addiction training. All of the experts indicated that process addiction training was important, although they expressed it in different ways and to different degrees.



Multiple experts indicated that one of the reasons students may not be getting enough training is that our profession cannot agree on the definition of specific process addictions, or even if some are addictions at all. The experts called for more unification within the counseling profession so that the need for process addiction training becomes more recognized and credible. Another reason that students are not receiving much training on process addictions that several experts mentioned is that the DSM is currently not recognizing many process addictions as official diagnoses.

The experts also agreed that process addictions are a relatively new, but growing, problem facing clinicians today, and that training would help prepare clinicians to help their clients presenting with these issues. Although it is a more recent problem, several of the experts stated that the process of addiction is the same and that we can treat clients with addictions, rather than avoiding what we do not know or are not comfortable with. The experts called for more research to be done in the areas of diagnosis, assessment, treatment and interventions for clients addicted to processes and behaviors.

**Current state of process addiction training.** Currently, programs that have an addictions course in their program are most likely teaching it from a medical model and cover drugs and alcohol addictions either exclusively or heavily. None of the experts thought the current state of process addiction training was acceptable. It is also clear that the experts thought this issue is critically important. The consensus is clear that process addiction training is critical and currently undervalued, underexplored and inadequate.

The experts noted that increasing process addiction training would increase competence and confidence, and would help prepare clinicians for the inevitable contact they will have with clients who are facing process addictions. Counselors cannot be

expected to screen for and ask questions about process addictions if counselor educators do not prepare them to do so. The experts also felt that counseling was behind psychology and social work and other professions with our current state of process addiction training. Treatment methods for sexual compulsivity/addiction should be improved, because as of now, the average graduate is not at all well prepared to counsel clients who are addicted to pornography.

**CACREP acknowledgement of process addictions/Internet pornography addictions.** Currently, there are no CACREP standards that address process addiction instruction specifically. Because of this, there is little incentive for programs to make process addiction training a priority in their programs. There are some states that do require a course in human sexuality or sexual counseling, but as yet it is not a CACREP requirement. If CACREP were to acknowledge and require process addiction instruction by making new standards, or enhancing the current standards, this would assist counselors to be more prepared to successfully work with a client who is addicted to Internet pornography. CACREP drives what is currently offered in accredited programs, and addictions courses do not meet a lot of competencies. That being said, some experts questioned whether it is really CACREP's place to ensure adequate coverage of process addictions in academic training programs. Analysis of the interviews revealed that the competencies should be clearer, and the importance of process addictions training should be more specifically addressed within the competencies.

**Addiction course content delivery.** Often when conversations come up about program courses and the need for a topic to be addressed within counselor education, someone states that there is simply no room in the curriculum for adding a course.

Although this is likely true, does this mean that there will never be any additional topics/courses taught, ever? The experts addressed this topic and it became the fourth general theme. Basically, three options arose from the interviews: (a) counselor educators could create a stand-alone course for process addictions and leave the traditional addictions course centered on drug and alcohol addiction; (b) process addiction instruction could be infused into the existing curriculum giving it much broader coverage than one class can offer, but not at the depth of knowledge a stand-alone course can offer; or (c) a combined method of teaching process addictions both in a stand-alone course and infused throughout many CACREP core classes.

One addiction class will not make a student an expert on addictions, but it is clear from both the quantitative and qualitative data in this study that counselor educators have to do more than they are currently doing to emphasize to students the importance of sexually related process addictions as well as the prevalence and etiology of process addictions. Some experts suggested having the existing addictions class be half process addiction and half chemical addiction, while some suggested having a 1-credit stand-alone course in process addictions. Other experts have already begun a specialization in process addictions at their institution that involves several classes, and one expert stated that this is not a CACREP issue at all and an external organization such as NBCC should take it up and offer a certification program.

#### **Counselor education programs' inclusion of process addiction training.**

There are currently six programs that are accredited by CACREP: addiction counseling; career counseling; clinical mental health counseling; marriage, couple, and family counseling; school counseling; and student affairs and college counseling. A theme that

emerged from analyzing the qualitative data collected from the expert interviews had to do with which of those programs should include process addiction training, especially sexual and pornography addiction training? The interviews revealed three categories of answers: (a) all CACREP programs should include process addiction training; (b) some programs should include it, particularly clinical mental health counseling and marriage, couple, and family counseling, and to a lesser degree, school counseling; and (c) none of them.

Most of the experts agreed that all of the programs should receive training in process addictions because all clinicians serving clients will likely encounter someone suffering with a process addiction. These experts went on to explain that currently counselors are not prepared to deal with these addictions, and clients do not self-report their addictions, especially without the clinician screening for it. Some experts specifically stated that all six programs' graduates will encounter client with process addictions.

Other experts asserted that there will naturally be some program graduates that will encounter clients with process addictions more than others. Programs mentioned most often by these experts were clinical mental health counseling and marriage, couple, and family counseling. Other program options mentioned less often were school counseling and student affairs and college counseling.

The other option is that no program should require process addiction training. One expert explained that special treatment options are not required for process addictions, so special training is not necessary. He suggests existing drug and alcohol addiction treatments can simply be adapted to clients addicted to process addictions.

**Qualifications for teaching addictions courses.** While talking about who should receive process addiction training, and how the class should be organized (infusion, stand-alone or combined) there was also a great deal of discussion as to the qualifications of the instructor of the addiction class, their experiences, and their training.

An instructor of an addictions class in a CACREP accredited program should have a Ph.D. in Counselor Education and Supervision, as well as understand the addictions field. Instructors should be knowledgeable about techniques and strategies for clients who suffer with process addictions, and should have taken a master's level course in addictions. One expert suggested that instructors also have accumulated a number of continuing education units (CEUs) in addictions, process addictions, and sexual/pornography addictions.

The instructor of an addictions class should be familiar with, have researched, and have experience counseling individuals with process addictions and individuals with chemical addictions. The instructor should have spent time preparing to teach, and understanding process addictions, as well as have access to good resources to share with students. The experts seem to cluster around the instructor needing to have at least 3-5 years' worth of clinical experience working with populations with process addictions.

An instructor should be prepared not only through formal education, but also by the clinical experiences mentioned above. The instructor also should be certified in the area of addictions by one of several certification bodies (National Certified Addiction Counselor, or Certified Addiction Counselor, etc.). The experts also mentioned the desire to have the instructor be a person who conducts research in this area, as well as holding

membership in professional organizations which encourage sharing of research through conference presentations.

**Addiction class course design.** The ideas shared surrounding the design of an addictions course included both experiential activities and assignments intended to increase the awareness of students surrounding process addictions, which include Internet pornography addiction. The experiential learning activities suggested by the experts included attending a support group to learn the accountability and structure of recovery, having students give up something during the semester in which they take the addictions class and journaling about their experience, having some contact with addicted clients either through field experiences or having recovering individuals come to class and speak, and having students interview either a clinician or a client who is dealing with addictions.

Other assignments designed to increase student awareness of process addictions include supplemental readings which might include case studies in which a client shares one's struggle with freedom from addiction, videos or guest speakers which portray the life of a person who is/was addicted, assignments that include substances and process addiction, and other activities that increase student awareness, empathy, and competence surrounding process addictions.

In conclusion, this chapter presented both the results of the quantitative analysis and the findings from the qualitative analysis of this research project which examined counselor views, attitudes and perceived competencies regarding the treatment of internet pornography addiction.

All three major research questions were addressed through the use of an electronic survey and seven telephone interviews with experts in the field. In the next chapter, the researcher summarizes and discusses the findings, outlines conclusions that can be made, and discusses limitations, implications and recommendations based upon this study.

## **CHAPTER V**

### **DISCUSSION**

Chapter V contains four sections. The first section is a summary of the study which includes the methodology. The second section of chapter five provides a frame in which to understand the quantitative and qualitative results, findings, and conclusions of the research questions. The third section describes both the quantitative results and qualitative findings, and further illustrates the similarities as well as the differences between the results and findings. The fourth and final section of this chapter conveys the limitations of the study and implications for the Counselor Education and Supervision profession, counseling and clients. Within this final section, the importance of this research will be explained as it relates to the training of master's-level counseling students, along with the study's limitations and delimitations and recommendations for future research.

#### **Summary of the Study**

The purposes of the study were to examine counselors' views, attitudes and perceived competencies regarding the treatment of Internet pornography addiction, and explore the current status and best practices as perceived by experts in the field of sexual and Internet pornography addiction training in CACREP-accredited counselor education programs.

This study is believed to be the first to ascertain counselors' comfort with, attitudes toward, and perceived sense of competence in working with clients who have a



self-assessed Internet pornography addiction. The purpose of obtaining expert opinions was to determine if there was a discrepancy between what is occurring and what should be occurring according to those most able to make the assessment by their education, experience, and research surrounding Internet pornography addiction.

The following are the research questions which guided the study:

- 1) What is the perceived sense of competence counselors have in regards to treating the process addiction of Internet pornography?
  - i) How satisfied are counselors with the amount of training they have received in regards to the process addiction of Internet pornography addiction?
  - ii) How competent do counselors believe they are in counseling clients who are addicted to Internet pornography?
  - iii) How comfortable are counselors in discussing Internet pornography addiction issues with clients?

Respondents seem generally more dissatisfied with sexual addiction training in their programs of study than process addiction training. Overall, men are statistically significantly more likely to be more satisfied with their addiction training than female counselors are. The literature reviewed in Chapter II pointed out that if counselors feel prepared, then likely their confidence to adequately assist the client will be increased (Miller & Byers, 2008; Miller & Byers, 2009; Ng, 2006). If counselors are confident in their training and ability then they will tend to more effectively benefit clients (Harris, 2008; Snyder, Baucom, & Gordon, 2008; Swisher, 1995) and be less likely to miss or

ignore issues with pornography that are brought up by clients (Turner, 2009).

Respondents generally feel competent to work with clients who say they are addicted to Internet pornography, although, comparatively, working with this client population ranked 27<sup>th</sup> out of 29 items in order of feelings of competency around dealing with sexual issues. Scholars addressed this issue by asserting that there continues to be a void in the counseling literature regarding training competent counselors to handle Internet pornography addiction as a topic in counseling or even healthy sexuality in general (Gray & House, 1991; Hagedorn, 2009a). Those topics that respondents had the most negative attitudes toward included those that dealt specifically with pornography and topics addressed in pornography, which, at least theoretically, will be what clients will need to discuss. One's sexuality and sexual activities are special topics that many people and some professionals do not feel comfortable talking about. Counselors, however, should understand that a significant portion of the first few sessions will involve some powerful emotional expression by individuals and the therapist needs to maintain a safe environment in which clients can comfortably share and be heard (Maltz, 2009).

- 2) What are the relationships between counselor demographic variables (ethnicity, age, gender, program emphasis, and religiosity) and counselors' self-assessed attitudes and skills?
  - i) What are the relationships between counselor demographic variables and counselor self-efficacy with treating addictions?
  - ii) What are the relationships between counselor demographic variables and counselor attitude toward pornography?

- iii) What are the relationships between counselor demographic variables and counselor comfort discussing sexual issues with clients?

Male counselors appeared more likely to report as feeling somewhat or very competent with their ability to counsel individuals with an addiction. Counselors whose identified religiosity is very important to their counseling work have a lower attitude toward pornography than do the other groups. Men are more comfortable discussing client sexual concerns including Internet pornography use than are female counselors. Students in CACREP programs receive similar core training and those with adequate knowledge and comfort regarding pornography should be better able to serve clients and avoid ignoring client concerns, imposing counselor values, or giving inaccurate information (White & Kimball, 2009; Wiederman & Sansone, 1999; Yarris & Allgeier, 1988). Ayers and Haddock (2009) found that therapists' personal attitudes about pornography have an effect on the treatment approach they use with clients. The authors called for more continuing education opportunities to be available to clinicians in order to help change preconceived thoughts about pornography addictions.

- 3) What do counselor educators with expertise in process addictions related to sexuality view as best practice in the education of counselors regarding sexual addictions?

- i) What are these experts' current assessments of the training counselors receive in regards to sexual addiction in general and Internet pornography addiction in particular?

- ii) What do these experts view as best practice in the training and continuing education of counselors regarding process addictions related to sexuality?
  - a) What are recommended by experts as the preferred ways to develop adequate knowledge and competency in this area?
  - b) Should a class in sexual addictions in general be required in counselor education training programs?
  - c) Should counselors be required to receive continuing education units involving the assessment and treatment of Internet pornography addiction?

The experts explained the need for process addiction training to be included in CACREP-accredited programs by explaining that this training is critically important for students to receive because of the likelihood that students will encounter process addictions in the field. The experts shared that CACREP's current standards do not adequately cover the importance of process addictions, nor do the standards require that students develop adequate knowledge and competency in this area. Most experts expressed that process addictions should be taught in a stand-alone course and the concepts should also be infused throughout the other courses within CACREP's core curriculum. The experts also agreed that certainly students enrolled in the marriage and family track, as well as community mental health counselors should especially receive

sexual addiction training, and several experts mentioned that all CACREP-accredited programs should be required to teach this content to students.

### **Methodology**

The researcher used a mixed methods design for this investigation. A 90-item questionnaire was loaded onto the online platform QuestionPro and a U. S. postal mailing directing potential participants to the online survey was sent, along with a one dollar bill, to 1,000 professional members of the American Counseling Association, with three subsequent reminder mailings. There were 286 completed usable surveys, for a final response rate for the quantitative portion of this study of 28.6% which is better than the predicted 25% response rate. An analysis of the data was conducted through the use of QuestionPro and SPSS so that statistics could be presented for the quantitative part of the study.

After an extensive review of the scholarly and popular literature pertinent to this subject, the researcher created a semi-structured interview guide to assist with the qualitative methodology. The sample consisted of seven counselor educators who met the pre-determined criteria to be deemed an expert in sexual addictions. The researcher followed the semi-structured interview guide and asked questions regarding the current state of counselors' ability and willingness to counsel individuals with sexual addictions and the perceived best practices in addiction training in counselor education. Thematic analysis was used to examine the data (Braun & Clarke, 2006). As part of the thematic analysis, thematic networks were created in order to provide a visual representation of the findings. Additionally, member checking was used to ensure the validation of the study, as well as the use of a "devil's advocate" to ensure the resulting themes were accurate

representations of the data. These procedures provided a more rigorous design and allowed the researcher to incorporate the feedback into the analysis of the data and presentation of the findings. The most significant assistance the use of a devil's advocate provided was reduction of redundancy among the basic, organizing, and global themes. A secondary, but valuable, benefit of the devil's advocate was tweaking the titles of those themes to better capture the content of the themes.

The use of interviewing experts in qualitative research is not new, but it is not without its debate, either. No study was found where experts were interviewed to ascertain their perception of best practice regarding how to conceptualize and treat individuals, couples and families where an Internet pornography addiction is presented as an issue in counseling. Since so few studies have been done regarding Internet pornography addiction, information obtained by interviewing experts who have valuable experience, specifically those who are experts in the area of addiction and addictive behaviors, is crucial in the attempt to determine best practices. The research design for this study utilized elite interviewing of counselor educators who are also experts in the addiction field based upon criteria described in chapter three.

The design of this study yielded the answers to the three research questions. The mixed methodology determined the following aspects related to counselors' treatment of clients with Internet pornography addiction: (1) the current state of addiction training, (2) the best practice in counseling as perceived by counselor educator experts in regards to the education of counselors and the practice of counseling clients, and (3) the sexual comfort, attitude toward pornography and perceived competency of counselors in regards

to Internet pornography addiction. This investigation produced the data needed to answer the research questions.

## **Discussion of Key Quantitative Results**

### **Research Question 1: Counselor Competence**

What is the perceived sense of competence counselors have in regards to treating the process addiction of Internet pornography? This question contained three sub-questions relating to satisfaction with training, competence in counseling clients who are addicted, and comfort discussing Internet pornography addiction.

**Sub-question 1.1: Training satisfaction of counselors.** Respondents are generally satisfied with their chemical addiction training, their human sexuality training, and their couple and family issues training. Respondents are generally dissatisfied with their process addiction training as well as their sexual addiction training. The quantitative data collected supported the notion that counselors are generally dissatisfied with their Internet pornography addiction training, since that is both a process addiction and a sexual addiction. These findings back up what we are currently seeing in the training of counselors. The areas above that counselors feel satisfied with are the areas of great emphasis in counselor education programs. The areas that counselors do not feel as satisfied with are the areas that most programs ignore in their training, or spend very little time covering.

**Sub-question 1.2: Counselor competence.** In order to measure counselor competence The Addiction Counseling Self-Efficacy Scale (ACSES) was used which was described earlier. As was mentioned before, the mean score for respondents to this study on this scale ranged from a low of 1.14 to a high of 5.00 with an overall mean of

3.91, indicating that generally the sample seemed confident in their ability to counsel individuals with an Internet pornography addiction. Overall, respondents feel the most competent in general counseling skills and areas that deal directly with the client as a person, such as establishing a trusting, therapeutic relationship with the client, being empathetic, and expressing care and concern. Respondents shared that they generally do not feel as competent with areas that deal with assessing for specific problems, writing reports, developing treatment plans, and working with clients who have co-occurring disorders when one of them is a sexual addiction. These issues could easily be solved if counselors were trained how to handle sexual addictions including Internet pornography addiction.

**Sub-question 1.3: Counselor comfort discussing sexual issues.** In order to measure counselor comfort discussing sexual issues, the Sexual Comfort Scale (SCS) was used which measured counselors' willingness to address client sexual concerns especially those concerns related to Internet pornography use. The mean score on this five-point-scale ranged from a low of 2.36 to a high of 4.64 with an overall mean of 3.38. A mean of 3.38 would indicate slightly more comfort than ambivalence (neutral comfort) in discussing sexual issues with clients. Respondents seem most comfortable discussing sexuality, sexual beliefs and lifestyles different from their own, tolerance, and sexuality as part of the human personality. Respondents were the least comfortable with the idea that Internet pornography in general is positive and adds zest to living. These attitudes also have the potential to bias counselors against clients who use Internet pornography.



## **Research Question 2: Demographic Variables and Self-Efficacy, Comfort, and Attitudes**

What are the relationships between counselor demographic variables (ethnicity, age, gender, program emphasis, and religiosity) and counselors' self-assessed attitudes and skills? This question contained three sub-questions relating to counselor demographic variables and (a) counselor self-efficacy with treating addictions, (b) counselor attitude toward pornography, and (c) counselor comfort discussing sexual issues with clients.

**Sub-question 2.1: Self-efficacy and demographic variables.** The results show that the only counselor demographic variable that was correlated significantly with counselor self-efficacy was that males are statistically significantly more likely to self-assess as feeling somewhat or very competent with their ability to counsel individuals with an addiction. This is not a surprising finding as males are commonly viewed in society as being generally more confident. Perhaps this could be because men are more likely to have had contact with pornography and in the absence of training to facilitate effective treatment are indeed falling back on their own personal beliefs about pornography in answering these questions.

**Sub-question 2.2: Attitude toward pornography and demographic variables.** The second sub-question of this research question looked at the counselor demographic variables and counselor attitude toward pornography. In order to measure counselor attitude toward pornography the Attitude toward Pornography Scale was used and the mean scores ranged from a low of 1.77 to a high of 3.50 on a five-point-scale with an overall mean of 2.76. This suggests respondents in general have a somewhat negative attitude toward pornography. This somewhat negative attitude toward pornography could

possibly lead counselors to look negatively upon clients who struggle with a self-diagnosed Internet pornography addiction. A statistically significant relationship was also found between the counselor's identified religiosity and their attitude toward pornography. Counselors whose religious values, spiritual beliefs and morality are *very important* to their clinical work have a significantly lower attitude toward pornography as compared to those whose religious values are somewhat important, neither important or unimportant, and not important at all. Since over 30% of counselors identified the impact of their religious values, spiritual beliefs and morality to their clinical work as *very important*, and since more than 70% of counselors have had a client discuss Internet sexual activities with them, there seems to be great potential for counselors to be biased against their clients on this issue even before meeting them.

**Sub-question 2.3: Comfort discussing sexual issues and demographic variables.** The third sub-question examined the relationships between counselor demographic variables and counselors' comfort discussing sexual issues with clients. The mean score of the Sexual Comfort Scale ranged from a low of 2.36 to a high of 4.64 with an overall mean of 3.38. When this mean was compared to the respondent's gender, a statistically significant difference was found. Male counselors are statistically significantly more comfortable discussing client sexual concerns including Internet pornography use than female counselors. Since the majority of counselors are female, and the majority of clients who struggle with Internet pornography addiction are male this could lead to problems in effectively treating clients with this issue.

## **Discussion of Key Qualitative Findings**

### **Research Question 3: Experts' Perspectives**

The third research question was addressed by interviewing seven counselor educators identified as experts in the area of sexual addiction and Internet pornography addiction. The third research question asked what do counselor educators with expertise in process addictions related to sexuality view as best practice in the education of counselors regarding sexual addictions? There were two sub-questions within this research question, and the second sub-question was further divided into three follow up questions related to it. All four questions will be covered in this section.

**Sub-question 3.1: Addiction training.** The first sub-question involved the assessment of the training counselors currently receive in regards to sexual addiction in general and Internet pornography addiction in particular. The experts shared that process addiction training, which would include Internet pornography addiction training, is fundamental to the education of counselors, though process addictions are undervalued and underexplored. The experts mentioned that counselor education is doing its trainees a disservice by not preparing them to handle process addictions. The experts also shared that process addiction training increases competence and confidence in counselors. Inadequate training in this area leaves counselors feeling incompetent and results in unprepared professionals, because if counselors are not trained, they are unlikely to ask clients about these sensitive issues. The experts lamented that the profession is currently far from having the average clinician understand process addictions. Counselors are generally not competent in assessing for process addictions, and the profession needs improved treatment methods for sexual addiction. Interviewees believed that the

counselor education field is behind other fields in using evidence-based practice in treating process addictions, and the fact that Internet pornography addiction and other process addictions are not being recognized as addictions in the mental health profession is problematic.

**Sub-question 3.2: Best practices.** The second sub-question examined these experts' views on best practice in the training and continuing education of counselors regarding process addictions related to sexuality. This researcher believed it was important to gain the perspectives of experts on the "best practices" in addictions training of master's-level counselors, such as necessary curriculum components and effective pedagogical methods, so the profession has goals to move toward if change is to occur in how process addictions are taught. This sub-question was further divided into three sub-questions for easier management of the answers.

***Sub-question 3.2.1: How to develop competency.*** As part of the best practice in training and continuing education of counselors regarding process addictions, this sub-question addressed the experts' preferred ways to develop adequate knowledge and competency in this area. The experts mentioned infusing process addictions into already existing CACREP core classes, and creating a stand-alone course in process addictions to augment the existing addictions course that is often heavily dominated by chemical addictions. In addition to these suggestions, the experts also recommended that students should be expected to engage in experiential as well as knowledge-based experiences that deal directly with process addictions during their education. The interviewees also remarked that as part of the experiential activities students should have an opportunity to meet and interact with process-addicted clients in a therapeutic atmosphere whether that

is through 12-step groups, interviewing clinicians, recovering clients, and/or their families. Other suggestions included continuing education is important, including through supplemental readings, experiential activities, staying abreast by reading related journal articles, and attending conference presentations.

***Sub-question 3.2.2: Require a sexual addictions course?*** Another research sub-question asked if a class in sexual addictions in general should be required in counselor education training programs. Overwhelmingly the experts advised having process addictions covered in the CACREP-required addictions course, and that sexual addictions, including Internet pornography addiction, should also be covered. The experts also admonished that this is not being done enough currently, and many experts called for a stand-alone process addictions course, in addition to the already existing addictions course. The experts described how a stand-alone course would convey the importance of training in process addictions and the urgency of being competent in this area. The interviewees did comment that one course will not make counseling students an expert in the area of process addictions, however. Many experts also called for process addictions to be infused into the other CACREP core courses, as well as having a stand-alone course.

***Sub-question 3.2.3: Require continuing education courses in Internet porn addiction?*** The last sub-question for the third research question asks whether counselors should be required to receive continuing education units involving the assessment and treatment of Internet pornography addiction. The experts interviewed addressed this by stating that the specific content of continuing education units cannot be required at this time. Many of the counselor educators interviewed explained that counselors-in-training

would be much better served if their preparation to counsel clients with Internet pornography addiction and other process addictions came from their formal, CACREP-accredited, education. This is much easier to control and determine what is taught, how it is taught, and ensures uniformity of education and training. Counselors are already required to obtain continuing education units, and one can hope that counselors choose to attend training related to process addictions, sexual addictions, and Internet pornography addictions to enhance competence in these areas since their formal education probably did not include training in this area.

### **Summary**

Findings indicate that the experts interviewed during the qualitative portion of this study believe that process addiction training is fundamental, yet undervalued and underexplored. Recommended best practices in this area included a combination of infusing process addictions into already existing CACREP core classes, and creating a stand-alone course in process addictions, along with both knowledge-based and experiential activities. When questioned about continuing education in the area of Internet porn addiction, many of the counselor educators interviewed explained that formal graduate education would be a more adequate way of ensuring that counselors receive this training. The section below offers comparisons of the study's total quantitative results and qualitative findings.

### **Comparing Quantitative Results and Qualitative Findings**

In this section, the opinions garnered from the quantitative survey of professional members of the American Counseling Association are compared to the interview findings of counselor educator experts in the field of sexual and Internet pornography addiction.

Some important observations are made and discussed in this section of chapter five. The first part of this section deals with similarities, while the second part focuses on differences between the survey results and expert interview findings.

### **Similarities**

The vast majority of respondents to the quantitative survey graduated from a CACREP-accredited program (70.8%). All of the experts had a degree and worked in counselor education. The vast majority of respondents identified as White (83%) and all of the experts identified as White. Both the program emphasis and the emphasis of their counseling practice for the respondents were overwhelmingly in areas covered by CACREP programs. All of the experts are currently professors at universities whose counseling programs are CACREP accredited, and several of the experts are chairs or program coordinators.

The survey asked if the survey respondents had ever had a client discuss their Internet sexual activities with them, and then specifically if they ever had a client discuss being addicted to Internet pornography. The majority of the respondents answered affirmatively to both questions: Internet sexual activities, 71.8%; Internet pornography 54%. This thought was expressed by many of the experts during the interviews. One expert simply stated, “More and more clients are coming in with process addictions.” Another expert emphasized, “Process addiction training is critical, undervalued, and underexplored, because of the frequency of process addictions and sex addictions, etc. [in clients].” Two experts stated simply that “Every master’s student will encounter addicted clients.” Another expert added to this thought by saying, “All counselors have seen

clients with addictions; school counselors are not immune from exposure to this population because of exposure of youth to technology.”

A question in the survey asked respondents to rate their satisfaction with process addiction training. Respondents could choose a number between one (completely dissatisfied) and five (completely satisfied) when rating their satisfaction. A majority of respondents (54.4%) were either somewhat or completely *dissatisfied* with their *process addiction training*. A question was also included in the survey which asked respondents to rate their satisfaction with sexual addiction training, using the same scale as above, and 61.7% of the respondents are either completely or somewhat *dissatisfied* with their *sexual addiction training*. These data are similar to what the experts reported in their interviews. One expert asserted that “The average counseling graduate is poorly prepared to counsel clients for Internet pornography or other process addictions.” Another expert understood this point by sharing, “The average clinician doesn't know what to do when someone presents symptomatology that's created by process addictions.” The experts pointed out that counselors do not feel competent because they have not been trained to treat these presenting issues. An expert supported this theme by sharing, “In general, the average counseling graduate is lacking in preparation to counsel for process addictions.

A question was asked of survey respondents about typical procedures for intake or assessment of clients. They were asked if there were any questions or items on these forms or in these procedures that allowed them to address Internet sexual activities. An overwhelming majority (80.5%) do not ask clients about Internet sexual activities in the intake. The fact that counselors are not asking clients about problematic Internet sexual activities was iterated by the experts, as well. If the client knows there is a problem, but



does not recognize a process addiction may be causing it, then the counselor may not ask about the possibility of addictions. One expert touched on this topic, “The average clinician is far from understanding what they need to do when somebody presents with symptomatology that’s specific, or created by process addictions. If the counselor does not bring it up and screen for it, the client will likely not bring it up either.” One expert pointed out, “People will not usually self-report process addictions (especially sexual addictions).” Another expert agreed, “There is a lot of shame around sexual addiction. People [clients] and clinicians don’t talk about it.” Yet another expert said, “Counseling graduates are not prepared at all to handle pornography addiction; we don’t teach them to ask. Counselors don’t ask about online activity during intake and counseling sessions because they are not informed.”

The Attitudes Toward Pornography Questionnaire includes a series of 30 questions, and had respondents indicate their answer by choosing from a Likert scale that ranged on a scale from one (Strongly Disagree) to five (Strongly Agree), with lower scores indicating more negative attitudes toward pornography. The mean score on this scale ranged from a low of 1.77 to a high of 3.50 with an overall mean of 2.76. Since a choice of three on the Likert Scale indicated a neutral attitude, a mean of 2.76 would seem to indicate a slightly negative attitudes overall toward pornography. It should also be noted that in the range of the means on this scale, the highest was only .5 above a neutral score, while the lowest was 1.33 below a neutral score. This suggests that counselors tend to have a negative attitude toward pornography, which could lead to problems when a client presents with issues related to pornography addiction or compulsion. Certainly with training specific to Internet sexual activities and helping

clients with addictive pornography use, counselors' attitudes toward these behaviors might improve and position them to be less judgmental towards pornography use.

The experts addressed this topic by sharing their opinions about healthy and unhealthy sexuality. There still seems to be a lack of communication about healthy sexuality and what healthy sexual behavior looks like. Because this topic is not covered in many training programs, counselors may be no more likely to be comfortable discussing these issues than is society as a whole. As one expert put it, "when you're talking about sexual compulsivity, because of the sexual component, in our society people are still uncomfortable with that, even on a professional level, even on a scientific level." Another expert also touched on this topic when he stated, "The field seems to be about 10 years behind in the area of technology; people are under-informed about process addictions, [and this] creates unprepared professionals." Counselors learn what they are taught about this topic and yet another expert stated, "Faculty need to be brought up to speed and answer questions from students about what that means. Many faculty cannot answer those questions about healthy or unhealthy sexual behavior."

## **Differences**

Of the 286 participants, 70.8% (199) were female and 29.2% (82) were male, which is quite similar to the actual breakdown of the professional membership of the ACA. All of the experts interviewed for this study were male. One female counselor educator expert was invited to participate in the screening process but she never replied. No other female potential expert counselor educators were identified by the researcher or through snowball methods. The majority of counselor education faculty are male, and the majority of department chairs are male. All of the experts interviewed were male.

This suggests a call for female faculty to research and publish regarding this topic, which may add a valuable and needed perspective. Only 41 of the 286 respondents (14.3%) identified their education and training as being in counselor education and supervision, but all seven experts identified as counselor educators.

A question that appeared in the survey asked respondents if they had ever attended a continuing education course, or an educational session at a professional conference that was specifically pertaining to Internet pornography addiction. Most (71.1%) had not, in spite of the fact that the majority of these same counselors have had clients discuss their Internet sexual activities with them (71.8%), as well as the clients' Internet pornography use (54%) being discussed in session. All of the experts interviewed were counselor educators, had presented on online sexual activities at a professional conference, had five or more years of counseling experience, had taught addictions classes that included process addictions, and had provided professional service in the area of process addictions for a year or longer. The high number of clients discussing Internet sexual activities with counselors could be related to the explosion of Internet ready-devices marketed to society. With hand-held, portable devices capable of connecting to the Internet comes the ability for more people to access pornography easier, and with impunity. Pornography has become portable and mobile as well, thus increasing the number of people presenting to counselors with issues related to this. The training and research in this area has not yet caught up to the technological advances that have been made.

Survey respondents were asked to rate how confident they were in their ability to perform specific skills as they related to clients who identify as being addicted to Internet

pornography. The 29-item Addiction Counseling Self-Efficacy Scale (ACSES) was used which was described earlier. The survey endeavored to identify counselors' levels of competence and confidence in counseling clients who are addicted to Internet Pornography. The scale provided ranged from one (no confidence) to five (absolute confidence). As was mentioned before, the mean score for respondents to this study on this scale ranged from a low of 1.14 to a high of 5.00 with an overall mean of 3.91, indicating that generally the sample seemed confident in their ability to counsel individuals with an Internet pornography addiction. This result does not match with the experts' assessment of the current state of process and sexual addiction training in counselor education programs.

This discrepancy might be explained by the fact that counselors don't know what they don't know. Having been trained to be competent in many things, perhaps counselors view their competency higher than it might actually be, until they actually encounter a client with this problem and realize they may not have effective treatments in their arsenal. Another possible explanation for the experts thinking counselors are not as competent as they should be is that for many of these experts this topic has been their life work and they are passionate that all counselors should be trained to handle this topic and are advocating for their passion to be included in academic counseling programs.

The experts also indicated that many counselors will feel inadequate to address this issue. One expert said, "Most students graduating from counseling programs are ill-prepared to handle Internet pornography addicted individuals." Another expert further elaborated by saying, "Counseling graduates not prepared at all to handle pornography addiction; we don't teach them to ask. Counselors don't ask about online activity during

intake and counseling sessions because they are not informed to do so.” An additional expert added, “The average clinician doesn't know what to do when someone presents symptomatology that's created by process addictions.”

The Sexual Comfort Scale (SCS) measured counselors' willingness to address client sexual concerns, especially as those concerns relate to Internet pornography use. Respondents were asked a series of 11 questions and provided possible answer choices that ranged from one (strongly disagree) to five (strongly agree), and the mean score of their comfort was calculated based on their answers. The mean score on this scale ranged from a low of 2.36 to a high of 4.64 with an overall mean of 3.38. A mean of 3.38 would indicate slightly more comfort than ambivalence (neutral comfort) in discussing sexual issues with clients. This survey finding also contradicted the experts' opinions regarding the comfort of counselors to discuss clients' sexual activities in session. The experts conveyed that sexuality and sexual conversations are still awkward and uncomfortable for many in the American culture, in spite of being inundated with sexual images. Because sexuality and sexual conversations are difficult in society, this makes sexual compulsivity and pornography addiction even greater difficulties especially since these topics are not covered in training programs, counselors are no more likely to be comfortable discussing these issues than is society as a whole. As one expert put it, “when you're talking about sexual compulsivity, because of the sexual component, in our society people are still uncomfortable with that, even on a professional level, even on a scientific level.” As another expert noted, “If we are not trained then we don't know to ask clients these questions. If we increase student comfort with sexuality topics, and

increase their awareness, then that might encourage them to ask more questions of clients in sessions.”

Perhaps this is not as much a discrepancy as one might first imagine. Counselors only indicated a *slightly* higher than neutral comfort in discussing sexual matters. That does not indicate a very high degree of comfort. Another possible explanation is that counselors may have more comfort than the experts might have thought discussing sexual matters in general, but counselors’ attitudes about sexual compulsivity and Internet sexual activities might yield much less comfort among counselors in general.

The next section of this chapter discusses limitations or conditions that restricted the scope of the study or that may have affected the outcome. This next section will also describe delimitations which were restrictions or limits that this researcher imposed prior to the inception of the study to narrow the scope of this research.

### **Limitations**

The limitations of this mixed-method study are important to note when reading and using the findings and discussing the implications for the training of counselors and for the practice of counseling.

#### **Limitations Related to Sample**

Some respondents to the online survey contacted this researcher to report that they could not access the survey online. This could possibly have been due to the fact that instead of typing the address of the survey into a browser, several potential respondents reported that they tried to “Google” the survey and couldn’t find it. Also, the proper address was <http://pornographystudy.questionpro.com> so one could assume that some respondents did not put the dot between “study” and “questionpro.” A card, with a dollar

bill, was mailed to them giving the potential respondent instructions on where to go on the web to access the survey. This researcher received a total of 19 emails specifically regarding issues with accessing the survey. Given the nature of humanity, there might have been others who did not email to explain their difficulty and simply gave up trying to access the survey.

Another limitation identified by the researcher is that both the survey and the expert interviews are self-report. Both the qualitative and the quantitative studies asked participants to remember what they have done with clients and people can tend to “remember” their actions in a better light than what really occurred, so their answers are subjective.

### **Limitations Related to Procedures**

Another limitation, especially in the quantitative portion of the research was that an invitation containing the word ‘pornography’ in the URL likely made some people hesitant to type that into their browser and participate in a survey with questions about sexuality, pornography, and Internet sexual activities. At least one potential participant contacted this researcher with an explanation of why he/she would not be taking the survey by including this statement, “Entering the link to your questionnaire requires me to put a word into my computer that I will never, ever enter. It would trigger all kinds of unwelcome and obscene responses, based on that simple word...” Others might have felt similarly and avoided putting the word “pornography” into their browser. This potentially reduced the number of participants and could possibly have artificially inflated the confidence, attitude, and comfort of the participants. In other words, people

who are more comfortable discussing sexual topics, particularly pornography, might also have been more likely to take the survey.

Yet another procedural limitation surrounds the use of a devil's advocate for cross-checking. This devil's advocate served as this researcher's graduate assistant, and was a student in another department, and the researcher discovered some hesitance on the assistant's part to challenge his direct supervisor since the assistant was employed by the researcher. This could have limited the independent cross-checking ability of the devil's advocate, and should have, in hindsight, been anticipated by this researcher. This hesitance was not discovered until the cross-checking was already complete and the results reported. Perhaps a devil's advocate who served as a peer to the researcher would be a better choice in order to avoid this power differential. On the other hand, this researcher's dissertation chair provided several challenges to the naming and organization of themes which helped to refine the final report of the qualitative findings.

Another limitation of this research study was the use of three scales which all appeared in separate dissertations published by their authors. Using scales developed in conjunction with dissertations involve shortcomings in terms of a lack of testing and retesting reliability and validity. Scales from dissertations have also not been exposed to blind peer review that occurs for most professional journals. Also, this researcher modified all three scales by altering the wording to include pornography, and on one scale some items were not used, all of which could have affected the reported psychometrics of the scales.

The final limitation is that the American Counseling Association had recently stopped providing email addresses for their members for a fee, so this researcher



purchased their regular postal mail addresses. Potential participants were mailed a card that asked them to log on to a website and take a survey. Each step of that process has the potential to lose valuable participants. There perhaps would be greater participation if the survey link was emailed to potential participants, or if a hard copy of the survey was sent by postal mail.

### **Delimitations**

Delimitations of the study are also identified in this section. This researcher chose to interview only counselor educators as experts, excluding all other people who may be experts but who have different degrees, such as counseling psychologists and social workers. This, potentially, excluded individuals who have worked, or are working, in the training of students in addictions, have experience working with clients with process addictions, and have valuable input in what is the best practice in training future mental health providers.

The sample for the quantitative survey was randomly chosen from the total membership of the American Counseling Association. Some of these members are people who may not actually counsel clients, such as professors, retired individuals, some school counselors, or people who maintain their membership for other purposes. Perhaps choosing to survey members of the American Mental Health Counseling Association membership (a division of the ACA) would have yielded better results and contained more people whose duties more directly relate to counseling clients.

Data collection was done during the summer months, and unfortunately some of the sample had their school or business address listed in the ACA's records and may have been on vacation during the data collection period. This may have affected both

participation and availability for completing the quantitative survey. This could have artificially excluded a significant number of school counselors.

The next section conveys the implications for the Counselor Education and Supervision profession. The importance of this research will also be explained as it relates to the training of master's-level counselor education students. Additionally, the next section also includes recommendations made by this researcher as to how counselor education should proceed to rectify the lack of empirically supported research and treatment methods for Internet pornography addiction.

### **Implications**

This study yields several important implications for the future of counselor education and for the treatment of clients who are addicted to Internet pornography. The focus of this study was on problematic Internet pornography use, which has been a relatively ignored topic in research (Hertlein & Piercy, 2008). Approximately 10-17% of those using the Internet for sexual purposes report having online sexual problems which might include spending more time online than planned, partner unhappiness with Internet use and browsing history, using the Internet for infidelity, and other problems related to compulsivity and addiction (Daneback et al., 2006; Dew & Chaney, 2004). The majority of respondents to the quantitative survey in this study have had clients speak of problematic Internet pornography use. Reason dictates that if problematic Internet pornography use is on the rise (Schneider, 2000), and it can cause significant challenges both intrapersonally and interpersonally, then counselors are going to see more and more clients presenting with this as an issue in counseling (Cooper, et al., 2000; Dew & Chaney, 2004; Hagedorn, 2009a). Treatment plans for Internet pornography addiction

are not readily available for counselors-in-training to access, and process addictions are not usually taught in programs of study. A deficit has occurred in this profession between what is actually happening in the field and what our programs are training our counselors to encounter. This researcher recommends that the profession begin to research this topic more often and more in depth so that empirically tested treatment programs can be developed so as to effectively treat clients who present with this issue.

### **Implications for Counselor Education and Supervision**

The 2009 CACREP standards address addiction training in the CMHC and School Counseling program options, but traditionally, an addiction class, if offered, covers chemical addictions much more heavily than process addictions. As has been already stated, it is the opinion of this researcher that the CACREP standards are currently limited in their view of addictions. This researcher recommends a shift in the focus from this narrow focus on chemical addictions to a broader focus which includes process addictions including sexual addictions. Additionally, it might be useful in future revisions of CACREP standards to include a requirement to include a requirement to address process addictions more specifically and more thoroughly. How to implement these new standards will be up to the individual programs as has always been the case. This researcher suggests requiring process addictions to be covered in an addictions' class with equal weight to chemical addictions, as well as require programs to infuse process addictions assessments, treatments, and case studies into other CACREP core classes.

While programs are waiting to see if CACREP will change the standards, programs should begin to address this issue of a gap in the training process. The experts

interviewed for this study indicated that the counseling profession has not reached agreement on how to approach process addictions, which prevents the profession from establishing a comprehensive training program. Process addictions are simply not recognized as “real” addictions by the whole of society, or the profession. This lack of recognition leads to issues with clients being taken seriously, and receiving the best care that they deserve. Many clients may not even recognize the presence of process addictions since this is not being talked about in mainstream society. The natural response of programs is resistance to add another course to their program because the credit hours are already dense. Perhaps the solution should be, according to this researcher, infusion of process addiction into an already existing addiction class(es) and throughout the core CACREP courses where client problems are discussed (ethics, theories, techniques, and others).

Of interesting note was that 57.8% of respondents identified their religious values, spiritual beliefs, and morality as having a very or somewhat important impact on the clinical work they do with their clients. This had a significant relationship to the counselors’ attitude toward pornography. Perhaps this also has an impact in other areas of work with clients as well. This might mean that Counselor Education and Supervision programs should spend more time training students how to integrate religion or spirituality into counseling in an appropriate and ethical fashion.

**Process addiction coursework.** Having a separate program for addictions certification is an idea for dealing with the growing problem of clients facing Internet pornography addiction. However, most programs that have an addictions program focus heavily (almost exclusively) on drugs and/or alcohol addiction and not all students would

take this special certification. Perhaps a better option would be to reach the majority of graduate students by either developing a course that addresses process addictions as the primary focus and includes sexual addictions, or to infuse the study of sexual addictions into the existing CACREP core courses so as to show its importance for students to understand and absorb. Students in a CACREP accredited program should be allowed to explore the world of a process-addicted client by increasing student awareness, empathy, and competence. Whether through infusion or a stand-alone course, there were six suggestions made by the experts to satisfy the survey respondents' dissatisfaction with process and sexual addiction training. The pedagogic strategies included having students: (1) visit a 12-step or other recovery type group, (2) engage in an abstinence exercise where they learn what it is like to try to quit something, (3) interview people affected by addiction, (4) participate in supervised in-field experiences with process addicted clients, (5) be exposed to guest speakers to teach students about process addictions, and (6) read supplemental material, including accounts from clients. This researcher recommends that CACREP create standards around process addiction training and more carefully outline that both process and chemical addictions be taught and leave the details up to each program to ensure they are meeting the standards, which is the current process.

**Instructor qualifications.** In the related mental health profession of psychology, many students do not appear to be receiving adequate education or training related to sexuality issues in psychology training programs (Miller & Byers, 2008). The vast majority of the respondents would be interested in obtaining additional training related to sexuality and thought it was very important for psychologists to receive sex education and training to increase their comfort in discussing this issue with clients (Miller &

Byers, 2009), a finding that was supported by this current research study, as well.

Counselor comfort with sexual issues has a direct correlation to client comfort with discussing this topic with the practitioner, a more significant impact than training and clinical experience (Ayers & Haddock, 2009; Berman, 1996). A correlation has been established between sexual education in graduate school and therapist comfort in discussing this topic with clients (Fife, Weeks, & Gambescia, 2008; Miller & Byers, 2008, Miller & Byers, 2009).

Many faculty members are also not comfortable talking about sexuality and related issues in the classroom. This hesitancy certainly does not make counselors more comfortable discussing this issue with their clients. In order to make students more comfortable, it is imperative that programs hire instructors for addictions' courses class that are comfortable discussing sexual issues, answering students' questions, and preparing mental health professionals to work with clients who present with this issue. The ideal experience, education, and training have been identified by experts and hopefully Counselor Education departments are producing more doctoral level graduates with these qualifications. The instructor of an addictions class should understand the addictions field, and have taken the masters level addictions class from an accredited institution. The instructor should also be knowledgeable about techniques and strategies for the addicted population, preferable by having had three to five years of clinical experience counseling individuals with a wide variety of addictions. The instructor should have a Ph.D. in counselor education and a strong foundation to teach addictions. The instructor should also be active in researching addictions, and presenting the research at professional organizations. Again, it is recommended that more research needs to be

done on this topic and that more sessions need to be offered at the ACA conference, as well as at its divisional conferences including Counselor Education conferences, the American Mental Health Counselors Association (AMHCA) conference and the American School Counselors Association (ASCA) conference, and others.

### **Implications for Counselors**

The information obtained regarding counselor training and counselor attitudes from the present study is valuable to counselor educators and the counseling profession. Reason dictates that if problematic Internet pornography use is on the rise (Schneider, 2000), and it can cause significant challenges both intrapersonally and interpersonally, then counselors are going to see more and more clients presenting with this as an issue in counseling (Cooper, et al., 2000; Dew & Chaney, 2004; Hagedorn, 2009a). There are few studies that look specifically at the counseling process, counselor preparation, and pornography (Hertlein & Piercy, 2008). Treatment plans for Internet pornography addiction are not readily available for counselors to access, and process addictions are not usually taught in programs of study. This is reinforced by the quantitative data from this study in which 61.7% of the respondents are either completely or somewhat dissatisfied with their sexual addiction training, and 54.4% of the respondents are either completely or somewhat dissatisfied with their process addiction training. This researcher recommends that counselors attend conference presentations pertaining to Internet pornography addiction training so as to become more competent, confident and knowledgeable about how to treat clients with this issue. Although programs need to train counselors in this area, if clinicians are to be competent counselors they must seek out training where they are aware it is needed.

Clinicians have not received much training to prepare them to know what to do with clients that present with pornography use problems (Ayres & Haddock, 2009). Many mental health practitioners, in a variety of professions, are reporting that they currently are not comfortable discussing sexual issues with clients (Berman, 2006; Hagedorn & Juhnke; Harris & Hays, 2008; Hertlein & Piercy, 2008; Lerza & Delmonico, 2002; Maltz, 2009; Ng, 2006). Mental health practitioner comfort with sexual issues has a direct correlation to client comfort with discussing this topic with the practitioner (Ayers & Haddock, 2009; Berman, 1996; Gray & House, 1991). Among the topics counselors feel the least competent to be discussed with clients by clinicians in this study were: (a) assessing a client's readiness to change problematic Internet sexual activity, (b) using assessment data to develop a treatment plan for clients addicted to Internet pornography, and (c) working effectively with a client who has an Internet pornography addiction. Counselors generally are not being trained in problematic Internet sexual activity, and they generally are not satisfied with their training in this area of their academic program, yet the majority of those surveyed in this study had clients bring up this topic with them. If the profession begins training counselors, they will likely become more competent and feel more confident in discussing this issue with clients. If counselors are confident in their training and ability then they will tend to more effectively benefit clients (Harris, 2008; Snyder, Baucom, & Gordon, 2008; Swisher, 1995) and be less likely to miss or ignore issues with pornography that are brought up by clients (Turner, 2009).



## **Implications for Clients**

Research has shown that it is important for counselors to ask clients about their sexual concerns and not wait for the client to bring these issues up in session. The counselor should be prepared to discuss these issues comfortably and openly (Haney, 2006; Harris & Hays, 2008). A correlation has been established between sexual education in graduate school and counselor comfort in discussing this with clients (Fife, Weeks, & Gambescia, 2008; Miller & Byers, 2008; Miller & Byers, 2009). Counselors who are embarrassed or uncomfortable discussing sexual topics may inadvertently harm clients who are dealing with sexual issues (Gray & House, 1991; Hagedorn, 2009a; Hagedorn, 2009b; Hagedorn & Juhnke, 2005; Harris & Hays, 2008; McCarthy & McDonald, 2009). All practicing counselors need to be comfortable and competent in responding to clients' sexual concerns as sexuality is an integral part of humanity. By not asking clients about their sexual history and any problematic sexual activities, it is the opinion of this researcher that we are omitting a very integral part of their identity and we are doing them a disservice by not exploring this important part of human nature.

The experts interviewed for this study indicated that the prevalence of problematic sexual activities in clients and the special skills necessary to diagnose and treat clients' sexual concerns makes the training not only a priority, but puts our clinicians at a disadvantage not to be trained in process addictions. The experts also expressed that counselors are likely to encounter clients who present process addictions for treatment, including pornography addiction. The shame and guilt surrounding an Internet pornography addiction will make it unlikely for a client to bring this up in session, they will likely depend upon the counselor to ask, and to know how to address

this issue. At any rate, counselors will encounter clients who self-identify as being addicted to Internet pornography. By not including this topic in counselor training programs, the profession is setting counselors up to be unprepared to properly handle this issue, thus potentially harming clients by not addressing it at all, or addressing it improperly.

### **Recommendations for Future Research**

This study suggested multiple implications for future counseling research during the course of its completion. This last section contains implications gleaned from this study for future research in addictions and counselor training. First, this study could be replicated with a more specific sample of counselors who actually practice counseling in a professional setting. The sample used for this study contained a number of retired counselors, professors who no longer actively counsel clients, and other individuals whose opinions may not have been directly relevant to this research. Perhaps surveying members of the American Mental Health Counselors Association (AMHCA) and the American School Counselors Association (ASCA), which are both divisions of the American Counseling Association, would yield better results which might be more specifically focused on individuals who might actually be working with clients who suffer with this issue. Perhaps also surveying members of these divisions who have graduated in the last 20 years would be helpful, since some participants of this study were trained long before CACREP's inception, which undoubtedly affected their training, which, in turn, likely affected their answers. Future research in this area could include inclusion criteria in order to exclude those who are not actively practicing in a counseling setting.

A second logical area for future research would be the issue of terminology. This study's main focus was Internet pornography addiction. Two of those three words are controversial in this profession. We have yet to agree, as a profession or a society, on exactly what "pornography" is. Most people in the United States have a notion of what pornography is, but most people become quite confused when faced with defining exactly what is and is not pornography, and exactly when viewing it becomes problematic. Another controversial word that needs an agreed upon definition is "addiction." The counseling profession seems splintered in a three-way divide. There are mental health professionals who are of the opinion that the only addictions recognized are related to drugs and alcohol. Any other problematic behavior is a compulsion, or something else. Other mental health professionals believe that drugs and alcohol are chemical addictions, but the only process addictions recognized are gambling and eating disorders, consistent with the DSM-5 definitions. Still other professionals think that there are chemical and process addictions, and process addictions encompass shopping, sex, pornography, food, gaming, and multiple other addictions. In order for the counseling profession to be recognized as contributing to the knowledge base about these topics, it must come together with unified definitions and develop assessment, diagnostic, and treatment strategies for these issues.

A third recommendation for future research involves the development of an instrument specifically related to Internet pornography addiction, counseling training, knowledge, and training satisfaction. After an extensive search, no instruments were found by this researcher, and existing attitudinal and competence scales had to be modified to include Internet pornography addiction. Since the Internet offers

unprecedented opportunity for individuals to have anonymous, cost-effective, and unrestricted access to an essentially unlimited range of sexually explicit text, pictures, videos, and audio materials (Haney, 2006), this issue is not going away and it is an area that begs further research after this introductory study. Internet pornography is becoming a public health hazard that is hidden because not many researchers or public health practitioners are identifying it as an area of importance (Abell, Steenberch, & Boivin, 2006; Ciclitira, 2004; Cooper, et al., 2004; Manning, 2006).

The data show that those who did *not* graduate from a CACREP accredited program are more likely to be more satisfied with their addictions training. This finding raises an interesting and potentially concerning point. This finding needs more research as to why non-accredited program graduates are more satisfied with their training. What factors make them more satisfied? Might it be that they do not know what they are missing or are they truly happier with their training? It could be that non-accredited programs have more flexibility in their program offerings as they are not constrained by CACREP standards. More studies are needed that compare CACREP accredited program graduates with non-CACREP accredited counseling programs, their treatment of clients, their attitude toward training and their self-efficacy with addicted clients.

All expert interviews for this study were conducted over the phone, were recorded, and analyzed later. An area for further research would be to bring these experts together in a focus group format and have them discuss their interviews and opinions in an open format. This could be used to triangulate the data further and may enable the profession to come to some sort of consensus regarding training of counselors to handle

addictions, including process addictions, in a competent manner and feel capable of addressing sexual concerns.

The literature has found that pornography use and addiction by 11-17 year olds are among the fastest growing group of problematic Internet pornography users. This is an area that needs further research including whether our sexual education courses in middle school and high schools are effective and whether they include the use of mobile technology with Internet capabilities. There have been a number of news stories recently that include “sexting” and children being arrested for distributing child pornography of their own peers. This is an area that not only needs further research, but also calls for more specific education and technology support to enhance protections for children.

Finally, additional work and research can be dedicated to surveying or interviewing clients who have gone to counseling and discussed Internet pornography addiction. This current study addressed counselors and counselor educators, but a study that examined clients who have attended counseling would be valuable to this profession. Such a study might examine client satisfaction with the treatment they have received, their expectations, and the effectiveness of treatment. Perhaps a quantitative survey could be done in conjunction with social media, or some other web presence that gathers information with smart technology and can tailor an advertisement directly to people who access websites that might be related to the topic at hand. Another alternative would be to qualitatively interview clients who have received counseling in which Internet pornography was a topic. There has been a lack of reliable, empirically sound research which limits the conclusions that may be drawn regarding the effects of addictive pornography use on individuals, relationships, families and society (Griffiths, 2001;

Hagedorn, 2009a). There are few studies that look specifically at the counseling process, counselor preparation, and pornography (Hertlein & Piercy, 2008). Further research is extremely important in order to empirically validate which assessment and treatment methods are most appropriate to use, and with what type of client population.

### **Conclusion**

This research study has found that counselors and experts in the field of counselor education are pleased with many aspects of the training of counselors and the interactions they have with clients. At the same time, there is certainly room for improvement in the training and preparation of counselors. Indeed, programs are resistant to add classes to programs, but technology changes the landscape of society and so it should change the landscape of the profession of counseling. With the advent of more portable, Internet-ready technology, Internet pornography addiction is not going away, as evidenced by recent news stories of celebrities in sports, government, and media being caught in the web of problematic Internet sexual activity. Pornography addiction is not a new phenomenon. It is time it is recognized by the DSM as a legitimate addiction so that it can receive the attention and research it deserves. Without the counseling profession rising to the occasion to produce well-prepared counselors, it is leaving clients who are addicted to Internet pornography to learn the skills necessary to cope with this problem without the assistance of a trained counselor, which is unfortunate for the profession, for counselors in general, and for our clients. The purpose of this study was to introduce the topic of training satisfaction, attitude toward pornography, addiction counseling self-efficacy, and the comfort of counselors in discussing sexual issues with clients, particularly Internet pornography. It is the hope of this researcher that future studies will

continue to look at these issues in depth so as to develop empirically supported treatment protocols in order to keep the profession of counseling relevant for all clients.

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Appendix A  
Survey Instrument

Survey Instrument:

For the purposes of this study, pornography will be defined as sexually explicit text, pictures, videos, and audio materials designed, produced and distributed for the purpose of sexual enticement, excitement and gratification (Haney, 2006; Kingston, Malamuth, Fedoroff, & Marshall, 2009). Pornography shows genitals and sexual activities in unconcealed ways (Flood, 2009).

1. Have you seen clients in a counseling setting after completion of your graduate program?  
☐ Yes  
☐ No
2. Did you graduate from a graduate level, CACREP-accredited counselor education program?  
☐ Yes  
☐ No
3. What is your gender?  
☐ Male  
☐ Female  
☐ Transgender
4. What is your current age?  
☐ \_\_\_\_\_
5. How would you describe yourself racially/ethnically? (check all that apply)  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Black or African American  
☐ Hispanic or Latino  
☐ Native Hawaiian or Other Pacific Islander  
☐ White  
☐ Mixed Race/Ethnicity  
☐ \_\_\_\_\_

6. How would you rate the impact of your religious values, spiritual beliefs and morality to the clinical work you do with your clients?

- ☐ Very Important
- ☐ Somewhat Important
- ☐ Neutral
- ☐ Somewhat Unimportant
- ☐ Not Important at all

7. What was the emphasis (program) of your master's or doctoral level degree? (Check all that apply)

- ☐ Community Counseling
- ☐ Mental Health Counseling
- ☐ Clinical Mental Health Counseling
- ☐ Career Counseling
- ☐ Marriage, Couple, and Family Counseling
- ☐ School Counseling
- ☐ Student Affairs and College Counseling
- ☐ Addiction Counseling
- ☐ Non-accredited program option
- ☐ Counselor Education and Supervision
- ☐ Other: \_\_\_\_\_

8. What is the focus of your clinical practice? (Check all that apply)

- ☐ Community Counseling
- ☐ Mental Health Counseling
- ☐ Clinical Mental Health Counseling
- ☐ Career Counseling
- ☐ Marriage, Couple, and Family Counseling
- ☐ School Counseling
- ☐ Student Affairs and College Counseling
- ☐ Addiction Counseling
- ☐ Other: \_\_\_\_\_

9. Approximately how long have you been practicing counseling?

- ☐ \_\_\_\_\_

10. Think about when you do an intake or assessment for clients. Are there typically any questions or items on these forms or in these procedures that allow you to address the Internet sexual activities that your clients may be engaged in?

☐ Yes  
☐ No

11. Please check all of the topics or courses that were addressed during your graduate education:

\_\_\_\_\_ Addictions class that included process addictions such as pornography.

\_\_\_\_\_ Addictions class that did not include process addictions such as pornography.

\_\_\_\_\_ Human sexuality

\_\_\_\_\_ Reproductive biology

\_\_\_\_\_ Sex roles

\_\_\_\_\_ Sexual therapy or education

\_\_\_\_\_ Cross-cultural aspects of sexual behavior

\_\_\_\_\_ Psychological aspects of sexual behavior

\_\_\_\_\_ Sexuality development

\_\_\_\_\_ Sexual ethics and values

\_\_\_\_\_ Marriage therapy or relationships

\_\_\_\_\_ Sexual variations

12. Please check all of the following topics that have been addressed during your graduate program (including supervision):

- \_\_\_\_\_ Pornography use and addiction
- \_\_\_\_\_ Masturbation
- \_\_\_\_\_ Orgasm
- \_\_\_\_\_ Homosexuality
- \_\_\_\_\_ Personal conflicts in sexual relationships
- \_\_\_\_\_ Abortion
- \_\_\_\_\_ Contraception/safer sexual practices
- \_\_\_\_\_ Sexually transmitted diseases
- \_\_\_\_\_ Sexual dysfunction
- \_\_\_\_\_ Sexual guilt
- \_\_\_\_\_ Sexual violence (abuse or rape)
- \_\_\_\_\_ Frequency and intensity of sexual expression

13. Have you ever attended a continuing education course, or an educational session at a professional conference that was specifically pertaining to Internet pornography addiction?

- ☐ Yes
- ☐ No

14. Have you ever had a client discuss their Internet sexual activities with you?

- ☐ Yes
- ☐ No

15. Have you ever had a client discuss being addicted to Internet pornography?

- ☐ Yes  
☐ No

On a scale from 1 to 5, where 1 is Strongly Disagree and 5 is Strongly Agree, please indicate the extent of your agreement with the following statements:

16. \_\_\_\_\_ I believe that Internet pornography in general is positive and adds zest to living.
17. \_\_\_\_\_ I have a foundation of support for my own values, knowledge, and beliefs about Internet pornography.
18. \_\_\_\_\_ I am tolerant of sexual beliefs and lifestyles that are different to my own.
19. \_\_\_\_\_ I consider the expression of sexuality to be an integral part of the total human personality.
20. \_\_\_\_\_ In my opinion, the expression of sexuality is an acceptable topic for everyday conversations.
21. \_\_\_\_\_ Internet pornography is a topic worthy of academic study.
22. \_\_\_\_\_ I feel in turmoil about my sexuality.
23. \_\_\_\_\_ I feel anxious about my own sexual standards and behavior.
24. \_\_\_\_\_ When confronted with sexual values different from my own, I feel tolerant.
25. \_\_\_\_\_ I avail myself of opportunities to increase my comfort with sexuality.
26. \_\_\_\_\_ I avail myself of opportunities to increase my comfort with discussing Internet pornography.

On a scale from 1 to 5, with 1 being completely dissatisfied, and 5 being completely satisfied, please rate your satisfaction with your training program in regards to each of the following:

- 27. \_\_\_\_\_ Training about healthy sexuality.
- 28. \_\_\_\_\_ Training about abnormal sexuality.
- 29. \_\_\_\_\_ Training about addictions.
- 30. \_\_\_\_\_ Training about process addictions (pornography, gambling, shopping, etc.).
- 31. \_\_\_\_\_ Training about issues faced by couples and families.

On a scale from 1 to 5, where 1 is Strongly Disagree and 5 is Strongly Agree, please indicate the extent of your agreement with the following statements:

- 32. \_\_\_\_\_ Looking at pornography can be educational.
- 33. \_\_\_\_\_ It's important for a couple to share the same taste in pornography.
- 34. \_\_\_\_\_ Looking at pornographic material can make clients' sex life more exciting.
- 35. \_\_\_\_\_ When a person is sexually frustrated it is good to have ready access to pornography to relieve the tension.
- 36. \_\_\_\_\_ Using pornography to masturbate is like scratching an itch.
- 37. \_\_\_\_\_ Only really religious people are morally against pornography.
- 38. \_\_\_\_\_ All men look at pornography, and there is nothing wrong with that.
- 39. \_\_\_\_\_ Pornography lets people indulge the harmless fantasy of an endless variety of partners, whether in a relationship or not.
- 40. \_\_\_\_\_ It is not a good thing for clients to want to watch other people having sex on a video when they are with a partner.



41. \_\_\_\_ Pornography devalues human sexuality by presenting sex in an impersonal and tasteless way.
42. \_\_\_\_ Many times I feel that pornography is something clients may indulge in when they are younger, but by the time clients settle down they should outgrow it.
43. \_\_\_\_ People use pornography to avoid intimacy or avoid having a real relationship.
44. \_\_\_\_ Pornography is just another kind of harmless entertainment when clients are bored-like watching TV.
45. \_\_\_\_ I feel it is over controlling for one partner to tell the other to stop watching pornography.
46. \_\_\_\_ If clients are in a relationship, it is better for them to use pornography than cheat on their partner.
47. \_\_\_\_ It is not good when clients hide from their partners how much they use pornography.
48. \_\_\_\_ The problem with pornography is that it makes users want to cheat on their partner.
49. \_\_\_\_ One problem with watching too much pornography is that real live sex becomes boring.
50. \_\_\_\_ Pornography is not just for guys: women have the right to access the same kind of empowerment that comes from discovering and owning their sexual desires.
51. \_\_\_\_ Pornography is a healthy outlet.
52. \_\_\_\_ Pornography is more enjoyable if it has a romantic storyline in which the couple lives happily ever after.

53. \_\_\_\_ Pornography is good because it shows images of strong independent sexually confident women.
54. \_\_\_\_ Pornography fundamentally exploits women because it degrades them.
55. \_\_\_\_ There would be nothing wrong with a student club at college publishing a magazine with pictures of naked students and other sexual content.
56. \_\_\_\_ Knowing about stuff like landing strips and thongs is key to a girl having a full and satisfying sex life.
57. \_\_\_\_ More girls than is commonly thought look at pornography – it's just more secret and less overtly acceptable among women.
58. \_\_\_\_ One of the benefits of pornography is that it can open a person up to fantasies, sexual acts or positions that once were thought of as taboo.
59. \_\_\_\_ There's a difference between erotica and pornography. Erotica is a turn-on for me; pornography is not.
60. \_\_\_\_ Occasional pornography use is okay, but if a client has to view it every day, they have a problem.
61. \_\_\_\_ Any pornography use is a problem.

For each of the following items, please rate how confident you are in your ability to perform these skills as they relate to clients who are addicted to Internet pornography. There are no right or wrong answers. This is your opinion only. Use the following rating scale where 1 is no confidence and 5 is absolute confidence.

62. \_\_\_\_ Assess a client's previous experience with self-help groups like Sex Addicts Anonymous, Sexual Compulsives Anonymous, S-ANON, etc.

63. \_\_\_\_ Show empathy towards a client who is addicted to Internet pornography.
64. \_\_\_\_ Create a therapeutic environment where the client will feel that I understand them.
65. \_\_\_\_ Convey an attitude of care and concern for the client.
66. \_\_\_\_ Work effectively with a client who has an Internet pornography addiction.
67. \_\_\_\_ Include a client in the referral decision-making process.
68. \_\_\_\_ Develop trust with a client who has an Internet pornography addiction.
69. \_\_\_\_ Screen clients for co-occurring mental health disorders.
70. \_\_\_\_ Help a client determine who is available to support her/his recovery.
71. \_\_\_\_ Work effectively with a client who has an Internet pornography addiction and a psychotic disorder (e. g., schizophrenia).
72. \_\_\_\_ Use assessment data to develop a treatment plan.
73. \_\_\_\_ Responsibly challenge a client with problematic Internet sexual activity.
74. \_\_\_\_ Work effectively with a client who has problematic Internet sexual activity and a personality disorder.
75. \_\_\_\_ Assess a client's readiness to change problematic Internet sexual activity.
76. \_\_\_\_ Help a client develop realistic expectations about recovery.
77. \_\_\_\_ Work effectively with a client who has both problematic Internet sexual activity and trauma-related issues.

78. \_\_\_\_\_ Teach a client about self-help support networks and related self-help literature.
79. \_\_\_\_\_ Help a client figure out what behaviors will support recovery.
80. \_\_\_\_\_ Help a client recognize what triggers her/his use of Internet sexual activity.
81. \_\_\_\_\_ Write accurate and concise assessment reports.
82. \_\_\_\_\_ Summarize a client's treatment and recovery information for other professionals.
83. \_\_\_\_\_ Establish a warm, respectful relationship with a client.
84. \_\_\_\_\_ Gather information about a client's prior experiences with problematic Internet sexual activity treatment.
85. \_\_\_\_\_ Challenge behaviors that interfere with a client's recovery.
86. \_\_\_\_\_ Select high quality referral sources for a client if needed.
87. \_\_\_\_\_ Work effectively with a client who has both problematic Internet sexual activity and a mood disorder (e. g., depression).
88. \_\_\_\_\_ Refer a client when I cannot treat her/his co-occurring mental illness.
89. \_\_\_\_\_ Use active listening techniques when working with a client who has problematic Internet sexual activity.
90. \_\_\_\_\_ Maintain a respectful and nonjudgmental atmosphere with a client.

## Appendix B

### Consent Document for Study's Quantitative Portion

WESTERN MICHIGAN UNIVERSITY  
Department of Counselor Education and Counseling Psychology

**Principal Investigator:** Gary H. Bischof, PhD  
**Student Investigator:** Bradly K. Hinman, MA  
**Title of Study:** Mixed Methods Analysis of Counselor Views, Attitudes and Perceived Competencies Regarding the Treatment of Internet Pornography Addiction.

You have been invited to participate in a research project entitled "***Mixed Methods Analysis of Counselor Views, Attitudes and Perceived Competencies Regarding the Treatment of Internet Pornography Addiction.***" This research is intended to study how prepared counselors feel they are to counsel an individual who self-diagnoses as being addicted to Internet pornography. This project is ***Brad Hinman's*** dissertation for the requirements of the Doctor of Philosophy in Counselor Education. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and contact the student or principal investigator if you have any questions.

The anonymous, 90-item survey is hosted on QuestionPro, an Internet-based research site. Your participation in this study should take approximately 15 minutes, according to the pilot survey. There is one requirement for participation in the study. Participants must have seen clients in a counseling setting after graduation. You will also be asked to provide general information about yourself, such as age, level of education, attitudes toward pornography and experiences surrounding discussing sexual issues with clients. As a small incentive and as a token of appreciation, a \$1 bill was included in your invitation.

As in all research, there may be unforeseen risks to the participant. If you feel you experience adverse reactions to this survey you are asked to discontinue your involvement immediately. One potential risk of participation in this project is that you may be upset by the content of the survey; however, should you become significantly upset you are asked to discontinue your involvement immediately.

Time spent on completing this survey is likely equivalent to time lost spent on other activities. Participating in this research provides the opportunity to think about your attitudes toward an important topic in our profession, which may be a potential benefit to you. There are no costs associated with participating in this study. One way in which you may benefit from this activity is having the chance assess your reactions to your training, program requirements, attitudes, and beliefs about pornography which will be used to improve the counseling profession. Clients who are experiencing difficulty as a result of their Internet pornography use may benefit from the knowledge that is gained from this research.

All information entered by researchers and participants into QuestionPro's site is kept in a secure data facility that is monitored for operational security. The surveys are protected by Check Point FireWall-1, decreasing the chances the survey information can be intercepted or manipulated by a third party during transmission. All of the information collected from you is anonymous. Your name is not recorded on any of the information collected. If you have any questions or concerns about this study, you may contact either **Dr. Gary Bischof** at (269) 387-5108 or [gary.bischof@wmich.edu](mailto:gary.bischof@wmich.edu) or you may contact **Brad Hinman** at (269)471-5968 or [hibradly@andrews.edu](mailto:hibradly@andrews.edu). You may also contact the chair of Human Subjects Institutional Review Board at 269-387-8293 or the vice president for research at 269-387-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old. Your signature below indicates that you have read and/or had explained to you the purpose and requirements of the study and that you agree to participate.

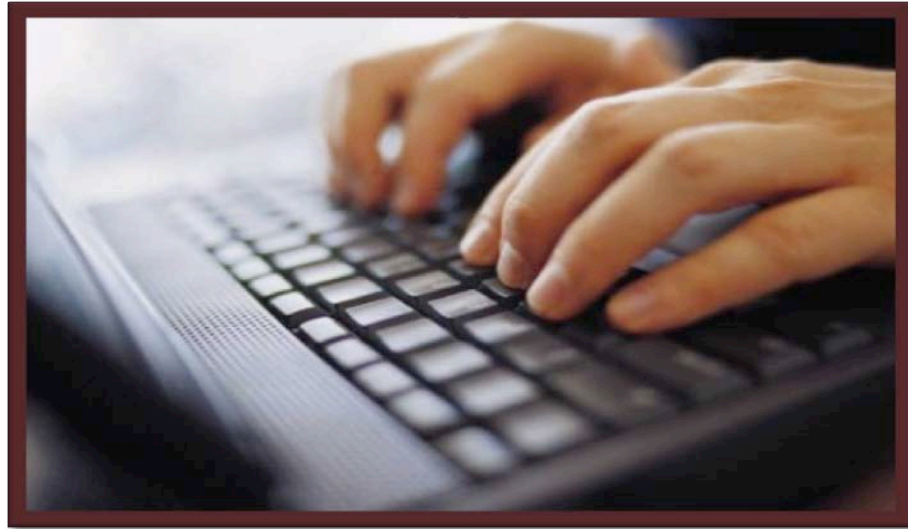
I have read this consent document. The risks and benefits have been explained to me. If you would like to participate, please click on the "Continue" button below to indicate your consent to participate in this study.

## Appendix C

### Invitation Greeting Card for Survey



## You are Cordially Invited...



To assist in a dissertation research project entitled, “MIXED METHODS ANALYSIS OF COUNSELOR VIEWS, ATTITUDES AND PERCEIVED COMPETENCIES REGARDING THE TREATMENT OF INTERNET PORNOGRAPHY ADDICTION”

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### *Inside of Greeting Card*

My name is Bradly K. Hinman and I am a doctoral candidate in the Counselor Education program at Western Michigan University. My research is assessing counselors' comfort with discussing sexual issues with clients, the counselors' attitudes toward pornography, and counselors' addiction counseling self-efficacy.

This research is being supervised by my faculty mentor and chair, Gary H. Bischof, Ph.D., and it has been reviewed by the Human Subjects Institutional Review Board at Western Michigan University. This survey link is being sent to you because you are a member of the American Counseling Association, and I have included a small incentive and a token of my appreciation to you. I know your time is valuable and I truly appreciate your consideration in submitting the survey. If you have questions about this survey, please email me at [hibradly@andrews.edu](mailto:hibradly@andrews.edu).

This anonymous, online questionnaire will take approximately 15 minutes to complete. If you would kindly like to learn more about the study, the consent information and survey are available and can be accessed by clicking on the following link: {insert link here}

Sincerely,

Brad Hinman, MA, NCC, LPC, LLMFT

Appendix D

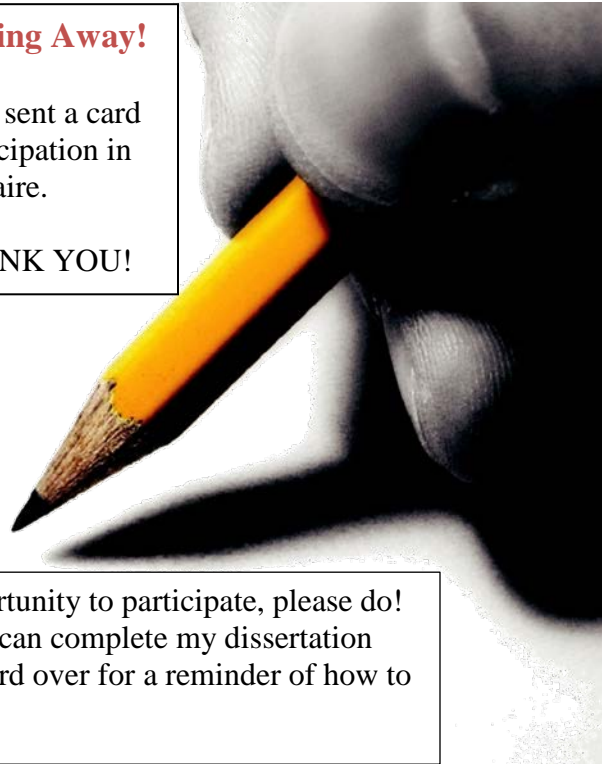
Reminder Cards for Survey

Front of Reminder Card (Sent twice, 10 days after Initial Mailing, and then after another 10 days)

**Research Opportunity Slipping Away!**


Approximately two weeks ago, I sent a card and an incentive requesting participation in an online, anonymous questionnaire.

If you participated already, THANK YOU!



If you have not yet had an opportunity to participate, please do! I really need your help so that I can complete my dissertation research. Please turn the postcard over for a reminder of how to access the survey!

Back of Reminder Card (Sent twice, 10 days apart or until N is reached)

<p><b>WESTERN MICHIGAN</b> <b>UNIVERSITY</b></p> <p><b>Bradly K. Hinman</b>, MA, NCC, LPC, LLMFT Student Investigator <b>Gary H. Bischof</b>, Ph.D, Principal Investigator</p> <p>This anonymous, online questionnaire will take approximately 15 minutes to complete. If you would kindly like to learn more about the study, the consent information and survey are available and can be accessed by clicking on the following link: {insert link here}</p> <p>“MIXED METHODS ANALYSIS OF COUNSELOR VIEWS, ATTITUDES AND PERCEIVED COMPETENCIES REGARDING THE TREATMENT OF INTERNET PORNOGRAPHY ADDICTION”</p>	
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## Appendix E

### Telephone Script for Screening Potential Expert Participants

### Telephone Script for Qualifying Potential Expert Participants

“Hello. My name is Brad Hinman and I am a doctoral candidate in Counselor Education at Western Michigan University. I am conducting research for my dissertation, which is investigating the current state of addictions training in counselor preparation programs, as well as the attitudes, perceptions and self-efficacy of counselors regarding clients with a self-assessed addiction to Internet pornography. As you know, the 2009 CACREP standards were released and there are several changes and additions related to addiction training, including the new Addiction Counseling program option. I am trying to determine what may be considered ‘best practices’ related to the addiction education of counselors-in-training, as well as what may done to improve the preparation of counselors-in-training so that the counselors may be more comfortable to discuss sexual matters with clients, including the use of pornography. In order to do this, I need to interview counselor educators who are also ‘experts’ in pornography abuse and addictions counseling. Participation would involve a semi-structured, tape-recorded, telephone interview and it will take approximately 45-60 minutes to complete. I am contacting you because I am familiar with some of your work in pornography addictions (or because someone referred me to you). I was hoping to have the opportunity to discuss my research with you and see if you would be interested in possibly becoming a participant in this study.”

<Potential participant indicates his or her interest or lack of interest. Also, I will answer any questions the potential participant may have at this time>

“If you are interested in participating, I must determine first if you are considered an “expert” based on some pre-determined criteria I have set. I need to confirm that you meet at least four of the following eight criteria (Lee, 2011):

- (1) Employed full-time as a counselor educator at a CACREP-accredited program at the time of the interview.
- (2) Published one or more journal articles related to the process addiction of online sexual activities.
- (3) Conducted research related to the process addiction of online sexual activities.
- (4) Presented information on the process addiction of online sexual activities at a conference.
- (5) Provided five or more years of counseling.
- (6) Obtained credentials in the sexual addictions or sex therapy arena (i.e., AASECT)
- (7) Taught at least one sex therapy or addictions course.
- (8) Provided professional service in the areas of sexual addictions or sex therapy for a year or longer (e.g., committee or board member, editor, etc.)

Which of the tasks have you completed?”

<Potential participant will answer>

<If the potential participant is interested and considered an “expert,” I will proceed to the next paragraph. If not interested or not considered an expert, I will skip down to the paragraph with the two asterisks>

“I would like to discuss a little further what is requested of a participant. After the interview is transcribed and I have typed up the analysis of your interview, and findings from the cross-case analyses, I would like to provide you with those documents to review. The amount of time spent on this will vary based upon how closely you choose to review the findings. Would you be willing to provide me with comments and feedback about the accuracy of my analysis?

<If yes, continue with script below. If no, discuss the lack of interest in participating with potential participant. If they still do not want to be involved with the study, then I would skip down to the paragraph with the two asterisks>

“Great. So I will be sending 2 copies of a consent document by mail with a pre-stamped envelope. Please review it, sign one copy, and keep the other for your records. Once I have received the consent document, I will contact you by telephone or e-mail in order to set up the interview. Do you have any questions at this time?”

<Answer any questions>

“I would like to get all your contact information, including an address to send the consent document. Is that ok?”

<Obtain the contact information and also provide my contact information to the participant>

“Great. I am looking forward to the interview and appreciate your time. Your input will be essential to this investigation. I have one other question for you. Would you know of any other counselor educators with expertise in this area who may qualify for this study?”

<Yes or No; Obtain potential participant’s contact name/information, if possible>



“Ok. Thank you again. I will be putting the documents in the mail tomorrow. Please contact me if you have any questions in the meantime. Goodbye.”

\*\* <If unwilling/unable to participate>

“Thank you so much for your time today. I appreciate it. I was hoping you may know of any other counselor educators with expertise in this area who may be potential participants for the study. Do you know of anyone you could refer me to at this time?”

<Yes or No; Obtain potential participant’s contact name/information, if possible>

“Thank you again. Have a great afternoon/evening.”

## Appendix F

### Consent Document for Study's Qualitative Portion

## WESTERN MICHIGAN UNIVERSITY

Department of Counselor Education and Counseling Psychology

**Principal Investigator:** Gary H. Bischof, PhD  
**Student Investigator:** Bradly K. Hinman, MA  
**Title of Study:** Mixed Methods Analysis of Counselor Views, Attitudes and Perceived Competencies Regarding the Treatment of Internet Pornography Addiction

You are invited to participate in a research project titled " *Mixed Methods Analysis of Counselor Views, Attitudes and Perceived Competencies Regarding the Treatment of Internet Pornography Addiction.*" This project will serve as Bradly K. Hinman's dissertation for the requirements of the Doctor of Philosophy in Counselor Education. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in the qualitative part of this research project. Please read this consent form carefully and completely and contact the student or principal investigator if you have any questions.

The purpose of this study is to investigate the current state of process addiction training in master's-level, CACREP-accredited programs, more specifically in relation to the new 2009 CACREP standard requirements. It is the researcher's intent to determine what may be considered "best practices" related to the process addiction education of counselors-in-training, as well as what may be regarded as best practices when faculty attempt to implement the standard requirements related to the addiction competencies.

In order to participate in the interview portion of this study, the participants must be a full time counselor educator and must be considered an expert by the researcher based on pre-determined criteria. Your participation in this portion of the study should take approximately 45-60 minutes.

The semi-structured interview questions are focused on three main areas and you will be asked your expert opinion about:

- (1) The current status of process addiction training at CACREP-accredited programs.
- (2) The recommendations regarding the preferred ways to develop adequate knowledge and competency in this area
- (3) What would be considered "best practice" in the education of student counselors regarding sexual addictions.

There are two documents sent with this consent form which should be reviewed prior to the interview. This review will take approximately 10 minutes. After your participation in the interview, a copy of the findings will be sent to you for your review and your

feedback on the findings will be requested. The time commitment for this portion of study will vary based upon how closely you choose to review the findings.

Time spent on completing this interview may result in equivalent time lost to spend on other activities. Participating in this research provides the opportunity to think about your attitudes toward an important topic in our profession, which may be a potential benefit to you. There are no costs associated with participating in this study.

If you choose to participate in this study, your interview will be confidential and coded with a number and transcribed verbatim by the researcher. You may request a copy of your transcribed interview at any time. The tapes will be held in a locked cabinet and erased once the transcripts are transcribed and verified. No identifying information will appear in the write-up of the findings. There are no other potential risks known for participating in this study.

You can choose to stop participating in the study any time for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience no consequences if you choose to withdraw from this study. Should you have any questions prior to or during the study, you can contact the primary investigator, Gary H. Bischof at 269-387-5108 or gary.bischof@wmich.edu, or Bradly K. Hinman at 269-471-3466 or hibradly@andrews.edu.

You may also contact the Chair of the Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study. This research study and consent document have been reviewed by the Human Subjects Institutional Review Board (HSIRB) of Western Michigan University.

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I have read this consent document. The risks and benefits have been explained to me. I agree to take part in this study. Please return a signed copy in the envelope provided; the other copy is for your records.

---

Please print your name

---

Participant's Signature

---

Date

## Appendix G

### Interview Guide Questions for Expert Participants

## Interview Guide Sheet

Title of Study: Mixed Methods Analysis of Counselor Views, Attitudes and Perceived Competencies Regarding the Treatment of Internet Pornography Addiction

Time of interview: \_\_\_\_\_

Date of interview: \_\_\_\_\_

Location: \_\_\_\_\_

Interviewer: \_\_\_\_\_

Interviewee: \_\_\_\_\_

**Thank you for consenting to participate in this study. I would like to record the interview so the study can be as accurate as possible.**

Questions:

1. Can you please start by describing your professional expertise related to Internet pornography and process addictions?
2. In your opinion, how important is process addictions training in counselor education and why?
3. In your opinion, what is the current state of process addictions training in master's-level, CACREP-accredited programs?
4. In your opinion, how well prepared is the average counseling graduate to effectively counsel an individual addicted to Internet pornography?
5. How should process addiction instruction be taught? In other words, what would be considered best practice?

*Note: Be sure each of these sub-questions are answered*

- (a) Is the best practice of implementing the CACREP standards by infusion, stand-alone course, or combined methods?
- (b) Which students should be exposed to addiction training (e.g., Career, CMHC, Marriage, Couple, and Family, School, etc.) and why?
- (c) What should be the qualifications of an instructor who teaches this content?

- (d) In respect to course design, what have you found to be the most valuable course assignments or learning experiences that help students gain competence in this area (e.g., testing; reflection papers based on 12-step meetings, interviewing a counselor, or recovery panel; visiting a treatment center)?
  - (e) In regards to best practice, what method should be used to implement competencies into CMHC programs (e.g., infusion, stand-alone, combined)?
6. Based on your expertise, can you identify any specific changes that still need to be made in this area? (e.g., related to the profession, the CACREP standards, CACREP-accredited programs, or students and faculty)

Closing comments; thank the participant

## Appendix H

Western Michigan University Human Subjects Institutional Review Board Approval



## WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: July 16, 2012

To: Gary Bischof, Principal Investigator  
Brad Hinman, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

A handwritten signature in cursive script, appearing to read "Amy Naugle".

Re: HSIRB Project Number 12-07-09

This letter will serve as confirmation that your research project titled "Mixed Methods Analysis of Counselor Views, Attitudes, and Perceived Competencies Regarding Internet Pornography Addiction" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., *you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."* Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

**Reapproval of the project is required if it extends beyond the termination date stated below.**

The Board wishes you success in the pursuit of your research goals.

**Approval Termination: July 16, 2013**

Walwood Hall, Kalamazoo, MI 49008-5456  
PHONE: (269) 387-8293 FAX: (269) 387-8276