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Overlapping themes in treating infidelity: Is sex therapy integrated into treatment?

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Entitled

Overlapping Themes in Treating Infidelity: Is Sex Therapy Integrated into Treatment

was approved in partial fulfillment of the requirements for the degree of

Master’s of Science in Counseling

By the undersigned on April 14, 2008

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ABSTRACT

Overlapping Themes in Treating Infidelity: 
Is Sex Therapy Integrated Into Treatment?

by

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Infidelity is a frequent treatment issue in couples treatment and poses a number of challenges for clinicians who treat cases of infidelity. Research and literature on the treatment of infidelity is often scattered, inconsistent from author to author, and, in general, can be difficult for clinicians to grasp and comprehend. The present study will add to existing literature on infidelity treatment with sexual/intimacy components.

The present study investigated the integration of sex therapy techniques/philosophy into the treatment of infidelity and attempted to identify the degree to which practitioners are integrating sex therapy into their infidelity treatment. Clinicians participated in a focus group and interview and were asked questions about their assessment and treatment practices regarding infidelity and overlapping sexual issues in such cases.

The findings indicated that clinicians do address sexual/intimacy issues in infidelity treatment, but most do not incorporate sex therapy techniques. The findings of this study provide direction for future research on the treatment of infidelity.
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CHAPTER 1

INTRODUCTION

Purpose of the Study

Therapists often encounter the problem of infidelity when treating couples and individuals. A couple may initiate therapy with the presenting problem of infidelity or an individual may report infidelity as a common theme of conflict in his or her past or present relationship. Literature may provide guidance to practitioners treating infidelity. Such references typically identify various stages in treatment to process grief, emotions, level of commitment, family of origin influences, cognitive distortions, reframing, accountability, trust and restructuring (see for example, Weeks & Treat, 2001). These treatments frequently address not only the problem of infidelity, but also the concurrent or overlapping issues in infidelity treatment, such as a lack of intimacy within the relationship, communication difficulties, or specific sexual issues. Involvement in infidelity may encompass a variety of behaviors, which commonly have sexual themes. The purpose of this research is to investigate the integration of sex therapy techniques/philosophy into the treatment of infidelity and to identify the degree to which practitioners are integrating sex therapy into their infidelity treatment. Additionally, this research will provide an opportunity for therapists to suggest to what degree this implementation is necessary.
Significance of the Study

In recent literature, it has been suggested that few consistent, research supported approaches to treating infidelity exist (Blow & Hartnett, 2005; Hertlein & Weeks, in press). This can be frustrating and confusing for practitioners who treat infidelity. Infidelity is an ancient issue, but with contemporary means (media, internet, alternative lifestyles), the issue is evolving into new territories. Many current conceptualizations of infidelity appear out-dated or insufficient of addressing current themes. Glass (2003) contends that there are no generally accepted standards for the treatment of infidelity and the treatment literature is inconsistent. In addition, it can appear nearly impossible to conceptualize the treatment of infidelity collectively given the disjointedness of approaches. Is it reasonable to expect consistent treatment approaches? Some practitioners may suggest that it should be reasonable to expect consistent treatment approaches, or at least acknowledge common themes among treatment approaches.

Even the definition of infidelity is inconsistent across the literature. Clearly, the conceptualization of infidelity is not simplistic, but historically, it was defined in fewer terms. In the past, adultery, being unfaithful or having sex with another woman/man may have been clear definitions of infidelity. Thompson (1983) originally defined extramarital sex as genital involvement. Today’s definitions require focusing on “what it is” and “what it is not”. Lusterman (1998) defines infidelity occurring “when one partner in a relationship continues to believe that the agreement to be faithful is still in force, while the other partner is secretly violating it ”( p.3). Other clinicians contend that a definition of infidelity is gender dependent in that men and women in committed relationships themselves have different conceptualizations of infidelity (Glass, 2003). Definitions such
as these, highlight valid considerations however, they are clearly inconsistent with one another.

Sex therapy is generally thought of as treatment for sexual disorders such as hypoactive sexual desire or sexual aversion. Kaplan (1981), in part, defines sex therapy as focused on the resolution of sexual problems. It can be speculated that these “sexual problems” have largely been thought of as those published in the DSM IV-TR (APA, 2000). People in relationships experience a variety of sexual problems which do not always fall into the categories of the DSM IV-TR (Weeks & Hof, 1987). Clinicians who treat couples know that in many cases, sexual problems can stem from a variety of sources, including physiological, relational, family or origin, etc. In this study, sex therapy is defined as psychosocial treatments, strategies, interventions, techniques or philosophies associated with the treatment of traditional sexual dysfunction.

As mentioned, infidelity is mostly conceptualized as extra-relational sex, and even when it is not, such as emotional affairs, those involved may experience levels of intimacy comparable to consenting sexual interactions. For the purpose of this research, we will consider all forms of infidelity as there will be sexual themes, and/or emotional and physical intimacy themes. In consideration of the above mentioned ideas regarding infidelity and sex therapy, one may inquire, “Is it possible for infidelity to be a sexual problem?” We know that a sexual problem has the potential to become a marriage/relationship problem; therefore it is evident that overlapping issues can exist.

Research Questions

The research questions that will be explored in this study are:

1) To what extent do marriage and family therapists treat sexual issues when it is an
overlapping theme in treating infidelity?

2) To what extent do marriage and family therapists integrate sex therapy techniques into their infidelity treatment?
CHAPTER 2

LITERATURE REVIEW

Infidelity is alive and well represented in our world today. Although an intriguing source of entertainment, as depicted in the media and films, it is a serious problem for society and the health of couples and families. Practitioners and clients alike would agree that involvement in a committed relationship poses many challenges. When infidelity is added, a whole new category of challenges surface. The effects can be both direct and indirect. Humphrey (1987) discussed a list of consequences that clients being treated for infidelity had reported. The following consequences were included, and the author also noted that the list could be considerably expanded:

- the breaking of religious teachings;
- the breaking of trust;
- guilt;
- dishonesty;
- lies;
- anger;
- humiliation;
- depression;
- suicide;
- homicide;
- marital conflict;
- separation;
- divorce;
- anxiety;
- regret;
- lost respect and love;
- disruption of careers, marriages, and families;
- their illegality;
- loss of reputation;
- unwanted pregnancies;
- abortions;
- sexually transmitted diseases;
- time and money lost;
- fears;
- masking of the need for individual, marital, family, or sexual therapy;
- exploitation;
- jealousy;
- the length of time needed to "heal" their repercussions;
- sexual conflicts and dysfunctions. (p.161-2)

With consideration to this list, it is often the case that couples seek assistance in dealing with an incidence of infidelity and its consequences.
In couples therapy, many clinicians would agree that infidelity can seem like a frequent issue across cases. A number of studies have been done in attempt to determine the prevalence of infidelity. Non-clinical populations have been monitored from earlier studies to most recent, examining the existence of extramarital sex (EMS). Earlier research by Kinsey, Pomeroy, and Martin (1948) and Kinsey, Pomeroy, Martin, and Gebhard (1953) obtained data estimating that 50% of husbands and 26% of wives had experienced EMS during the course of their marriage. A number of sex surveys were conducted decades later which report similar findings: 40% for males and 36% for females (Athanasiou, Shaver, & Tavris, 1970); 41% for men and 18% for women (Hunt, 1974); 20% for men and 10% for women (Johnson, 1970). Populations regarding dating relationships, 30% of couples are involved in infidelity (Hertlein, Wetchler, & Piercy, 2005; Sheppard, Nelson, & Andreoli-Mathie, 1995). Most recently, Laumann, Gagnon, Michael, and Michaels (1994) reported that 24.5% of married men and 15% of married women (from 1,200 respondents) reported having at least one extramarital affair sometime during their married life. It is apparent that the recorded prevalence of infidelity has varied throughout the years. This does not necessarily mean that rates of infidelity have significantly changed, because differences may be due to research methods or samples. Spring (1996) contends that exact percentages will be unknown; it is easy to predict that someone who lies to their spouse might also lie to a researcher. With this in mind, practitioners and researchers may turn to the idea of incidence as an alternate way to calculate the existence of infidelity. It may be more valid to consider accumulative incidence (Thompson, 1983), the idea that people who said "no, I haven’t cheated" in a study will cheat later in their lives. With reference to incidence, Spring
(1996) also supports the conservative estimate that 1 in every 2.7 couples is touched by infidelity.

**Conceptualization of Infidelity**

In addition to being a problem for society, the conceptualization of infidelity by researchers, clinicians, and other related practitioners is problematic. Presently, many clinicians, researchers and clients are unable to agree on an acceptable definition of infidelity. There are various labels for infractions of intimacy. Some common terms are extramarital sex (EMS), extradyadic sex (EDS), adultery and affair. They are often used interchangeably, used incorrectly without articulating the meaning intended, and are value laden. The latter terms *affair* and *adultery* can refer to flirting, sexual relations, emotional affairs, Internet infidelity, or any other actions that would be considered a violation of emotional and/or physical intimacy (Weeks, Gambescia, & Jenkins, 2003). Across the literature, such language often does not share the same meaning or understanding. The meaning of infidelity has evolved beyond sex outside of an exclusive contract between two people who are dating, married or in a committed relationship, and an act of infidelity can potentially encompass a wide range of behaviors (Hertlein, Wetchler, & Piercy, 2005). Every committed relationship has a stated or assumed contract concerning sexual and/or emotional intimacy, and violating that would mean infidelity (Weeks, Gambescia, & Jenkins, 2003).

Lusterman (1998) describes that, infidelity occurs when one partner in a relationship violates the existing agreement to be faithful. These updated definitions cover vast territory for what constitutes infidelity. However, researchers and clinicians still do not agree on a consistent guideline for defining infidelity. The literature discusses many
representations of infidelity, but the recurring theme suggests that all forms of infidelity are potentially damaging to emotional and/or physical intimacy between two people who are dating, married, or in a committed relationship.

Types of Infidelity

In addition to varying semantics about definitions of infidelity, are considerable variations in categorizing types of infidelity. Based on the literature, most infidelity falls into the categories of physical, emotional, and infidelity that combines elements of both (Hertlein, Wetchler, & Piercy, 2005). Further discussion of infidelity will include typology of “affairs” as this is often how infidelity is identified by various researchers. Brown (2001) discusses five types of affairs that have to do with the interaction between the two spouses and the issues underlying the affair. Brown (2001) has identified types of affairs as conflict avoidance, intimacy avoidance, sexual addiction, split self, and exit. Each type of affair has a characteristic pattern, marked by differences in feelings, behavior, age, gender, and outcome.

Another quite comprehensive typology is that of Charny (1992). This typology consists of eighteen general types of affairs classified into three broad categories that includes six types within each. For instance, Charny’s (1992) first category is Types 1-6, in which there is a lack of commitment and emotional intimacy in the primary relationship. Following are Types 7-12 which are characterized by commitment to the marriage, but failed attempts to resolve differences. Charny’s (1992) third category is Types 13-18, in which hedonism is the primary motivator. This typology is based on observation and not empirical data, and may be considered too global for clinical application (Weeks, Gambescia, & Jenkins, 2003).
Levine (1998) presents a much simpler typology with four classifications. These include: Affairs, Just sex, Making do, and Imaginary partner sex. Pittman (1989) presents another more simplistic typology of infidelity consisting of: The accidental encounter, Habitual philandering, Romantic affairs, and Marital arrangements. These typologies would be most consistent with the idea that infidelity mostly consists of solely physical relationships, solely emotional relationships, and those that combine physical and emotional elements (Hertlein, Wetchler, & Piercy, 2005). However complicated the descriptions of these typologies may be, there can be some suggestion for the overlapping component of intimacy. Intimacy is a component of sex, and the two are often interrelated.

_Treatment Approaches_

Infidelity can enter the therapy room in a number of ways: an initial phone call by a prospective client, the product of a therapist’s continued probing with established clients, a new issue added to an already troubled relationship, and many other scenarios. Research dictates that immediate attention is given to the existence of infidelity in one form or another. The matter of an affair requires the therapist to confront the client immediately and never ignore the affair despite any attempts by the client to minimize or dismiss (Weeks & Treat, 2001).

As infidelity comes to be the central focus of therapy, the therapist’s ground work is put into place. Weeks, Gambescia, and Jenkins (2003) describe some of the key issues in building the foundations of treatment to include: understanding the level of commitment to both therapy and the relationship, taking into consideration the manner in which the infidelity was discovered, managing feelings of the betrayed and unfaithful partners.
These are fundamental steps that several approaches describe as necessary in order to proceed with treatment. Another initial concern would be whether or not an affair has been discontinued. Ending an affair immediately or committing to do so within a reasonable amount of time is often suggested by therapists in order for couples treatment to proceed (Brown, 2001; Elbaum, 1981; Weeks & Treat, 2001). Although several approaches are consistent with how treatment should begin, the strategies and techniques can vary greatly. The opposite can also be true, that common themes exist with techniques and strategies, but setting the foundation for treatment is not consistent. This discussion regarding treatment will continue by highlighting some models that are frequently referenced in the literature.

Given that infidelity has been disclosed as the presenting issue or as new information, the next logical step following any foundational or pre-assessment strategies would be to conduct an assessment that revolves around the affair. Some of the literature begins precisely at that point, in terms of treatment, and describes a textbook-like approach for treating infidelity. Other approaches are structured, but more integrative and flexible, and others still are loosely structured and more eclectic.

Conventional Approaches

Infidelity is often treated using conventional couples therapy formats that do not employ special conceptualizations or interventions for infidelity. Traditional Behavioral Couple Therapy (TBCT) is one of those formats. This approach, TBCT (Jacobson & Margolin, 1979) was developed using behavior and social-learning theory. During couples therapy, the focus is on teaching the couple behavioral skills. For example, learning new and improved communication and problem-solving skills would be
expected to help their relationship problems. In a case of infidelity, the approach would be the same. Couples would learn how to communicate about their concerns regarding the infidelity and then be able to articulate a specific desired behavior change. A couple would together solve the problem of what individual and couple behaviors relating to the affair need to occur in order to improve the relationship (Baucom, et. al, 2006).

Integrative Behavior Couple Therapy (IBCT) is an evolution of TBCT developed by Christensen and Jacobson (2000) and Jacobson and Christensen (1998) in order to employ the same principles of TBCT, in addition to emphasizing emotional acceptance. IBCT assumes that all couples have genuine differences that are difficult to change, but it is the emotional reactions to these differences that can and often do become more problematic than the actual differences (Baucom et. al, 2006). Interventions in this approach to couples therapy focus on balancing active behavior change of each partner and achieving acceptance between partners regarding their differences. In order to emphasize the acceptance component of treatment, three major strategies are employed: empathic joining, unified detachment, and tolerance building. Empathic joining deals with feelings and reactions and building empathy between partners about their feelings and reactions. During unified detachment, the therapist helps the couple take an outside look at the problem and identify interaction patterns that may ensue. Tolerance building essentially helps couples to become more tolerant of each partner’s differences by focusing on the positive aspects of differences, becoming more aware of problematic interactions, and desensitizing themselves to the negative implications of their differences. In applying this approach to infidelity, the IBCT therapist would translate the above mentioned techniques into the problem of infidelity. A couple’s differences,
feelings, reactions and patterns regarding the infidelity would be addressed using the same techniques as any other relational problem (Baucom, et. al, 2006).

Structured Approaches that do not Discuss Intimacy

Young and Long (1998) suggest The Integrative Model as an approach to treating infidelity. This includes five stages as follows: Assessment, Goal Setting, Interventions, Maintenance and Validation. The first stage of Assessment includes: 1) understanding each member’s viewpoint, 2) gathering information such as family of origin issues, and 3) creating an interactive definition of the problem. The next stage of Goal Setting includes: 1) externalizing the problem, and 2) setting behavioral and affective goals. The third stage, Interventions includes: 1) assessing each member’s strengths, and 2) designing interventions. Stage four, the Maintenance stage includes: 1) challenging commitment, and 2) identifying roadblocks. The final stage of Validation includes: 1) celebrating success, and 2) building in follow-up strategies. Using an integrative position, Young and Long (1998) propose that practitioners have an ideal opportunity to recognize and implement contributions from many fields and techniques from a variety of theoretical positions. This literature includes examples of techniques, such as specific verbiage used by the clinician in actual sessions, and case scenarios to illustrate how application of the model may play out in therapy.

Another elaborately described approach to treating infidelity comes from Emotionally Focused Therapy (EFT). Johnson (2005) uses emotion focused therapy and the context of adult attachment in the treatment of infidelity. With this approach, infidelity is first conceptualized as an attachment injury. In implementing this approach, it is the attachment significance that is key and not the degree of involvement in any
particular incident. For instance, the level of impact of a long-term affair versus a one-time incident of extra-marital sex on the betrayed partner can not be predicted. Johnson’s (2005) key stages involve the therapist closely facilitating a series of emotional discussions between partners which begins with one partner describing the initial impacts of betrayal by the other partner who then has an opportunity to respond. The stages continue involving a series of emotional exchanges that are expected to take the couple through the following: the articulation of the injury’s attachment significance, an experience of the emotions that surface, identifying connections of the injury to negative cycles in the relationship, an acknowledgement of the betrayed partner’s pain, an acknowledgement of the betraying partner’s responsibility in the attachment injury/infidelity, and a commencement of the injured partner requesting comfort and caring and the other partner responding appropriately as an antidote to the traumatic experience of the attachment injury. It is finally expected that the couple is able to construct together a new narrative of the injury. Johnson (2005) discusses that treatment beyond this focuses on more trust building and healing that move into further phases of EFT. This approach defines clearly the beginning and resolution and gives insight as to possible tangents and routes during the course of treatment.

A newly developed approach, developed by Gordon, Baucom, and Snyder (Baucom, Gordon, & Snyder, 2005; Gordon & Baucom, 1998; Gordon, Baucom, & Snyder, 2004), is intended specifically for the treatment of infidelity. This approach helps couples recover from an affair, integrating treatment strategies from cognitive-behavioral couple therapy, trauma interventions, forgiveness interventions, and insight-oriented couple therapy. The first stage of this approach addresses the impact of an affair, in which the
treatment components are primarily cognitive-behavioral and are specifically directed from problems that arise from the immediate impact of the affair. In the second stage, the focus is on helping the couple explore and understand the context of the affair, in which a realistic, well formulated set of attributions for the infidelity is developed. Stage two of the treatment model is more insight-oriented and incorporates cognitive restructuring strategies. Stage three presents the idea of moving on for the couple. This includes 1) addressing the issue of forgiveness, 2) consolidating what they have learned about each other, and 3) deciding how or whether they wish to continue their relationship. Successful treatment would involve progressively moving through each stage and addressing barriers to the final culmination of forgiveness.

Eclectic Approaches that Discuss Intimacy

Lusterman (1998) proposes that a crisis of infidelity can be viewed as an opportunity for growth and change. It is emphasized that upon the discovery of infidelity, there be no rushed or indecisive actions. Lusterman (1998) suggests three phases for recovering from infidelity: Phase One: Restoring Trust, Phase Two: Reviewing the Marriage/Relationship, Phase Three: A Better Marriage or a Better Divorce. The author points out that it is not assumed that recovery moves in an orderly progression, as issues from one phase will tend to come up again. Phase one involves focusing on honesty in the relationship in order to produce trust. Honesty and trust will facilitate discussing the affair, its aftermath, and the relationship itself. Phase two encourages both partners to develop new skills that will create a foundation for a stronger relationship. Couples are encouraged to record their thoughts and feelings in a journal and then designate specific time to have talks with one another. New skills such as more effective and intimate communication, active
listening, and taking individual responsibility. Phase 3 addresses the continuation of the marriage/relationship based on the principle of intimacy. The idea is that if honesty and trust have been restored, then intimacy can make its way into the marriage as another essential component for recovery. It is, however, possible that honesty and trust can be restored, but intimacy can not. At this point, the author suggests that the couple consider ending the marriage/relationship. It is clear with this approach, that addressing intimacy is a key issue during the process of recovery.

Couples can survive infidelity if each partner is willing to look at themselves honestly and look at their partner honestly and then is also willing to acquire the skills needed to see themselves through the crisis, contends Spring (1996). As previously discussed, because the research on prevalence rates have been scattered, inconsistent, and possibly skewed, Spring (1996) supports the conservative estimate that 1 in every 2.7 couples is touched by infidelity. Spring’s approach guides a couple recovering from infidelity through three identifiable stages. The First Stage is described as Normalizing Your Feelings. This stage is intended to help both partners appropriately deal the emotional impact of a revealed affair. The Second Stage is titled Deciding Whether to Recommit or Quit. At this stage, ambivalence about staying in the relationship or leaving is confronted. Partners explore their options in order to make a thoughtful decision based on their circumstances and needs. The Third Stage deals with Rebuilding Your Relationship. Couples who are fully committed to relationship recovery after infidelity will spend months, and possibly years, working to restore trust and intimacy. Key components pointed out in this stage are to: decipher the meaning of the affair, and accept an appropriate share of responsibility for it; earn back trust, or communicate what you
need to trust again; recognize how you may have been damaged by early life experiences, and how you can keep these experiences from contaminating your relationship today; become sexually intimate again; forgive your partner, and yourself. A unique component in this stage that should be highlighted is the focus on “sex again”. Spring uses the metaphor of “the ghost of the lover” to describe the awkwardness that sexually intimacy can have after an affair. Here, Spring addresses the effectiveness of processing intimacy needs, each partner’s assumptions about sexual intimacy, each partner’s fears about sexual intimacy and the reality of reconnecting both physically and emotionally.

Pittman and Wagers (2005) suggest that “secrecy, not sex” is the hallmark of infidelity. In other words, it is the secrecy that is more damaging than the sex in infidelity cases that involve EDS. Pittman (2005) also suggests that those who become involved in infidelity are merely seduced and distracted from monogamy. Humans are generally monogamous beings and anything contrary to that such as polygamy, promiscuity, or serial monogamy is something that one adapts to. Pittman, author of Private Lies (1989) as well as various articles and books has been often cited in the infidelity literature. Pittman discusses many ways in which to conceptualize infidelity, including definition, types of affairs, and types of people who become involved in affairs. The author also addresses treatment, but it is unclear exactly how his treatment approach is organized. In reference to treatment, Pittman and Wagers (2005) discuss treatment myths, ineffective tactics that some therapists employ when treating infidelity, and advice to therapists on how to deal with a crisis of infidelity, none of which clearly describe their treatment approach. Pittman (1989) also fails to clearly describe his treatment approach in his book. The very last pages describe a case scenario which suggests that once a couple is
committed to recovery following infidelity, the therapist might try to figure out what was "missing" in the relationship or kind of the idea of, where did it go wrong, in order to help a couple make it better. In addition, Pittman's approach here appears to support identifying some foundation in the marriage in order to make suggestions for strengthening and rebuilding. This rebuilding should also include emotional and sexual intimacy.

Structured Approaches that Discuss Intimacy

Some researchers view the experience of infidelity as traumatic. Glass (2003) describes that the betrayal involved in infidelity as so traumatic that the effects can result in PTSD or something very similar. For couples who are committed to working through the trauma of infidelity, the initial focus of this approach is to confront and understand what has happened to them, designate the unfaithful partner to be the healer of the betrayed partner, and identify ways to reframe bitterness into opportunities for growth. All of this may take some time and will require much patience as emotional intensity can be high as well as inconsistent. For example, Glass (2003) discusses the importance of exploring the sexual side of marriage in order to fully understand an incidence of infidelity. Affairs have the potential of developing despite either satisfaction or dissatisfaction with marital sex. However, deficits in the sexual side of the marriage may help to intensify emotional intimacy and sexual chemistry with an affair partner or potential affair partner. According to Glass (2003), after an affair is discovered, the effect on marital sex varies slightly between increased sexual satisfaction, decreased satisfaction, and no effect on satisfaction. However, Glass (2003) contends that an affair
can be a catalyst for improving the sexual relationship and creating a new bond in the marriage.

When signs of stability begin to appear, a couple can begin the steps of "repairing". Glass (2003) titles these steps as: Repair 1: Getting Back to Normal, Repair 2: Fostering Positive Exchanges, and Repair 3: Learning Compassionate Communication. "Repair 1" involves spending time together to experience fun and companionship, showing affection through physical intimacy with or without sex, reminisce about better times in your past including the feelings and thoughts involved, and discuss ideas for the future after the healing from this trauma. "Repair 2" involves re-examining what caring means and training oneself to demonstrate caring in a variety of ways, expressing appreciation for what your partner does to please you, identifying any resistance, and overcoming resistance. The last step in the "repairing" component of treatment is "Repair 3". This involves building intimate and compassionate communication by inhibiting negative interactions, engaging in dialogue, using "I" language, and listening with reflection, validation, and empathy. During these steps and following these steps the "healing" component of treatment continues to be addressed. All things affected directly and indirectly by the trauma of the infidelity are addressed. For example, some lingering issues may be confronting unanswered questions, triggers to painful memories, flashbacks, or feelings of insecurity, reestablishing trust, repairing relationships with family and friends, and healing the couple’s sexual relationship.

The final stage of treatment in Glass’s (2003) approach is “forgiveness”. As we know, forgiveness takes time and is a unique process for everyone; therefore, this approach does not give a step by step formula for this stage in treatment. Couples are
encouraged to follow some guidelines, but as with other stages in recovery, treatment may vacillate between moving forward and background. Glass (2003) suggests that couples define forgiveness, describe what forgiveness means to them, process discrepancies in each partner's perception of forgiveness, confront any barriers to forgiveness, and follow some form of forgiveness ritual. Glass's approach can appear overwhelming, but can be described as quite comprehensive, rather than following a strict formula. This approach gives an outline of what needs to happen for recovery to be successful (i.e., making meaning of the infidelity, healing, repairing, forgiveness) with suggestions for varying interventions and strategies along the way. The author also provides examples of common challenges as well as signs of progress through the course of recovery.

Another comprehensive approach to treating infidelity is that of Weeks, Gambescia, and Jenkins (2003). This approach is a systemic-based forgiveness model, that applies the Intersystems Approach (Weeks, 1989; 1994). The Intersystems Approach addresses three perspectives that can influence an incidence of infidelity: individual risk factors of each partner, relationship issues, and family-of-origin influences. It is used in all couples treatment and sex therapy and the authors believe it especially helpful in treating infidelity because of the multidimensional nature of the issue.

In their approach, Weeks, Gambescia, & Jenkins (2003) begin with an initial phase of treatment that addresses the feelings of the betrayed and unfaithful partners, commitment, accountability and trust. According to the authors, both partners will be experiencing pain and a variety of feelings. It is therefore essential that the therapist "listen actively, accept, and moderate these feelings while encouraging the partners to
remain on task." In terms of commitment, a couple will need to determine their commitment to both therapy and commitment to the relationship. This may fluctuate during the course of treatment, but in the beginning a couple must confirm some level of commitment to working through the infidelity and rebuilding the relationship. Broken trust is extremely difficult to reestablish. With this approach, the slow process of rebuilding trust should begin in the initial phase of treatment through accountability and honest communication.

As a couple appears to be moving toward the rebuilding of confidence in their relationship, the next phase of treatment should ultimately engage the couple into new and different territory. At this phase in treatment, the systemic aspect of this approach (Weeks, Gambescia, & Jenkins 2003) is heavily integrated into treatment. The therapist begins gathering history of individual risk factors by taking a detailed psychological assessment, examining relational issues, gathering intergenerational history and family of origin information, and the use of the therapeutic reframe. Each individual psychological assessment should address any existence of depression or anxiety, biological conditions, psychiatric conditions, and addictions. Relational issues should be examined for relationship discord, unresolved conflict and anger, and lack of intimacy. It is highly recommended to use an assessment device such as the focused genogram (DeMaria et al., 1999) when gathering information on the family of origin. Various aspects of familial functioning should be considered, such as: secrets, incest, parentification, triangulation enmeshment, and other dysfunctional patterns that could have an impact on intimacy and sexuality. A crucial part of helping the betrayed and unfaithful partners to understand the
affair is viewing the infidelity as a symptom of the couple’s dysfunction. It is suggested that the technique of reframing is most helpful in doing this.

The next phase of treatment (Weeks, Gambescia, & Jenkins 2003) involves incorporating forgiveness into the treatment process. Forgiveness will be defined in a way that both partners are using common guidelines when they are referring to forgiveness. Any meaning attached to the sexual aspect of infidelity will be processed in order to identify what needs to be forgiven. This will not be brief or simple process, the therapist and the couple will have to work at facilitating forgiveness. The therapist should encourage the unity of the couple by promoting empathy, humility, commitment, and hope. It is the intention that the unfaithful spouse can then carefully construct and deliver a genuine apology which will initiate a series of forgiveness transactions in the couple.

As a systemic-based forgiveness approach (Weeks, Gambescia, & Jenkins 2003), treating factors that trigger infidelity are addressed in the final phase of treatment. According to the authors, these factors in one way or another, are related to intimacy. This phase involves processing the meaning of love, addressing commitment problems, treating problems with passion in the relationship, dealing with fears of intimacy, and developing effective communication. Treatment is complete when all phases have been thoroughly and successfully completed and when it is clear that a restructuring of the relationship has occurred in that the couple achieve more satisfaction and a greater experience of intimacy.

**Distinctions of Infidelity Literature**

Infidelity literature covers a broad spectrum of topics relating to efficacy, prevalence, typology, cultural factors, relationship attachment, sexual values, recovery, treatment, etc.
This review of literature narrowed the focus to include mostly literature which discusses the clinical treatment of infidelity. In order to conceptualize treatment, it is important to understand prevalence and meaning. However, the way in which researchers, clinicians and other practitioners conceptualize infidelity is problematic. This has been illustrated by a lack of consensus in defining infidelity as previously discussed. The varying use of terms to describe behaviors associated with infidelity and those participating or not participating in infidelity—all of which can be extremely value laden. The wide range of typologies confuses the conceptualization still, and what studies have been conducted and published bring us prevalence rates that differ study to study.

Much of the literature that discusses treatment for treating infidelity is not based on empirical research, but on clinical experience. However, this clinical experience is highly regarded by most in the field as it is based on thousands of hours and often decades of experience. In recent years, two empirical studies have been conducted that addressed the effective treatment of infidelity. Approaches highlighted in this review, a forgiveness-oriented approach developed by Gordon, Baucom, and Snyder (Baucom, Gordon, & Snyder, 2005; Gordon & Baucom, 1998; Gordon, Baucom, & Snyder, 2004), Integrative Behavior Couple Therapy developed by Christensen and Jacobson (2000) and Jacobson and Christensen (1998), and Traditional Behavior Couple Therapy (Jacobson & Margolin, 1979) were used in these studies. Results of the first study (Gordon, Baucom, & Snyder, 2004) suggested that with the use of their forgiveness approach, the majority of couples who participated were significantly less emotionally and/or materially distressed, and a high level of forgiveness developed in relation to the infidelity. An exploratory study by Atkins et al (2005), examined the treatment of infidelity using
TBCT and IBCT. Couples dealing with infidelity and couples not dealing with infidelity, but with other relational issues, participated. The study concluded that couples dealing with infidelity improved in therapy at a greater rate than the other couples not dealing with infidelity. Results did not indicate a lack of effective treatment for infidelity with the implementation with either TBCT or IBCT.

Both a methodological review and a substantive review of infidelity research were conducted in recent years (Blow & Hartnett, 2005). Upon reading of these reviews, it is clear that much research exists on the topic of infidelity, both as a primary topic and also as a secondary or sub-topic. Little research has been conducted to address effective treatment models, interventions or strategies for infidelity. Also included in these reviews is a vast amount of research on sex and infidelity, either as primary topics together or inter-related topics. However, no empirical research exists to address effective treatment for the sexual aspect of infidelity.

In consideration of the literature that discusses treating infidelity in couple relationships, there appear to be many common factors. For example, discontinuing an affair and conducting an assessment that includes a comprehensive couple history and relevant details about the affair itself. Also frequently described is a sequential process or progression of steps or phases that treatment for infidelity should follow. What happens when therapy does not proceed in the manner described? It is apparent that many approaches next move to the question of commitment, “Do they want to stay in the relationship?” and “Are they committed to do the work required for recovery?” This may begin the goal setting component of therapy. This is where much of the literature becomes confusing, overwhelming or unclear in describing a certain treatment approach.
What many practitioners may be asking at this point is, "With all these varying interventions and strategies, which ones are effective?" Many practitioners and researchers would agree that the answer is, "We don't know." Without research to support efficacy, it seems that practitioners simply rely on their best judgment. Glass (2003) states, "there are no generally accepted standards for therapists and counselors who treat infidelity." There appears to be a lack of emphasis on commonality of assessment and treatment approaches across the literature. Hertlein, Wetchler, & Piercy (2005) suggest that the most important components when treating infidelity may simply be an open mind and clinical flexibility.

Sex Therapy

Sex therapy is often used in treating couples who present with specific sexual dysfunction or intimacy issues. According to the DSM-IV-TR (APA, 2000), sexual dysfunctions are categorized among the following types: sexual desire disorders, sexual arousal disorders, orgasmic disorders, sexual pain disorders, and paraphilias. Subtypes are sometimes used to make further distinctions. Dysfunctions can be categorized as primary (lifelong type) in cases where adequate functioning has never existed, or secondary (acquired type) in cases where there is some adequate functioning in the midst of sexual problems. Further distinction about sexual dysfunction can be determined as situational type, where dysfunction only occurs with particular partners, or generalized type, where dysfunction occurs in all settings and with all partners (APA, 2000; Piercy, et al., 1996). However, sexual problems do not have to fall within DSM-IV-TR categories or criteria for treatment to be necessary. Depending on the individual or the couple,
sexual or intimacy issues can present themselves in a variety of forms that may require treatment.

The concept of sex therapy is often misunderstood by the public as well as by marriage and family therapists and related clinicians. Some common myths about sex therapy are that it involves being observed while engaging in sexual interactions, having sex with a therapist, and assuming that one’s physician, psychologist or therapist is trained in sex therapy and/or is comfortable discussing sex (Peterson & Peterson, 2007). The Dictionary of Family Psychology and Family Therapy, Second Edition (Kaplan, 1981; Sauber, L’Abate, Weeks, & Buchanan, 1993) defines sex therapy as:

A type of therapy, focused on the resolution of sexual problems, that (a) emphasizes the mutual responsibility of the couple for the sexual dysfunction, (b) stresses information and education in treatment, (c) is concerned with attitudinal change and performance anxiety, (d) increases communication skills and the effectiveness of sexual techniques, (e) prescribes changes in behavior, and (f) frees individuals from destructive life-styles and sex roles. Sex therapy also recognizes the pervasive interaction between sexual dysfunction and the marital relationship. (p.360)

A clinician who is trained in sex therapy has received training in using techniques to treat the above mentioned issues. The training is often above and beyond academic requirements of a degree program. As with other subspecialty areas in clinical practice, it is required that a therapist employing sex therapy be held accountable to practice at the highest possible standards of care and professionalism (VandeCreek, Peterson, & Bley, 2007). The Board of the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) has been guiding and managing the practice of sex therapy for
several decades. Marriage and family therapy clinicians can receive AASECT certification as a Sex Therapist upon completing specific education and training requirements. All clinicians are able to seek membership in AASECT, attend AASECT trainings and other related educational supplements. However, there appears to be a lack of professional integration between general marriage and family therapy associations, such as the American Association of Marriage and Family Therapy (AAMFT), and AASECT. Although there is some overlap between the two disciplines for licensure/certification, it is slight. For instance, licensed marriage and family therapists can become AASECT certified sex therapists with some additional training, but AASECT certified sex therapists are not required to have extensive training in marriage and family therapy, nor are licensed MFT’s required to have significant training in sexuality and sex therapy. Some improvements have been made to encourage cross-training. For example, at the 2007 AAMFT Annual Conference, there were more opportunities for clinicians to receive training specific to sexuality and sex therapy and earn AASECT continuing education credit (AAMFT, 2007). In addition, at the 2007 AASECT annual conference, marriage and family therapists had many opportunities to receive MFT continuing education credit (AASECT, 2007). It is plausible that many clinicians are not experienced or knowledgeable about sex therapy, because of the lack of integration with more broad formats such as AAMFT.

Another considerable factor, given that marriage and family therapy clinicians are not seeking or receiving education and training in sex therapy, is that there may exist a lack of knowledge about valuable resources. For example, administering a sexual history during the course of assessment can uncover valuable information applicable to almost
any problem presented for treatment. Sex therapists often support a systemic approach to treating sexual issues and will therefore include systemic-based assessment techniques. For example, the content of a sexual history should cover: 1) Brief history of the client's relationship with significant others, 2) Current sexual adjustment (whether or not the client addresses sexual needs and concerns with their partner, 3) Partner's sexual adjustment, 4) Effects of illness/injury on their ability to function sexually, and 5) Current difficulties and attempts at solving sexual problems (Gill & Hough, 2007). Therapists often choose to present client's with a more detailed questionnaire when the client has made it clear that sexual issues are indeed a problem or it is obvious that specific sexual issues exist (see Appendix B). In the absence of implementing techniques and tools such as these, valuable information pertinent to a client's treatment could be overlooked.

Although clients often initiate therapy presenting with non-sexual issues, during the course of assessment, it may become apparent that treatment for sexual issues is necessary. Addressing a client's sexual health, or at minimum including a sexual history in a therapist's assessment, will help to determine this. Specific assessment tools exist that could also be of use to clinicians, provided they have gained the appropriate knowledge and training for administration. Such instruments are: the International Index of Erectile Function [IIEF; (Rosen et al., 1997)], Female Sexual Function Index [FSFI; (Rosen et al., 2000)], and the Sexual Interest and Desire Inventory-Female [SIDI-F]. Therapists who commonly practice making appropriate referrals for the benefit of the client, and do not have the expertise of treating sexual issues themselves, may determine that sex therapy treatment is the best choice for the client’s well-being and refer them to
another therapist who has sex therapy training. Gill and Hough (2007) suggest following certain protocol to determine that sex therapy is the treatment of choice: 1. the primary problem is a sexual dysfunction or sexual desire disorder, 2. higher priority problems have been resolved or are absent, 3. physical factors have been identified and treated, 4. interfering situational events are not present, 5. the relationship is basically stable, or improving it becomes the first stage of treatment, 6. the client is positive about and motivated toward treatment. Within the context of a committed relationship, it is crucial for practitioners to develop an understanding of the treatment of sexual problems. Appropriate knowledge, training, and expertise in such treatment is, therefore, gained through theory and practice of treating every aspect of sexuality (Bley & Peterson, 2007).

As with other therapies, there are a variety of treatments that can be implemented to treat a variety of sexual issues (Crooks & Baur, 2002). After careful assessment, a sex therapist will use one or more, and often a combination of the following treatments to be discussed. Treatments may require individual sessions, couple sessions, referral to a medical practitioner, and daily home practice or exercises.

Often, sex therapy is as basic as providing factual information and a prescription for further education. Psychoeducation is one such strategy of sex therapy. During assessment it can be discovered that clients are simply uneducated about sexuality. Weeks & Gambescia (2002) suggest that the majority of men and women have no formal education in human sexuality, and therefore lack understanding of sexual anatomy and physiology. A sex therapist can be helpful in correcting much misinformation about sexuality. Integrating bibliotherapy and providing valid educational references are commonly used in increasing clients' knowledge about sexuality (Lazarus, 1995).
Throughout history in America, negative stereotypes about any sexual behavior other than heterosexual intercourse have been described as unnatural, sinful, selfish, immoral, unhealthy, or a sign of insanity and disease (Bley & Peterson, 2007). Such misinformation or myths can potentially perpetuate obstacles to experiencing sexuality. When additional treatment beyond psychoeducation is necessary, the processes of dispelling inaccurate information and correcting cognitive distortions may continue throughout the duration of therapy (Weeks & Gambescia, 2002).

Sexual problems can be, all or in part, referred to as psychological problems. Such problems are often the result of destructive mental and emotional processes and psychological defenses in the form of unconscious sexual conflicts, negative messages about sex, and relationship problems experienced throughout the course of one’s sexual development (Kaplan, 1987). Anxiety is frequently one of these sexual problems, in addition to being a barrier for experiencing sexual interactions. In cases of low sexual desire, Weeks and Gambescia (2002) have identified behavioral techniques as useful in decreasing anxiety. Their comprehensive version of sensate focus exercises, when prescribed by a therapist who understands the purposes of the exercises and can help the couple gain more understanding, create an environment that is “safe, nondemanding, and free from anxiety.” Also useful with anxiety, are techniques such as thought-stopping and thought substitution can be useful with lowering anxiety about sex (Hertlein, Weeks, & Gambescia, 2007). The use of cognitive treatments are known to be effective with changing negative cognitions, and restructuring cognitive distortions about sex. Part of treatment may involve such techniques as redefining or broadening definitions for sex, intimacy, affection, and sensuality (Hertlein, Weeks, & Gambescia, 2007). Cognitive
treatments in sex therapy may overlap somewhat with psychoeducational treatments as cognitive distortions can be the result of myths and misinformation.

The concept of sex therapy can be described as the combination of psychotherapy and prescribed behavioral exercises which focus on relaxation and skill acquisition related to sensual touch (Peterson and Fuerst, 2007). Sex therapists often prescribe such behavioral assignments as homework for clients to complete in the privacy of their home between therapy sessions. For example, the squeeze method (Masters & Johnson, 1970) and the stop-start technique (Semans, 1956) are often prescribed as homework for couples who are dealing with premature ejaculation or inadequate ejaculatory control (Kaplan, 1987).

*Sensate Focus* (Masters & Johnson, 1970), or *pleasuring exercises*, as later used by Kaplan (1979) is the most common sex therapy homework assignment. These exercises can be prescribed for a variety of sexual problems. This approach assists clients in learning to explore their bodies, relax, and overcome their fears and inhibitions associated with sex (Bley & Peterson, 2007). Although the exercises appear simple, they are complex and serve multiple purposes. Sensate Focus exercises are progressive, beginning with nonsexual touching exercises and ending with genital stimulation exercises, all which take place over the course of several weeks or months. Weeks and Gambescia (2002) describe the complexity of, in addition to the nine purposes of the exercises when implemented properly:

To help the partners become more aware of their own sensations; 2. To help the partners become more in touch with their own needs for pleasure and worry less about the other partner's; 3. To communicate sensual and sexual needs, wishes and
desires; 4. To facilitate an awareness of each other’s sensual and sexual needs; 5. To expand the repertoire of intimate, sensual, and sexual behaviors; 6. To learn to appreciate foreplay, or nongoal-oriented sex, more fully; 7. To create positive relational experiences; 8. To decrease physical avoidance and enhance sexual desire; 9. To enhance the sense of cohesion, love, caring, commitment, cooperation, and intimacy between partners. (p.199-202)

When prescribing sensate focus exercises, couples are asked to suspend intercourse and follow the incremental structure of the exercises as prescribed by the sex therapist and agreed upon by the couple. In subsequent sessions to the prescription of sensate focus as well as all other behavioral exercises, the therapist and couple will discuss barriers and challenges to achieving success with the exercises.

Sex therapies are not typically used in conjunction with medical treatments for sexual problems. Some sex therapists, however, will refer clients for medical attention to rule out biological causes or as a collaborative approach to a sexual problem. Medical and surgical treatments for male and female sexual problems include: oral pharmacological agents, local and mechanical therapies, and surgical interventions (Rosen, 2000). Perhaps the most well-known medical treatment is the prescription of sidenafil to treat male erectile problems. Other medical treatments include hormone replacement therapy which has been used for nonsexual and sexual symptoms of the menopausal transition, and testosterone to treat female hypoactive sexual desire disorder (Althof, 2006; Buster et al., 2005; Sherwin & Gelfand, 1985). Although medical treatments have long been used to treat sexual problems, new sexual pharmacology has been quite dominating with treating several sexual problems in the past few decades.
Pharmacological researchers continue to work toward remedies for both male and female sexual problems.

An over-arching goal of most sex therapy treatment is improving intimacy. Communication is paramount to the development of intimacy (Weeks, Gambescia, & Jenkins, 2003). Common techniques for facilitating intimate communication are "I" statements, reflective listening, and validation. Although these are basic strategies which can be applied to a variety of situations, they are helpful for the sex therapist to use in helping couples to promote intimacy and the use of effective messages about sexual desire and pleasure (Weeks, Gambescia, & Jenkins, 2003). Improving listening skills is a significant component to improving communication. Zilbergeld (1999) suggests that the key to effective listening is having empathy, which is the ability to understand what is being said from the partner's point of view. The sex therapist may prescribe the practice of using listening skills by following a set of rules. Zilbergeld (1999) describes these as:

1. understand your partner's experience, feelings, attitude, or point of view, 2. give your partner your full attention, 3. ask questions, 4. try to understand your partner's feelings, and 5. demonstrate your understanding. Another aspect of communication is that of communicating about physical intimacy. For example, the ability to openly and comfortably discuss touching, sensations and pleasurable feelings may be a new and different experience for some couples. Therefore, the practice of effective communication about other topics will help facilitate sexual communication (Renshaw, 1995).

Although there are a variety of treatments, marriage and family therapists who practice sex therapy most often employ integrative combinations of the treatments discussed. The reason for this being that relationship distress is often a component of
sexual problems in a committed relationship, therefore, interpersonal and systemic approaches to treatment remain most popular in the field (Rosen & Leiblum 1995).

**Rationale for Present Study**

Weeks, Gambescia, and Jenkins (2003) suggest that a lack of intimacy is often a major contributor to infidelity, which can make it an intimacy-based problem. In couples therapy, intimacy issues are often treated with sex therapy. As Kaplan’s (1981) definition of sex therapy suggests, the marital/committed relationship and the sexual relationship are closely connected. Some of the literature addresses this very point in discussing treatment of infidelity. In the final phase of infidelity treatment, Weeks, Gambescia and Jenkins (2003) emphasize the importance of addressing a couple’s sexual desire discrepancies, fears of intimacy, expectations of intimacy, and developing communication that promotes intimacy. In a committed couple relationship, sex and intimacy are inseparable (Weeks & Treat, 2001). Although some approaches support different foundational themes such as healing, forgiveness, or trauma, they are consistent with emphasizing the importance of addressing sexual issues when treating infidelity. For instance, Glass (2003) suggests that healing from the trauma of infidelity also involves healing of the sexual relationship. This may require a couple to begin this process by finding out what it feels like to be physically intimate without sexual intercourse, such as cuddling and giving massages. Lusterman (1998) advocates carefully assessing and analyzing the sexual aspect of infidelity in order to identify non-sexual influences for engaging in infidelity, such as power, addiction, fear of intimacy, and fear of commitment. When couples recovering from infidelity are able to become sexually intimate again, Spring (1996) suggests that the \textit{ghost of the lover} may possibly inhibit the
rehabilitation of the sexual relationship. Therefore, engaging in sex again means being able to first experience physical intimacy without sex, effective communication about sex, and for the betrayed partner to deal appropriately with insecurities and suspicions.

Other than specific suggestions and guidelines for implementing sex therapy during the course of treatment for infidelity, there exist other implications. McCabe (1999) identified, for women, a strong association between sexual satisfaction and relationship satisfaction. This may suggest that for some couples to recover successfully from infidelity, the women need to be sexually satisfied in their relationships. It has also been suggested that individuals with a great interest in sex are more likely to engage in extra-relational sex (Liu, 2000; Treas & Giesen, 2000). This can be referred to as sexual desire discrepancy (Weeks, Gambescia & Jenkins, 2003), which can potentially influence involvement in infidelity.

In the field of couples therapy, marital therapists have often assumed love and intimacy as their territory and sex therapists have often assumed sex as theirs (Weeks & Treat, 2001). With committed couples in effectively functioning relationships, these concepts are not split, therefore, a best case scenario for treatment would be that a therapist has the expertise to address love, intimacy and sex. Marriage and family therapists are presented with a wide variety of specialties to gain additional training and certification. Those working with couples, and more specifically, couples dealing with infidelity, may be of better service to their clients if they have at least some expertise in sex therapy.
CHAPTER 3

METHODOLOGY

This research will supplement existing literature and knowledge regarding the clinical treatment of infidelity, and potentially assist in bridging the clinician-researcher gap as presented by Hertlein and Weeks (in press). As previously discussed, there exists a lack of current empirical data describing effective treatment interventions for infidelity. In a qualitative study, currently practicing marriage and family therapy practitioners may provide valuable data to the field. Infidelity is a common issue in treating couples. Various marriage and family therapy practitioners’ perceptions of effective treatment models, common themes during treatment, strategies, and techniques may be helpful to the field. As we believe that a lack of intimacy in a relationship is often a contributing factor to infidelity, in this study, it is predicted that the common theme of addressing intimacy-based issues and implementing intimacy-based approaches (such as sex therapy) will also be represented with other practitioners.

Rationale for Qualitative Study

The primary support in favor of choosing qualitative research was to gather a rich set of data about therapists’ integration of techniques in their practices. Due to the nature of the research question, semi-structured interviews seemed the best way to get the data. Understanding the meaning of people’s experiences has been described as the intent of
qualitative research (Ambert et al., 1995). We believe that the “open-endedness” of qualitative research will most effectively help us to understand the meaning of therapist’s experiences with treating infidelity. Qualitative research is also considered to produce data with richness and describe a phenomenon in great detail (McWey, James & Smock, 2005). In recent years, there has been substantial support of the use of qualitative methods in studies focused on clinical processes (Hawley, Bailey, & Pennick, 2000). We believe this study is appropriate for qualitative methodology.

Participant Recruitment

Upon UNLV Institutional Review Board approval granted on October 5, 2007, marriage and family therapy practitioners who practice in the Las Vegas area were invited to participate in the study. Potential participants (138 marriage and family therapists) were identified through public registries (local yellow pages, internet directories) and contacted by mail requesting their voluntary participation in a focus group that will discuss clinical treatment of infidelity. An additional 20 letters were hand delivered to marriage and family therapists who share offices in a common building. The recruitment letter emphasized the value of participation as a contribution to the field as well as to the treatment of infidelity. The recruitment letter also explained that the study will not require the disclosure of personal information. Age, race and ethnicity were not determining factors for participation recruitment. Participant selection protocol was based on the first 12 persons who volunteer and assent to full participation in the study. Additional volunteers would be asked to remain on stand-by in the event that a second focus group was necessary. For example, the ideal number of participants in a focus group is 8-12. A focus group of less than 8 participants may not generate enough data for
the purposes of this study. In the event that this occurs, additional "stand-by" volunteers will be contacted for participation in a second focus group.

Four weeks following the distribution of recruitment letters, 20 letters of the 138 letters distributed by mail were returned undeliverable, and only 3 marriage and family therapists had responded as potential participants in the study. The student researcher maintained communication with potential participants by phone and e-mail to correspond updates regarding the scheduling of the focus group. After two more weeks, 3 additional marriage and family therapists responded as potential participants. After consulting with my advisor and committee, we proceeded with scheduling for 1 focus group. The first focus group was scheduled and it was expected that there would be 7 participants. The student researcher contacted potential participants by telephone and e-mail one week prior to the scheduled focus group, and then again one day prior to the scheduled focus group. One volunteer responded that they would be unavailable to attend the focus group, but reported that they would be willing to participate in the event another focus group would be conducted. On the scheduled day and time of the focus group, only 3 volunteers were present. The student researcher proceeded with conducting the focus group.

Upon completion of the first focus group, the student researcher consulted with her advisor and it was decided to schedule another focus group in the event that the original volunteers who did not attend, would agree to participation in a second focus group. The 4 other volunteers were contacted again and a second focus group was scheduled. Following the same communication protocol with reminders one week prior, and one day prior to the scheduled focus group, the student researcher contacted the potential
participants. On the day and time of the second focus group, only 1 participant was in attendance. The student researcher conducted an interview with the 1 participant using the same interview guide and procedures as were planned for conducting a focus group.

Participants

The 4 participants ranged in age from 32-56 years old and were 2 male and 2 female marriage and family therapists. Participants completed a brief questionnaire prior to beginning the focus group/interview (see Appendix C). Number of years in practice ranged from 2-15 years, and participants report of number of couples they treat per week ranged from 5-11. Information gathered from the brief questionnaire was to serve as supplemental data to provide further distinction between participants that may be necessary to assist in interpretation of responses.

Procedures

The student researcher assumed the role of moderator for the focus group. I utilized my training and experience facilitating process groups and conducting interviews necessary for performing intake and gathering client history. Prior to beginning discussion, participants completed informed consent and I described to the participants guidelines for participation. The emphasis of the guidelines was on respecting other participants by not interrupting other participants when they are speaking, waiting your turn to speak, and refraining from dominating the discussion. It was also emphasized that hearing from all members would be most useful to the research topic. I facilitated the focus group and interview using a semi-structured interview guide, which was a set of questions to ask participants. There were six open-ended questions in the interview guide as well as sub-questions within four of the main questions. These questions were derived
directly from the research questions being investigated in the study, referring only to participants’ professional practices and not to personal information. The questions were developed in conjunction with the research questions to facilitate identifying integrative techniques and frameworks. Participants were allowed ample time to respond and elaborate. The informed consent can be found in Appendix B and the interview protocol can be found in Appendix D. The duration of the focus group and the interview were approximately 90 minutes. The discussion of the focus group and interview were audiotaped and then transcribed producing 32 pages of transcripts.

Data Analyses

With consideration to the number of participants and the challenge of relying on volunteers to be present on a specific day and time, the student researcher consulted further with her advisor and committee. It was decided that time would not allow for more attempts at participant recruitment and/or a revision to protocol that would require submission to the IRB. With this study being a thesis in fulfillment of final graduation requirements, university deadlines and additional delays would not permit completion in time to meet graduation deadlines. The student researcher proceeded with data analyses.

The audiotape of the focus group and interview were written into verbatim transcripts. The verbatim transcripts of the focus group and interview session served as the data source. Any personal, identifiable information that was recorded on the audiotape of the focus group/interview discussion was not transcribed. The transcripts were carefully read over, then coded identifying themes and groupings of categories, and then analyzed using analytic induction and constant comparison (Strauss & Corbin, 1998). The organization of the data was interpreted into a final analyses in the form of a
coding outline reported in the "findings" section using quotes from participants to illustrate the nature of their thinking and perceptions around assessment and treatment of infidelity.
CHAPTER 4

FINDINGS

I conducted one focus group and one interview using the same interview questions for each. Before beginning the data analysis, I consulted with my advisor for additional training on the analysis procedures. Following transcription of the audiotapes, I read through the transcripts twice. Next, I employed “code mapping” (Knodel, 1993) also known as “data indexing” (Frankland & Bloor, 1999) underlining basic concepts that emerged from the data based on the interview questions (Piercy & Hertlein, 2005). I then completed another read through revising some underlining and then underlining additional ideas. This was followed by another read through focusing on the underlined words, sentences and conceptual units. During this read through, I began compiling a list of categories by which to sort the transcripts. I cut apart the transcripts and sorted the underlined ideas into the categories derived. Then I reviewed, merged and revised the categories to be able to identify overarching themes. Based on the categories, I began developing a new list to determine overarching themes. At this point, I consulted with my advisor once again to verify the outcome of the analysis. From this process, it was established that three main themes emerged and were present throughout the discussions in the focus group and the interview: approaches to treating infidelity, barriers during treatment, and addressing sexual issues.
Approaches to Treating Infidelity

Some of the initial questions in the interview guide were focused on determining how therapists approach treating infidelity. Participants alluded to some general approaches. A conception of what these participants were actually doing as marriage and family therapists in treating cases of infidelity unfolded throughout the discussion. Responses were not definitive or concise enough to allow for an understanding of their approaches early in the discussion. The following categories emerged to allow for a better understanding of participant’s approaches to treating infidelity: client-focused, exchange theory, strategies and techniques, rebuilding the relationship.

Client-Focused

Therapists interviewed frequently suggested the idea of being client-focused or “client-driven” as a way to describe how they approach treating cases of infidelity and how they structure the therapy. There were few responses identifying a specific framework as an approach to treating infidelity. In some instances, being “client-driven” was used to describe a “general manner of working with clients”, and that structuring the therapy is more “client-focused”. One participant articulated the following, “No, I wouldn’t say that there’s a model for treating infidelity, specifically... It’s more about a general way that I work with clients—sort of try to illicit goals from them—what they want.” This idea continued to emerge throughout the discussion. On the topic of dealing with personal and/or professional challenges during treatment, one participant stated that “[they] just kind of allow the process to happen at the client’s direction.”

Participants also believed that it was important for the client-focus to be reflected in assessment of a couple’s sexual behavior. For example, one participant responded “The
same, the same—it's just a check in—you know, how are things sexually for you guys? Get each of their views on it.” This reflects a client-focus because one thing may be working for one partner, but not for the other.

Other participants implied that addressing sexual issues is included in their approach as well. One participant clarified this by stating, “The sexual issues—absolutely, I think they need to be addressed.” Another participant describes, “. . . I think it is important to be able to begin to show affection—whether it goes into sexuality, intercourse or not—the different levels of affection need to be addressed.” One participant elaborated, “. . . everything’s connected, everything’s related to everything else in terms of couple issues, so certainly, the sexual aspect of their relationship is impacted by the infidelity, in some way.” In terms of discussing approaches to treating infidelity, all therapists directly stated or implied that sexual issues need to be addressed, and specifically identified themselves as being “client-focused” or implied it as characteristic of their approach.

Exchange Theory

Another approach mentioned was that of social exchange theory. The theory of social exchange, developed by Thibaut and Kelley (1959), suggests that people strive to maximize rewards and minimize costs in relationships (Nichols & Schwartz, 2004). For example, well-functioning relationships operate on the basis that both partners are working toward maximizing mutual rewards. On the other hand, in poorly-functioning relationships, both partners are more focused on preventing costs, which typically result in pain, instead of focusing on contributing something to their partner that will result in positive experiences for each other. This is a more simplistic and early approach to working with couple and family relationships. One participant mentioned “exchange
theory” as a “theory” to approach treating infidelity in that the therapist would try to "bring some balance to this thing that has been unbalanced.” It was also suggested that when each partner in a couple is trying to address something different than the other, or different from the therapist, such as wanting to talk about sex, this can be viewed from an “exchange theory” perspective.

Strategies and Techniques

Participants were less specific in identifying a structure for how they treat infidelity, but rather discussed several strategies and techniques that they believe to be important when treating cases of infidelity. Subcategories of strategies and techniques that emerged were in the areas of assessment and treatment. Areas important to assessment included assessing the meaning of infidelity, assessing safety/violence risk, and assessing the intentions of each partner regarding reconciliation. Areas within treatment included addressing aspects such as trust, accountability, and blame, facilitating validation, addressing forgiveness, rebuilding the relationship, specific diversion interventions, and the therapist’s use of flexibility.

Assessment Areas

Assessing the meaning of infidelity. Acquiring interpretations of the infidelity from both partners may then be a stepping stone to uncovering deeper issues with the couple. One participant illustrates this:

I really encourage them to speak from their hearts and try to be as honest as they can be with each other about what it meant to them—to the one that was cheating, what brought him or her to the point that they felt they needed to seek elsewhere outside the marriage for whatever needs weren’t being met, and
what that meant to the person who was cheated upon.

Therapists were consistent in referring to the concept that, "... infidelity happens when the relationship is not meeting the needs of the couple."

Some participants reported that they view infidelity as a symptom of a larger problem, and that helps determine how to proceed with treatment. The following illustrates this:

... we're always peeling the onion, we're always trying to go closer and closer to the source of what's really happening ... we move more and more away from the relationship and more and more into the intrasychic thing that's happening for this person.

It is implied that you're not only working with the couple, but also zoning in on what is happening for each partner individually. For example, Weeks, Gambescia, and Jenkins (2003) suggest that, indeed, infidelity often requires a combination of individual, sex, and marital therapy. One participant explains another way to view this idea:

I do see infidelity as sort of a symptom of the relationship not going right, and when we peel that back and we move away from the symptom (the infidelity), back to the relationship not being right, and then we move forward with correct measures ...

Participants discussed gender as being critical to the meaning of infidelity. There may be unique issues to consider depending on the gender of the unfaithful partner. One participant elaborated:

I'm also thinking that there's such huge gender issues in who had the affair ...

for the male who has gone out of the relationship, it tends to be very sexual ...
there’s not a whole lot of other stuff there... it’s really just the basic need of
having sexual experience... But the female who has gone out of the
relationship... I do believe that there’s much more of an emotional component that
happens there.

Another participant supported this by saying “gender issues do play a big role... you
kind of have to separate that [the infidelity] by gender as well.”

Assessing intentions. The word “intent” may be commonly used in couples and
family therapy. It is often that when there has been a violation by one partner or family
member, the therapist and the other partner or family member may be focusing on the
intent of the violating party. In other words, what do they plan to do next or what is the
purpose of what they are doing? Therapists in the present study responded to several
questions using the concept of intent. When asked about structuring the therapy, once
infidelity is an issue, one participant responded, “... I’m looking a little bit more
towards, with the person who had the affair, looking for where there intent is.” And,
again, when asked to elaborate on how therapy is structured including questions that
therapists ask or strategies typically used, another response was, “it’s asking the person
who had the affair what their intent is now...” Continuing on the topic of structuring
the therapy, participants were asked, “when, if ever, do you address sexual issues?” On
this, one participant implied that clients may bring up sexual issues prematurely and that
may be addressed in this way, “... as a therapist, needing to know that what’s
constructive for this relationship and what’s destructive—back to that intent, where do
you both intend for us to go with this?” In this scenario, the therapist would be trying to
determine if the intention of the client bringing up sexual issues was destructive or constructive to the therapy, and in turn, the relationship.

Assessing safety. Safety was also a common element in assessment in infidelity cases. For example, one participant stated, “What I have used, it’s actually borrowed from a sexual abuse training.” From this idea, discussion was directed toward a persistent effort to determine safety. One participant related, “I don’t do marital counseling unless I have assessed for domestic violence—because you don’t do marital counseling unless you’ve assessed for marital violence.”

Therefore, in describing the progression of treatment, one participant frequently returned to the idea of safety and other participants also began mentioning safety as key to a couple recovering from infidelity and also in addressing sexual and intimacy issues that may come up during the course of treatment. For example, it was repeated that “intimacy is safety, it’s not sexual.”

Treatment Areas

Addressing trust, accountability, and blame. The idea of addressing trust that does or does not exist within the couple was presented in various ways. Participants initially mentioned that couples may use the words “trust” and “mistrust” before an issue of infidelity has even been presented. Therapist sense that the couple may be dealing with a larger issue, such as infidelity, and through focusing on trust other issues may be uncovered. One therapist described that, “... there’s going to be a lot of those other issues that really only become issues because there’s this bigger elephant in the room.”

When infidelity is a presenting issue or has already been disclosed, the issue of trust is something that therapists address early on in treatment and may continue to address
throughout the entire process. One participant explained, "... it’s always a question as to whether they’ll ever be able to really trust again and it’s a long process." Another participant presented how trust may be an issue to address before it has even been decided as to whether or not the relationship will continue, he then illustrated, "... the offended partner is faced with a decision as to, is this worth working on? I think largely, that decision is about, “does my partner, the offender, have the potential to be trustworthy?”

Another way that participants referred to addressing trust during treatment was that of “rebuilding trust”. One participant elaborated about how this process may begin:

... how does trust get rebuilt? ... one person who has actually been the person who violated the trust needs to demonstrate a pattern of consistent trustworthy behavior while the other person needs to take a risk and invest trust in that individual if they deem that it’s warranted. So that’s rebuilding.

Addressing accountability was another key strategy identified by participants. Several distinct responses demonstrated that addressing accountability is absolutely necessary in treating infidelity. For example, addressing accountability was described by one therapist as “some of my first techniques.” One participant asserted, “My foundation—and this is probably my foundation for most therapy period—is that there’s accountability...” It was also discussed that, “Unless that person who’s offended does take accountability, there can’t be any change.”

Participants discussed avoiding and addressing blame. Therapists described that avoiding opportunities for partners to blame the other for the infidelity and addressing the blame when it came up during treatment is an important issue during the course of
treatment. This may come up in “sneaky language that someone else is responsible . . .
. . . this has got to be cleaned up first.” One participant adamantly states, “I do not allow the
offender to blame their affair, or infidelity, because of something else the other partner
did.” Another aspect of blame reported by participants was, “. . . the partner that was
cheated on continuously blames themselves,” and “that is important to discuss those
issues and make sure that the blame isn’t there.” Discussing blame, in some instances,
served as a lead-in or overlap into deeper aspects of the infidelity.

Facilitating validation. In couples and family therapy it is common to hear the term
“validate”. Clients often want validation from their partner, other family members, or
even the therapist. Validation refers to the idea that people feel that they are heard
through another person’s endorsement, support, or confirmation. This may be done
through various forms of communication. In the present study, participants discussed the
concept of validation in a multiple ways. Early on in treatment, it may be an important
experience for “the person who the affair was had upon . . . to have validation.” Along
the way, this may need to be repeated by “coming back over to the other person and
validating their experience . . .” One participant noted, “to try to facilitate that validation
process for them, that I think is vital in the healing process.”

Addressing forgiveness. Addressing forgiveness is another concept that participants
indicated as important in approaching treatment for infidelity. Some participants
suggested that this can serve as a theme for treatment, working toward finding how the
offended partner can forgive. It was also implied that the couple relationship can not
progress without forgiveness. There is a certain process that each couple needs to go
through to get to that point.
Rebuilding the Relationship. The idea of rebuilding the relationship was referred to frequently throughout discussion. From the various ways that participants discussed “rebuilding the relationship,” it was suggested that this can be both a way to approach treatment from the beginning, or a phase to be working toward and then working through. Participants used phrases like, “if the clients are committed to the relationship and want to rebuild their relationship” or “how are we going to start rebuilding this relationship.”

Promoting patience and understanding was suggested as a way to help rebuild the relationship. One participant pointed out, “the offended party’s healing process is kind of at their own pace. . . . so, work on patience, and understanding . . .” Other references were made to setting new boundaries around affection and intimacy. For example, participant described the use of a scaled system “yellow-red-green light” that involves three degrees of defining tolerable and untolerable physical affection and intimacy. Another piece that seemed to be emphasized as important for rebuilding the relationship was that sexual issues need to be addressed. Participants verbalized this in several different ways. One participant exemplified this by stating, “if they are committed to making the relationship work, then I think it’s important for them to see themselves as a functioning couple again—a normal, healthy couple—and I think sexuality is part of that.”

Diversion Interventions. Therapists often have to divert to doing something differently than they thought they would be doing based on the direction that treatment may be taking. In the present study, participants discussed commonly used interventions that typically help to divert the direction that treatment seems to be headed. Some participants described that it is sometimes necessary to “see the partners separately.”
This is mostly useful to allow one partner to discuss things that they believe they are not able to discuss in front of their partner that could, in turn, be very useful to how the therapist may guide the course of treatment. Establishing how commitment is going to be made throughout the course of treatment was also mentioned as an intervention.

Participants gave examples of addressing clients with certain questions such as, “outside of here... how are you going to make this commitment?... What is your commitment to this process?” Participants also suggested having couples do something outside of therapy sessions, such as bibliotherapy. Some participants supported that clients may need to “try something on their own” because “it can be a very individual learning process,” and therefore bibliotherapy is frequently recommended.

*Flexibility.* Implications of the need for a therapist’s flexibility were also made in various statements. One participant expressed that, “... every single one of the needs inside that couple needs to be met in order to make the marriage affair proof going forward.” More directly, participants, identified the idea of flexibility stating, “I think it is so important for us to be flexible,” or “... there isn’t really anything typical that I can really say [to clients]—so I just try to be flexible and fluid in the process.”

*Barriers During Treatment*

Participants consistently reported that there were points throughout the course of treatment, with cases of infidelity, where they felt “stuck”. In other words, there was a point where they either believed that therapy could not continue, or that it would be very difficult to continue in the direction that it seemed to be taking. The following were discussed as those issues or subject areas where therapists in this study reported therapy barriers: the client’s agenda versus the therapist’s agenda, addiction, hurting children,
one or both partners bringing up sexual issues, lack of progress, conflict around intimacy and/or affection, and training for treating infidelity. Therapy barriers are commonly experienced in the course of treating infidelity, and much of the time these can be categorized as countertransference issues. Weeks, Gambescia, and Jenkins (2003) discuss this aspect of treatment as “therapeutic dilemmas.”

Client’s Agenda v. Therapist’s Agenda

Similar to the idea of being client-focused, participants also described the idea that they intend to help treatment progress based on the client’s agenda. This is often a sticky area because the therapist has genuine intentions of doing what is best for the clients, but at the same time, they have to trust that the client’s will also want therapy to proceed in a way that is best for them. For example, one participant describes, “I think the stuck [italics added] part is often the assessment of my agenda versus theirs. My sense of what a good couple might look like and what they would be absolutely happy with may be very different. Another participant also agreed that therapy seems to come to a halt “when my agenda is different from the clients’ agenda.” The following scenario was given:

... the couple both seem very ready and willing to say, do homework assignments, ... then I see them the next week and they didn’t follow through with it. So then I know they weren’t ready for the assignment. Maybe that was something I wanted for them and they weren’t ready for it. And then I feel stuck when the three of us can’t come up with new ideas that would feel appropriate for them, for them to go forward.
One participant implied that a therapist's own beliefs can also be a barrier. Therapists may perceive that one partner may not be "a good candidate for remaining trustworthy." Therefore, it is often best to "refrain from those sort of judgments and remain optimistic."

**Addiction**

Participants reported that when addiction becomes part of therapy, there can definitely be some barriers. "Addiction would be a period—any addiction would be where I would get stuck," stated one participant. One participant discussed a specific aspect of addiction, "I get stuck with them, when say, sex addiction comes into the picture. I become stuck with the couple, and really that's such a barrier for me that I can't move on with the couple." When this particular participant was asked how therapy would then proceed, this response was given:

I work a lot with sex addiction, it's maybe a third of my practice . . . so . . . in the last case [that I mentioned] I actually referred the couple as a unit to someone else so that I could work with the individual on the sex addiction.

Both drug addiction and sex addiction can coexist with or be precipitating factors to infidelity. Weeks, Gambescia, and Jenkins (2003) identify a variety of scenarios in which these can be played out.

**Hurting Children**

When children come into the picture during the course of treatment for infidelity, participants responded that it becomes a "personal and professional challenge". This is especially difficult when they sense or it has been made known that a child is suffering emotionally or physically as a result of infidelity taking place. One participant articulated that it is challenging because the therapist is "an advocate for the child . . . and they're
always hurt the most. They pay the price for the indiscretions that their parents made.”

Another participant exemplified her stance by stating:

I think with the infidelity, is that the couple can get so lost in what has happened between the two of them that they believe it has no effect on (if they have) children, or the people living with them. . . . the challenge . . . is . . . that your relationship affects your relationship with the people who also live with you.

And if you’re distracted, . . . you’re kid’s sitting there by themselves, that’s a personal challenge because that affects me.

All participants in the focus group confirmed that it is challenging for them, in treating cases of infidelity, when it goes outside the couple and there is some kind of negative, or not so positive effect on children.

One or Both Partners Bringing up Sexual Issues

Participants suggested that there is an appropriate time to address sexual issues and the appropriate time is ambiguous. One participant responded that it is, “When the time is right.” With this in mind, it was also suggested that there may be instances when clients want to discuss sexual issues “prematurely.” One participant explains:

So much of the time, especially with these sort of cases, with infidelity, I do feel that they don’t have good measures of what is right and what is wrong. And a victim [of infidelity] . . . could be doing things destructively to end the relationship. And that could be bringing up sexual issues prematurely.

On the other hand, participants discussed that one partner could be very persistent in wanting to address sexual issues. There also existed the idea that, “the person who
cheated” will feel like everything is fine “when we have sex again.” One participant alluded to the idea of flexibility to help a therapist work through this when he presented:

For example, let’s say I don’t thing it’s appropriate for us to talk about sex right at this moment and I’m trying to move us away from that and it’s just not happening, then I would just go with it, I guess.

One participant mentioned that sexual issues may be more of an individual issue separate from the couple, suggesting a diversion from typical conjoint therapy. This was clarified when he stated:

“One of the partners really need some sex therapy [italics added] . . . whether it’s with myself or another therapist so that we can move forward (with the couple). . . . because certainly some of those issues could very well be holding up the process of the relationship.”

There was also some support for addressing “what they feel is an issue at the moment, whatever is important to them.”

Lack of Progress

When faced with the dilemma that therapy is simply not progressing, therapists in the present study referred to several common reasons. Typically, barriers exist to decreasing anger, increasing trust, and allowing forgiveness. Weeks, Gambescia, and Jenkins (2003) refer to these as “emotional barriers”. In referring such instances, participants used phrases such as: “hanging onto anger . . . has to do with a pride thing . . . an ego thing . . . stuck in the forgiveness process . . . can’t seem to get past the anger toward their partner.” Participants then identified several strategies for then proceeding with treatment. In order to address the pride or ego issues, one participant identified:
Probably [using] some sort of cognitive intervention . . . just kind of try to deconstruct the thinking that arrives at that conclusion . . . trying to identify how that logic follows, and is there any irrationality there? What sort of beliefs support that kind of notion, that kind of thinking?

As the word "commitment" was used quite often in terms of addressing barriers, it indicated that re-establishing commitment to treatment from the couple may be necessary. One participant demonstrated how he often uses a motivational pitch that can be effective when barriers exist:

... a pitch that I give clients is that, "The last thing that you want to happen is to make a premature, hasty decision to separate, or to divorce, or to terminate the relationship. You don’t want to have regrets later on. You want to make sure that if it does end up that you guys go your separate ways, at least you know that you’ve done everything that you could possibly do . . ."

Other strategies that participants identified were collaborating with the couple by talking to them about the lack of progress, and re-assessing the couple’s goals to ensure that they are working in therapy sessions as well as on their own, outside of therapy sessions.

**Conflict Around Affection/Intimacy**

There appeared to be a common ground, among all participants, that couples in treatment for infidelity will most likely experience conflict around affection and/or intimacy, both inclusive and exclusive of sexual intercourse and any other sexual contact. This was expressed throughout discussion in several different ways. One participant exemplified this in his response to a question about addressing sexual issues, by stating:

it seems like it’s come up quite often, I’d say, is that the pace of the
reconciliation seems to be different for the partners. Most often that the person who has been violated in the relationship may be kind of cautious, and moving slowly in the reconciliation process, while the offender is kind of trying to push the pace—you know, let’s get things back to normal as quickly as possible . . . I try to communicate to the person who’s trying to push the pace, that this healing process—the offended party’s healing process is kind of at their own pace. . . . so, work on patience, and understanding, and tolerance when it comes to the rate or pace of the other person.

Two other participants both identified implementing strategies that help the couple re-establish boundaries around affection and intimacy. One participant described this strategy:

It is a concept of having the couple scale on a three system yellow-red-green light as to what, if any, kind of physical affection is tolerable at this level, and what is absolutely not or is never going to happen . . .

Along the same lines, another participant stated, “I think I’ve used that . . . what can you do at this point, what types of affection can you accept from each other . . .”

Another strategy discussed to address conflict around affection and intimacy was the use of “premarital” concepts. Some participants agreed that it is often necessary to “turn the hands of time back to help them through topics that are, not necessarily sexual in nature, but about intimacy and closeness.”

Training for Treating Infidelity

Participants were clear in describing that there is a lack of training available for treating infidelity. “There’s pretty much a lack of training on infidelity,” and therefore
therapists are left to train themselves. Many workshops have been helpful in preparing
some therapists for treating infidelity. Other participants shared the belief that training
really only comes through field experience. For example:

... what we really learn, we learn on the job. . . . I did it all on my own,
through the experience of what works and doesn't work, very painfully, from
workshops, to books, to laypersons writing about it, to very clinical educated people
in the field writing—gathering as much as I can.

Therapists suggested that because of their lack of training for treating infidelity,
specifically, how they approach these cases were mostly based on field experience and
self-study.

**Addressing Sexual Issues**

As previously mentioned, some questions in the interview guide were specifically
developed to address the topic of sexual issues in infidelity treatment. During the focus
group, there appeared to be, at times, some contradiction regarding supporting or not
supporting the need for and appropriate approaches for addressing sexual issues. Under
the above mentioned theme, topics that frequently emerged were: the need for addressing
sexual issues, the idea that sexual issues are a symptom of something else, typical sex
therapy consisting merely of sensate focus, finding a baseline for affection and intimacy,
and the idea that sex therapy techniques can be integrated into treatment.

**Sexual Issues Need to be Addressed**

At one time or another during discussion, participants either directly stated that
“sexual issues need to be addressed,” or made relative implications. One participant
described sexual issues as “part of a routine assessment” with couples therapy, and are
therefore, brought up early on with cases of infidelity. Other participants were unable to
articulate an appropriate point or identify when sexual issues should be addressed. Other
participants identified that certain things need to have taken place. For example, this
participant exemplifies their idea of an appropriate point in therapy by indicating, “Once
they’ve [the couple] been able to express their anger, express their feelings about what
brought them to this point . . . then I think it needs to be part of: How do we go
forward?” Another participant expressed that he may ask the clients directly, “depending
on the quality of the therapeutic alliance,” about the relationship between infidelity and
sexual issues. This participant demonstrated, exactly how he may address the clients:

I might say something like, . . . for the purposes of our discussion today, let’s
look at the infidelity as a symptom of some problems that may have been present in
the marriage, or that contributed to . . . this infidelity outcome. What
might those be? And is the sexual relationship, . . . could that have been a
contributing factor in some way?

Humphrey (1987) suggests that infidelity involving extramarital (or extra-dyadic) sex
could possibly be interpreted as a cry for help from an already distressed marital/sexual
relationship.

Sexual Issues Are a Symptom of Something Else

Although participants agreed that sexual issues need to be addressed, another
agreement made by focus group participants was that “sexual issues are usually a
symptom of a larger problem.” One participant confirmed this by stating, “I see sexual
issues as secondary always—always—you can always find something else in that the
sexual issues are just symptomatic of something else.” Another participant returned to the
idea of “safety” and suggested that, for her, addressing sexual issues during treatment would, essentially, translate to “working on safety issues.” This was further illustrated by voicing the following statements:

And so it’s not just . . . working on sexual issues . . . not just intercourse—any kind of sexual intimacy—we’re working on safety issues . . . And safety meaning that I can talk to my partner and I am freaking out—I hate talking about this, but he’s going to love me right through it. . . that’s safety—that’s not sexual counseling, that’s not communication skills. That’s about understanding there has to be safety in the couple.

The contradiction seemed to be that focus group participants perceived that addressing sexual issues was necessary, but did not appear to perceive that it was necessary to treat sexual issues. Another idea was that infidelity therapy and sex therapy can not “coexist.” One participant verbalized, “I don’t think that you do sex therapy and infidelity therapy. I don’t think they coexist.” Once again, there seemed to be some contradiction, or at least, a fluctuation in participants’ responses as something would be stated that suggested addressing and treating sexual issues, and then at other times, the same participants would contraindicate the need for addressing or treating sexual issues in the course of infidelity treatment.

Misconception of Sensate Focus and Sex Therapy

Some participants seemed to have a misconception of the idea of sex therapy and treating sexual issues. “Sensate focus,” was repeatedly mentioned on the topic of integrating sex therapy into treatment. Participants also implied that “true” sex therapy is primarily used with couples that come to therapy stating something to the effect of,
"you know our sex life kind of sucks and we want to enjoy this more... but that couple is so rare." When sex therapy was mentioned, sensate focus was also mentioned. For example, participants made references as follows:

... the true, clean, what sex therapy is, as far as you open up a sex therapy book and we’re talking about sensate focus and blah, blah, blah... we move away from the symptom, the infidelity, back to the relationship not being right, and then we move forward with correct measures, as far as doing sex therapy, doing sensate focus—which I think I’ve only ever used twice...

Participants were asked, “To what extent are sex therapy strategies integrated into infidelity treatment.” One participant responded:

If there is safety to become intimate again—then using my little red light-green light-yellow light thing—is the reassessment of the yellow and the red. What do they need most help with, behaviorally, ... then you put them into sensate focus.

Without the mention of other sex therapy techniques, participants’ comments and responses indicated that they may not have had clear conceptions of the practice of sex therapy, and the conceptions that they did have largely includes only the technique of sensate focus.

Finding a Baseline for Affection and Intimacy

There were instances throughout discussion where the therapists in the present study identified strategies for addressing and treating sexual issues with couples. One participant referred to the idea of a “starting point” for affection and intimacy that should
be determined in order to continue with the recovery process of infidelity. Another participant described that:

I find that it’s important to try . . . to find a baseline—to find what at one time could have been normal for them, and even if at their most normal, functioning part of their marriage or relationship, they may not have been expressing intimacy in the way they wanted to—but trying to find for them a spot . . . so where do you want to be, where have you been, where are we gonna go . . . it’s easier for me to sort of have that anchor.

The idea of a couple’s “baseline” was also presented in reference to integrating sex therapy strategies into infidelity treatment. For example, in responding to *when* the therapy could move in that direction, one participant stated, “when they’re comfortable, when they feel like they are more at, or sort of back to that baseline, . . .”

**Integrating Sex Therapy Techniques**

The aspect of addressing sexual issues was brought up early on in discussions with participants. There appeared to be a fluctuation in the responses of some participants when responding to any question about addressing sexual issues or integrating sex therapy techniques. In support of integrating sex therapy techniques, one participant delivered the following example that she would use with a couple:

what do you want to incorporate in here that you absolutely have no idea how to even start, or it’s always been uncomfortable, and is there any help you need in . . . this therapeutic scenario to accomplish that? . . . a lot of times, they just want to feel normal. . . . So if the sex therapy, traditional sex therapy techniques will help them feel normal . . . absolutely, and we can incorporate that.
Participants also mentioned that couples may be more comfortable working on sexual issues “at home”. One way to facilitate this would be through the use of bibliotherapy. This was explained by one participant when she stated:

I think when it comes to sexuality, it really is very difficult for couples to talk in front of each other or in front of anyone else. . . . I’ve found that many times, couples are very open to bibliotherapy, in that situation, they can take a book home in their own private time and read.

Although some participants tended to fluctuate their responses in some areas, one participant was quite consistent in his responses, in that, early on in discussion he affirmed that “sexual issues” are indeed addressed, and typically part of a “routine assessment.” In addition, addressing sexual issues by asking questions to gain a history of the couple, which is often the case in the early stages of treatment, is different than treating sexual issues. This particular participant, however, reported, “what I’ve found useful . . . is sensate focus exercises. I think those are useful in the trust rebuilding process, and also the communication improvement.” Another technique mentioned by this particular participant was that of “prescribing hugs. . . it’s sort of a means by which to encourage physical intimacy and dissipate tension.”
CHAPTER 5

DISCUSSION

The purpose of this study was to explore approaches to treating infidelity by marriage and family therapists, and identify the degree to which practitioners are integrating sex therapy techniques and/or suggesting to what degree this implementation is necessary. Four practicing marriage and family therapists participated in 1 focus group and 1 interview about their treatment of infidelity cases. Participants completed a brief questionnaire and responded voluntarily to a semi-structured interview.

The data obtained from the focus group and the interview were transcribed and analyzed using analytic induction and constant comparison techniques. The number of participants in this study limits the nature of this study to exploratory. The research questions being explored in this study are:

1) To what extent do marriage and family therapists treat sexual issues when it is an overlapping theme in treating infidelity?

2) To what extent do marriage and family therapists integrate sex therapy techniques into their infidelity treatment?

Marriage and family therapists treat several common elements, and some may be treating sexual issues as one overlapping theme. As it was the case that some use of sex therapy techniques were vaguely indicated, it is difficult to suggest the extent to which
marriage and family therapists integrate sex therapy techniques. Therapists’ responses did not clearly articulate the frameworks they use for treating infidelity, and in addition, many responses appeared to be based on how they believe therapy should proceed without specific examples of what they actually do. There was some mention of treating sexual issues and integrating sex therapy techniques, but implications and reference to treating sexual issues and integrating sex therapy techniques were rather limited.

Common Treatment Elements

In many cases, clinicians approach infidelity treatment using a specific framework that allows them to structure their assessment, interventions, and the process of therapy. In working with infidelity cases, the therapists participating in this study did not identify a specific focus from which to structure treatment, but did address key assessment and treatment aspects common with theoretical frameworks. Some of the common elements of assessment and treatment included: attention to physical and emotional safety, emotional consequences regarding infidelity, gender issues, and sexual issues.

A frequent theme within the transcripts was the idea that clinicians viewed infidelity and sexual problems as symptoms of a larger problem, consistent with the findings of Hertlein (2004). This notion suggests that treatment is always moving in the direction of discovering the “real” problem, instead of treating the problem at hand and investigating major influences on the development of the problem. When clinicians go in search of the “real” problem, the effect on the process of therapy could be that they miss the concept of overlap, in which most problems are connected, instead of being merely symptoms of a larger problem that may or may not ever be uncovered. Problems in couples therapy are best conceptualized systemically and contextually, as consistent with Weeks (1994)
support of viewing the couple as an “interlocking system.” In addition, the “symptom of a larger problem” approach is less client-focused, impairing the therapist’s ability to join with clients and establish a stronger therapeutic relationship.

However, in addition to certain aspects of infidelity assessment and treatment (i.e., trust, accountability, validation, and forgiveness), more unique factors influencing assessment and treatment, as presented by participants in this study, are safety, gender issues, and sexual issues. For example, one participant’s advocacy for physical and emotional safety in couple relationships generated expression of concern by other participants. Assessment for safety/domestic violence was discussed as essential for doing couples therapy. Safety was also discussed in terms of addressing conflict around intimacy and affection.

Safety is an issue that is addressed in both infidelity treatment and the treatment of sexual dysfunction. In infidelity treatment, for example, lack of safety hinders all forms of couple communication and hinders the process of developing intimacy. For example, if a person feels vulnerable they will be unable to engage in effective communication or develop emotionally and physically intimate relationships. With cases of infidelity, Spring (1996) proposes that engaging in emotional and/or physical intimacy can surely make the violated partner feel vulnerable; however, this is part of the risk of rebuilding. In other words, it is a step one will have to take in order to work toward rebuilding the relationship, even if it does not feel “safe”. Other authors have also taken into consideration safety issues in that all feelings should be adequately discussed, acknowledged and validated, spending a great deal of time in sessions to just talk about the feelings (Weeks & Treat, 2001). Glass’s (2003) PTSD approach addresses the
possibility of a partner’s vulnerabilities re-surfacing as unresolved injuries that could have been reawakened by an incidence of infidelity.

In terms of physical safety, this would be very important to address when treating clients with sexual dysfunction who have had some sexual trauma in the past. In which case, for this type of client, the physical environment has to be safe from triggers that might set one off. Another potential scenario relating to sexual issues could be that, if someone feels physically threatened that may diminish sexual desire and create distance between the couple. Hof (1987) asserts that the existence of severe distress in a relationship (such as lack of emotional/physical safety) will be indicated in an evaluation of the relationship and be addressed as part of couples therapy in order to pave the way for future treatment of a sexual problem. This vulnerability that the safety concern speaks to is an important issue to address and should be addressed in the evaluation. However, it is not the focus of treatment, as a framework designed to treat infidelity will typically assess for and treat the issue in the early stages of treatment.

Gender issues are also an influence on treatment for both infidelity cases and sexual dysfunction cases. Gender has been investigated within the body of infidelity literature, although findings are inconclusive, suggesting that research should take into account interaction effects with other important variables such as education and ethnicity (Atkins, Baucom, & Jacobson, 2001; Blow & Hartnett, 2005). Therapists in the present study reported that different types of infidelity (sexual, emotional, or combined) can be dependent upon the gender of the involved partner, and may therefore influence the course of treatment. Glass and Wright (1985; 1992) suggest that gender has some bearing on types of infidelity and its meanings for couples. The notion of gender differences in
the healing and recovery process for men and women was also presented as having an influence on the therapeutic process of infidelity treatment. Gender is also important to address in sexual dysfunction cases, as men and women can experience different sexual dysfunctions and can experience the same sexual dysfunction in different ways.

Zilbergeld (1999) addresses many differences in the way that men and women experience sexuality and sexual dysfunction. For example, in addition to the sexuality differences in language, feelings, and styles of loving and styles of being sexual, when there is a sexual problem, say for instance with lack of desire, men are typically considered to have a higher and more constant appetite for sex, but can experience lack of desire just as many women do. However, the way the problem develops and plays out in their lives is usually very different. Another gender issue with sexual dysfunction is the lack of balance in research toward male and female sexual function and sexual dysfunction. Although in recent years, there has been an increase in research for female sexual issues, there has been an imbalance in comparison to the research for male sexual issues.

During the course of the interview/focus group, participants reported that they do use some sex therapy specific techniques in their infidelity practices. One participant, for example, reported the use of sensate focus exercises in treatment. Other participants did not definitively report the use of sex therapy techniques. On these topics, it was often the case that discussion either continued without reference to specific techniques and examples or discussion was diverted in a different direction that seemed unrelated to addressing or treating sexual issues. One diversion was emphasizing the need for safety in the couple relationship. In addition, inconsistent responses contradicting support for or against the need for addressing sexual issues was confusing and difficult to interpret.
However, participants did discuss intimacy and a limited number of examples for improving intimacy, such as increasing affection, bibliotherapy, and working on at home.

**Distinctions Between Sex Therapy Techniques and Infidelity Treatment**

While therapists expressed an on-going concern for addressing the challenge of the couple becoming emotionally and physically intimate again, the participants’ treatment did not reflect the incorporation of sex therapy techniques to achieve that end. With the exception of one participant, the investigation did not find that there were specific sex therapy techniques that they used within their infidelity practices. As previously mentioned, on the topic of addressing sexual issues in the context of infidelity treatment, it was often the case that participants uniformly confirmed that “sexual issues should be addressed” but did not elaborate in terms of techniques or illustrative examples. At other times, on the same topic, discussion was diverted in a different direction that seemed unrelated to addressing or treating sexual issues or the diversion was coming back to the notion of symptomology in that sexual issues are a symptom of a larger problem. In addition, inconsistent responses contradicting support for or against the need for addressing sexual issues was confusing and difficult to interpret. Most of the participants stated or strongly implied that sexual issues need to be addressed, but would then, at other times, make contradictory statements toward any support of addressing sexual issues during infidelity treatment. The participant clearly in favor of treating sexual issues, also suggested that, in some cases, there exists the potential that a couple’s sexual relationship may have had an impact on the incidence of infidelity. This is consistent with research suggesting that sexual satisfaction and the quality of the sexual relationship may be related to incidence of infidelity (Liu, 2000; Wiggins & Lederer, 1984).
It is important to acknowledge that researchers can never know the truth about what people say they do. In other words, for whatever reason, participants may describe certain techniques they use, certain topics that they address, etc. However, it is impossible to determine the preciseness of what people say they do. With the idea of therapists addressing and treating sexual issues during infidelity treatment, it is kept into consideration that therapists will say they do things that they simply do not follow through with during the course of therapy.

Why the Disconnect?

The tentative findings in this investigation tell us that MFTs do believe that it is important to address sexual issues in infidelity treatment; however, it is unclear as to the manner in which marriage and family therapists treat such issues within the context of infidelity management. This may be because of the immediate nature of the infidelity treatment. In many cases, people enter treatment to manage the infidelity because of the “crisis” of the event. As a result, the therapist is compelled to address the immediate issues brought to the room such as trust, flashbacks of the event, etc., which can then dominate the progression of therapy. This would then emphasize some of the common elements mentioned above and de-emphasize integrating sex therapy techniques. In addition, if therapy is lacking a structure and the application of a framework, other significant issues can be easily neglected.

Therapists in the present study did not specifically identify with any particular framework for treating infidelity. The absences of an identifiable framework, and lack of examples as to “how” therapists take action in treatment, also influences the ability to determine to what extent sexual issues may be treated. Participant’s responses about
infidelity treatment were not linked to specified frameworks. Major tenets of frameworks were mentioned, such as forgiveness, but only as assessment and treatment areas, not as a major focus of treatment. The use of a particular framework is typically useful in developing a conceptualization of the problem. Along with specific case scenario examples, identification with a framework is helpful in assisting with explanation of “how” one structures and then proceeds with treatment. In addition to confusion about “how” therapists treat infidelity, it is unclear as to how they develop their conceptualizations of couples’ infidelity. There was some report of training on infidelity through continuing education units, workshops, and independent reading. Often, this type of training leads to identification with particular theoretical models or frameworks. For example, some frameworks for treating infidelity are structured around rebuilding the relationship (Spring, 1996), forgiveness (Weeks, Gambescia, & Jenkins, 2003), and PTSD (Glass, 2003) and within these areas there is typically some overlap. The absence of framework identification has certainly influenced the findings of this study.

Another reason for the disconnect may be the conceptualization of infidelity as symptomology. This stance may have inhibited the possibility of viewing sexual issues as treatable and therefore integrating sex therapy techniques. For example, if clinicians view all problems as symptoms of something else and are constantly searching for a larger problem, then they may disregard key issues. In sexual dysfunction cases, for instance, pathology, communication style, underlying fears of intimacy, and conflict management can all be major influences on lack of sexual desire, erectile dysfunction, etc. (see Weeks, 2005). When viewing such cases from the “symptomology” perspective, the symptom can then serve both partners and therefore the other problems are not addressed.
Different definitions of intimacy may also contribute to the disconnect. Weeks & Treat (2001) discussed a variety of definitions from various authors of who divided the meaning into a range of concepts and components from 2 to 13. In most cases, infidelity is considered a “violation” of the relationship contract (Weeks, Gambescia, & Jenkins, 2003). Many authors and researchers suggest that infidelity is an “intimacy-based” issue and have identified the integration of sex therapy techniques as necessary in infidelity treatment because it would inherently treat the intimacy issues (Glass, 2003; Humphrey, 1987; Weeks et al., 2003). While the therapists in the present study were treating many basic stability aspects of a couple relationship, such as trust, accountability, and intimacy, intimacy was often separated into emotional intimacy and physical/sexual intimacy possibly suggesting that they are 2 different issues. If intimacy is two different issues, it is possible that they are not viewed as overlapping. How is the overlap between emotional intimacy and physical/sexual intimacy treated? Intimacy is typically the basis for sex therapy with couples. Hof (1987) suggests that intimacy needs that are not met, in a couple relationship, have the potential for developing into sexual problems. With cases of infidelity, unmet intimacy needs could have surfaced before or after infidelity has taken place. Talmadge & Talmadge (1985) propose that achieving emotional intimacy is key to experiencing physical intimacy in a couple relationship. The findings of the present study suggest little support that any overlap between emotional and physical/sexual intimacy is treated. Some authors and researchers may find this difficult to conceptualize. For example, Weeks & Treat (2001) state that sex and intimacy are inseparable. To elaborate, Weeks (2005 simplified the definition of intimacy to be “the feeling of closeness, feeling bonded, trust and respect toward another person.”
Finally, lack of education may be in part responsible for the disconnect. One way to describe this, as presented by Weeks (2005), is “fragmentation”, which can take place on multiple levels, directly and indirectly affecting the way that clinicians are educated, trained and later conduct therapy with couples. On one level, both the American Association of Marriage and Family Therapists (AAMFT) and the American Counseling Association (ACA) have established standards for couple therapy, and the American Association of Sex Educators, Counselors, and Therapists (AASECT) has established standards for certification in sex therapy. Neither organization requires extensive training in each other’s discipline, regardless of the obvious overlap, thus one level that fragmentation has taken place. On another level, Weeks (2005) calls attention to the fact that sex therapy, marital therapy and family therapy have historically aimed for separate directions in treatment. We do know that participants in the present study believe that there is a lack of training available for infidelity. They expressed that their academic programs were not sufficient for preparing them to treat infidelity and that self study and field experience have been most valuable in providing further training. In addition, only one participant reported receiving training specific to sex therapy through workshops and continuing education.

Implications

Implications for Treatment

Based on the findings of this study, MFT’s may be practicing treatment approaches that are loosely based on conventional couples treatment. With some reference to cognitive-behavioral interventions, systems perspectives, and the need for flexibility, therapists may be mostly practicing eclecticism. This is different from the concept of
integration that the present study was investigating. Therapists in the present study rarely related their infidelity treatment approaches to research or existing literature. There are several identifiable and well-recognized frameworks for treating infidelity and not one of them was mentioned as a point of reference or a means of exemplifying technique. This suggests that therapists are treating infidelity with little distinction from how they would treat other couple issues.

It would be unrealistic to expect MFT’s to be highly specialized in all frequent couple issues. However, therapists should be, at least, open about and aware of their therapeutic strengths and weaknesses and seek further training for weaknesses that will affect treatment with common issues, such as infidelity. With reference to couples treatment, Weeks (2005) describes Sternberg’s (1986) “triangle of love” framework as clinically useful. To elaborate, this triangle of love, consists of commitment, intimacy and passion represented by an equilateral triangle. Couple therapists have typically handled the commitment and intimacy and sex therapists have directly addressed problems of passion. The findings of the present study are consistent with this idea. If this were not the case, and instead therapists employed a more effective conceptualization of intimacy, commitment, and passion (i.e. couple functioning, stability, and sexual issues), using the idea of connectedness/interlocking, then it would be possible to determine overlapping issues and the extent to which they are treated. Weeks (2005) states that the goal for both sex and couple therapists should be “to have the knowledge and skill necessary to work with all three components of the triangle.”
Implications for MFT Education

Participants in this study reported that their academic programs did not adequately prepare them for treating infidelity. Some complaints were that some instructors taught too much from the textbook and not enough from practical experience, or that theoretical foundations were difficult to conceptualize with real-life cases. With reference to infidelity and couples therapy, the confluence of issues requires knowledge in and practice with a broad range of theoretical foundations, something that is surely challenging to accomplish in any master’s, doctoral, or post-graduate degree program. Perhaps, Weeks et al. (2003) describe this best by stating that, “Infidelity is difficult to treat effectively and requires a comprehensive, systemic approach that addresses cognitive, affective, and behavioral dimensions” (p. xxii).

Possibly maintaining on-going education beyond one’s academic program would help therapists to strive for this.

Nationally, most states (including Nevada, where participants were licensed) require MFT’s to complete the National Marital and Family Therapy exam with a passing score. The Association of Marriage and Family Therapy Regulatory Boards (AMFTRB) administers the exam and provides a handbook outlining the test specifications (AMFTRB, 2008). Sex therapy is included as an area that one should have knowledge in, however, no specifications or descriptions are provided. This is both supportive and unsupportive to the idea of integrating sex therapy into couples treatment. MFT’s should have knowledge of sex therapy, but what does that mean? Possibly, it means that the amount of knowledge required is not significant. Weeks (2005) encourages that programs such as psychology, marriage and family therapy, counseling, psychiatry, medicine,
nursing, etc. could include more integration of sex therapy into their training and strengthen their emphasis on sexuality.

Limitations

Some aspects of the design were limitations in this study. For instance, narrowing the data collection to only focus groups may have been the most obvious design limitation. Results from focus groups are never generalizable and can be largely influenced by a strong group member, unfamiliar surroundings, or the moderator (Piercy & Hertlein, 2005). Including other data collection methods, such as one on one interviews, may have increased the rate of participation.

In addition, the verbiage of the interview questions may have influenced participants to respond similarly to different questions, resulting in repetitive, nondescriptive responses. Participants often appeared perplexed as a new question was presented. Then, when they did respond, answers were frequently lengthy additions to one of their own previous responses, contradictory to one of their own previous responses, or piggy-backs of how another participant responded.

Choosing to not collect more background information on participants inhibited the ability to derive more meaning from participant’s responses. The personal and/or professional background of the therapist may have contributed to the findings. Very little personal information was requested of participants, nor was a complete professional profile obtained. Background information gathered was limited to responses to a brief questionnaire, and some volunteering of professional background information during discussion. This information was useful in several ways, for example, confirming therapists’ training specific to infidelity and sex therapy. Responses to the questionnaire
also confirmed that participants’ treatment of infidelity depends on the client’s definition. We then recognize that this may inhibit the therapist’s ability to adhere to a consistent treatment structure.

Other factors influencing therapist’s treatment practices may have been involved in this investigation, but we are unable to suggest this as an influence on the findings. We do not know much about these participants other than the fact that they are either licensed marriage and family therapists or marriage and family therapist interns. Many other unknown aspects of each individual participant may or may not have had a considerable impact on therapist’s responses. Personal and professional background of the therapist may also result in biases toward infidelity treatment. There are an unlimited amount of personal and professional experiences that can impact how therapists treat more challenging issues such as infidelity. Some examples are: academic experience, professional experience prior to marriage and family therapy, agency/private practice experience, religion, personal experience with infidelity. Again, because detailed information about the background and training of the participants was not collected, we are not able to describe how this may have lead to certain findings.

Recruitment of participants was the greatest obstacle to achieving more success with this study. The number of participants limits the nature of this study to exploratory. With a limited number of participants, the data did not have the depth that would have allowed for more clarity in the findings. It is disappointing for the field that only 7 out of 138 therapists actually responded to recruitment letters.

The role of the researcher is also important to acknowledge. A researcher holds certain thoughts and feelings about the topic at hand and that can influence the findings in
several ways. For instance, if the researcher was the person collecting the data first hand, as was done in this case, this can influence the way that participants respond. During a focus group and interview, it is important for the moderator/interviewer to remain neutral to responses and follow the interview guide without reacting or making unnecessary comments. When the researcher is the person conducting the data analyses, also based on his/her thoughts and feelings about the topic, certain ideas may stand out more readily than they would to someone else who reviewed the data. We believe this study was conducted with the utmost neutrality, but it is always important to acknowledge the role of the researcher as having some influence on the findings.

Recommendations for Future Research

Infidelity is a complicated, yet a frequent issue in couples treatment (Blow & Hartnett, 2006; Glass, 2003). The findings of the present study demonstrate this well, as they suggest that some marriage and family therapists may be treating sexual issues as an overlapping theme in infidelity treatment and that there is some integration of sex therapy techniques. As an exploratory study, the findings were unable to ascertain the extent to which either of these concepts are happening. However, the findings do indicate that sexual issues do further complicate infidelity treatment. Therefore, future research might focus on using a larger number of participants in order to obtain more salient findings and/or including an additional method of data collection. Research of a similar design may diversify the verbiage of the interview questions, and it might also gain more information related to the personal and professional background of the therapists in order to address biases. The qualitative intentions of this study were inconclusive, however, they may have provided direction for future research.
REFERENCES


Hawley, D., Bailey, E. C., & Pennick, K. (2000). A content analysis of research in family therapy journals. *Journal of Marital and Family Therapy, 26*(1), 9-16.


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APPENDIX A

INFORMED CONSENT
TITLE OF STUDY: Overlapping Themes in Treating Infidelity: Is Sex Therapy Integrated into Treatment?

INVESTIGATOR(S): Jerri Gallegos-Carr, Katherine M. Hertlein, Ph.D.

CONTACT PHONE NUMBER: 702-895-3210 (Office of Katherine Hertlein, Principal Investigator)

Purpose of the Study
You are invited to participate in a research study. The purpose of this study is to investigate treatment approaches for treating infidelity and to identify overlapping themes with other couples issues that may suggest the need for integrating other approaches or specialized techniques.

Participants
You are being asked to participate in the study because you are a Marriage and Family Therapist, who is licensed or in the process of licensing.

Procedures
If you volunteer to participate in this study, you will be asked to do the following: participate in a 90 minute focus group to answer discussion questions relevant to the treatment of infidelity, and complete a brief questionnaire.

Benefits of Participation
There may not be direct benefits to you as a participant in this study. However, we hope to learn new ways to conceptualize and advance the treatment guidelines for cases of infidelity. The knowledge shared during participation in this study could potentially be new and valuable knowledge that participants may implement into their professional practices. Participants may also experience validation of professional practices during the course of this study.

Risks of Participation
There are risks involved in all research studies. This study includes only minimal risks, such as: stress or discomfort related to discussion of subjects' professional practices, and discomfort participating in a focus group setting.

Cost/Compensation
There will not be a financial cost to you to participate in this study. The study will take 90 minutes of your time. You will not be compensated for your time.
TITLE OF STUDY: Overlapping Themes in Treating Infidelity: Is Sex Therapy Integrated into Treatment?

INVESTIGATOR(S): Jerri Gallegos-Carr, Katherine M. Hertlein, Ph.D.

CONTACT PHONE NUMBER: 702-895-3210 (Office of Katherine Hertlein, Principal Investigator)

Contact Information
If you have any questions or concerns about the study, you may contact Dr. Katherine Hertlein at 702-895-3210 or by e-mail at katherine.hertlein@unlv.edu, or Jerri Gallegos-Carr at 702-419-7022, or by e-mail at jmg-c@cox.net. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact the UNLV Office for the Protection of Research Subjects at 702-895-2794.

Voluntary Participation
Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality
All information gathered in this study will be kept completely confidential by the researchers. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least 3 years after completion of the study. After the storage time the information gathered will be shredded. It is requested of all participants to keep information that will be discussed during the focus group confidential. Due to the nature of a focus group setting, confidentiality cannot be guaranteed in a focus group setting.

Participant Consent:
I have read the above information and agree to participate in this study. I am at least 21 years of age. A copy of this form has been given to me.

Signature of Participant __________________________ Date ________________

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TITLE OF STUDY: Overlapping Themes in Treating Infidelity: Is Sex Therapy Integrated into Treatment?

INVESTIGATOR(S): Jerri Gallegos-Carr, Katherine M. Hertlein, Ph.D.

CONTACT PHONE NUMBER: 702-895-3210 (Office of Katherine Hertlein, Principal Investigator)

Participant Name (Please Print)

Audio Taping:

I agree to be audio taped for the purpose of this research study.

________________________________________________________________________
Signature of Participant Date

Participant Name (Please Print)

Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.
Dear Ms. Gallegos-Carr,

I hereby grant permission for you to use a copy of my Sex History Questionnaire in the appendix of your thesis.

I'm always happy to know of students who are interested in doing research in the area of human sexuality. Good luck with your study.

Jill W. Bley, Ph.D

P.S. If you feel that you need a copy with my signature, please fax that request to me at 513-569-0882.
Sex History Questionnaire

INSTRUCTIONS: Please answer the following questions and return the questionnaire to your therapist. If you and your partner are both completing this survey, DO NOT discuss the contents of the following questionnaire while you are filling it out. There are no “right” or “wrong” answers to the following questions, only what is accurate for you. Give honest and complete answers, but do not spend a great deal of time on any one item. If you need more space for an answer than is provided, use an additional sheet of paper and number the continued answer. This questionnaire is very important to our assessment procedure and treatment plans, so take the necessary time to complete it as well as possible. If there is any information that you wish to keep confidential from your partner, please indicate by writing your response in red.

Your gender (circle one)? Male Female
Your age? ______
Birth date? _____ / _____ / ______

Your current marital status (circle one)? Single Married Separated Divorced Remarried Widowed
If married, is this your first marriage? □ Yes □ No If no, which (number) marriage is this? _____

How long were you married to your previous spouse(s)? __________________________
If married or living with your partner, how long have you been married? ______ Living together? ______________

What is your average alcohol consumption? _______ How long does it usually take you to fall asleep? _______

Have you recently found yourself waking in the middle of the night and having difficulty falling asleep again? □ Yes □ No
 If yes, how often does this occur (e.g., every night)? __________________________

Have you noticed a change in your appetite for food? □ Yes □ No
 If yes, briefly explain: _______________________________________________________________________

Have you recently lost or gained a significant amount of weight? □ Yes □ No
 If yes, how much and over what period of time? _____________________________________________

Do you suspect that you might have a physical problem that you have not seen a physician about? □ Yes □ No
 If yes, briefly explain: ________________________________________________________________

Would you like a referral to a physician to investigate a possible medical problem? □ Yes □ No

Are you currently being treated or have you in the past 5 years been treated by a psychologist, psychiatrist, or other mental health professional? □ Yes □ No

If yes, briefly explain: ________________________________________________________________

Would you like for your physician, psychiatrist, and so on, to be notified of your progress in therapy? □ Yes □ No
 If yes, please list his/her name and address: ________________________________________________

Your signature here gives your therapist permission to discuss your treatment with the physician/therapist you designate: __________________________

Do you have any physical problems that interfere with your sexual enjoyment/performance? □ Yes □ No
 If yes, briefly explain: __________________________________________________________________

Is your mother alive? □ Yes □ No
 If yes, what is her health? __________________________ If no, when and how did she die? ______________

Is your father alive? □ Yes □ No
 If yes, what is his health? __________________________ If no, when and how did he die? ___________________
Did you grow up living with your natural parents? ☐ Yes ☐ No
If no, briefly explain: __________________________________________

Describe your memories of how your parents (stepparents, guardians, etc.) got along with each other while you were growing up:

________________________________________________________

Describe your memories of how your mother (or stepmother, etc.) treated you while you were growing up:

________________________________________________________

Describe your memories of how your father (or stepfather, etc.) treated you while you were growing up:

________________________________________________________

Were you ever physically abused as a child (beating, etc.)? ☐ Yes ☐ No
If yes, please explain: __________________________________________

Were you ever psychologically abused as a child (regular criticism, accusations, threats, etc.)? ☐ Yes ☐ No
If yes, please explain: _______________________________________________________________________

Were you ever sexually abused (incest, fondling, invasion of your privacy)? ☐ Yes ☐ No
If yes, please explain: _______________________________________________________________________

If your parents or stepparents are alive, how would you describe your relationship with them? __________________

What were your parents’ most important personal values that they attempted to pass on to you? __________________

Who or what had the largest influence on your emotional development during your childhood and adolescent years?
Briefly explain: __________________________________________________________________________

How many brothers do you have? ____ Sisters? ____ What was your relationship with them like while growing up?
________________________________________________________

What is your current relationship with your brother(s)/sister(s)? __________________

Within most families, children are often “labeled” by other family members (e.g., “the smart one,” “the troublemaker,” “the athlete,” etc.). What was your label? How did you get it? Was it accurate?

_______________________________________________________________________________________

Where or from whom did you gain most of your sexual knowledge? Looking back, was the information helpful? Accurate?

_______________________________________________________________________________________

Did your parents discuss sexual facts with you? ☐ Yes ☐ No Sexual feelings? ☐ Yes ☐ No
What was the general message that they (verbally and nonverbally) transmitted to you about sexuality?
Sex History Questionnaire

Do you recall ever playing “sex games” (e.g., playing doctor) prior to age 6? □ Yes □ No
Were you caught or punished? □ Yes □ No
Explain: ________________________________________________________________

Do you recall ever playing “sex games” (e.g., playing doctor) between ages 6 and 12? □ Yes □ No
Were you caught or punished? □ Yes □ No
Explain: ________________________________________________________________

As a child or adolescent, do you recall watching someone behave sexually? □ Yes □ No
Explain, including your memories of your reaction to it: ____________________________

At what age do you remember having your first sexual/genital feelings? ______
What are your memories of your reaction to these feelings? ________________________

At about what age did you first experiment with masturbation (or any other solitary activity which produced pleasurable
sensation)? ______ On the average, how often did you masturbate during adolescence? __________
What was your emotional reaction after you masturbated during that period of your life? __________

Were you ever caught or punished for masturbating or stimulating yourself sexually? □ Yes □ No
Explain: ________________________________________________________________

On the average, how often do you masturbate now? _____________________________
What are your feelings now about masturbation? ________________________________

Do you usually have a particular image or fantasy during sexual intercourse? □ Yes □ No
If yes, briefly explain: ______________________________________________________

FEMALE ONLY: At what age did you begin menstruation? ______ Did you understand menstruation when your first
period arrived? □ Yes □ No
How did you learn about menstruation? ______________________________________

FEMALE ONLY: Please describe any menstrual difficulties that you have experienced in the past or currently
experience: __________________________________________________________________

MALE AND FEMALE: What are your feelings about intercourse during menstrual periods? __________

When did you first learn about nocturnal orgasms (wet dreams)? _________________
Did anything negative happen to you in adolescence having to do with nocturnal orgasms (e.g., getting caught or
punished)? □ Yes □ No
If yes, briefly describe: ______________________________________________________
Did you have any sexual experience involving a person/persons of the same sex, either in adolescence or as an adult?  ☐ Yes  ☐ No

Briefly explain, including your current feelings about the incident(s):

Has any member of your family ever involved you in sexual activity?  ☐ Yes  ☐ No

If yes, explain:

Have you or anyone close to you ever been raped?  ☐ Yes  ☐ No

If yes, briefly explain, including your current feelings about the incident(s):

About how old were you when you began to date?  ______ Did you “steady-date”?  ☐ Yes  ☐ No

What was the most common activity you participated in on dates in high school?

How old were you when you began to “make out” and put on dates?  ______ Did you put on most dates, or only with certain individuals? Did you enjoy touching your partner’s genitals on these occasions? Did you enjoy having your genitals touched?

Comments:

At what age did you first have intercourse?  ______ Did you or your partner use a birth control device/method on this occasion?  ☐ Yes  ☐ No

Describe the first occasion, including your memories of your reaction and your partner’s reaction to it:

How much pleasure and freedom from concerns did you experience during your first few sexual interactions?

Were you ever suspected or caught behaving sexually?  ☐ Yes  ☐ No

If yes, were you punished? Explain:

Describe your most serious nonmarital relationship prior to your current one. Include, briefly, why it ended and whether you continue to have any form of relationship with the person presently.

Have you ever been previously married?  ☐ Yes  ☐ No

If yes, describe on an additional piece of paper, courtship, length of marriage, and why the marriage ended.

Does your current spouse/partner know (in general) about past love and sexual relationship(s)?  ☐ Yes  ☐ No

If no, briefly explain why not:

Describe briefly how you and your current partner first met and the courtship that followed:

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Sex History Questionnaire

What were your partner's physical and personality characteristics that first attracted you to him/her?


MARRIED ONLY: Did you and your partner live together before marriage? ☐ Yes ☐ No
If yes, for how long? _____ Speaking for yourself only, why did you decide to marry your partner?


Briefly describe your first sexual encounter with your partner (when, where, how, why, and what was the outcome as you remember it)?


If you have children, were they planned? ☐ Yes ☐ No
How do your children affect your current relationship?


What forms of contraception (if any) are you using now? Are you satisfied with this method?


Do you plan to have children in the future? ☐ Yes ☐ No
In your own words, describe the current sexual difficulties:


How has your sexual relationship with your partner changed since you first had sexual intercourse with him/her?


If you had to choose, which of the following two statements are most true for you (circle one)?
(A) Our nonsexual problems in our relationship are the main cause of our current sexual problems.
(B) Our sexual problems are the main cause of problems in the nonsexual part of our relationship.

How often did you and your partner have intercourse (on the average) during the first 6 months of your sexual relationship? Were you satisfied with the frequency level? If no, what would you have preferred?


How often (on average) have you and your partner had intercourse over the past 6 months? _____
Are you satisfied with this frequency level? ☐ Yes ☐ No
If no, what would you have preferred?

Do you feel free to express yourself SEXUALLY at any time with your partner and be warmly received? ☐ Yes ☐ No
Do you feel free to express AFFECTION toward your partner at any time and be warmly received? ☐ Yes ☐ No
(If the answer is no to either of these questions, describe or explain on an additional sheet of paper).

Describe a typical sexual encounter between you and your partner (be very specific on what each of you says, does, and feels from beginning to end of the encounter).

Now describe what an "ideal" or "perfect" sexual encounter would be like with you and your partner (again, be specific).


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Which of you usually chooses to begin lovemaking?__________ Does lovemaking lead to intercourse? □ Yes □ No
How would you change the lovemaking that occurs prior to intercourse? ____________________________________________

What would you like to change about intercourse itself?__________________________________________
What would you like to change about the time immediately following intercourse? ________________________________
Are you happy with the variety of methods that you and your partner use to express yourselves sexually? □ Yes □ No
If no, what changes would you like to occur? __________________________________________________________

Do you feel loved by your partner during lovemaking? □ Yes □ No
Do you usually feel loved by your partner when not behaving sexually? □ Yes □ No
What would you like to see your partner do more (or less) of to make you feel more valuable and loved by him/her? ____________________________________________________________

Do you have a preference for a time of day or specific situation for lovemaking? □ Yes □ No
If yes, briefly explain:__________________________________________________________________________
When you and your partner are making love, what are some of the typical things that you think about? _________________________________________________________
How do you let your partner know what pleases you and displeases you sexually (be specific)? ________________________________

Are you, or have you ever had one or more extrarelationship sexual affairs? □ Yes □ No
Does your partner know about this? □ Yes □ No
If yes, how do you think your partner feels about this? ____________________________________________
If no, how do you think he/she would feel about it if he/she knew? ______________________________________

What topics do you and your partner AGREE about most?______________________________________________
Has your partner had an extrarelationship sexual affair? □ Yes □ No
If yes, what are your feelings about this?________________________________________________________
What trait, habit, and so on does your partner have that tends to reduce your sexual feelings for him/her? ____________
What does your partner do too much that you would like to see him/her change? ________________________________
What does your partner do too little that you would like to see him/her change? ________________________________
Sex History Questionnaire

What do you want most from your partner that he/she does not provide now (be as specific as you can)?

________________________________________

Do you feel that you are an attractive person? □ Yes □ No
Do you feel that your partner thinks you are attractive? □ Yes □ No
If no to either, please explain:____________________________________________________

Which do you feel are your best attributes or characteristics that you have to offer your partner?

________________________________________

What do you notice most when you touch your partner (be specific)?

________________________________________

What do you notice when your partner touches you (be specific)?

________________________________________

Under what conditions do you find touching your partner to be irritating, annoying, embarrassing, and so forth?

________________________________________

Do you and your partner use body contact FREQUENTLY to express your feelings? □ Yes □ No
If yes, what form does it take?

________________________________________

What is the most comforting or pleasing form of touching that you remember from childhood?

________________________________________

Do you enjoy oral sex (giving and receiving)? □ Yes □ No
Is the frequency of this activity satisfactory? □ Yes □ No
Do either of you like to wear special clothes or devices during lovemaking? □ Yes □ No
If yes, describe:_______________________________________________________________

Do you need to physically hurt or emotionally humiliate your partner in order to become sexually aroused? □ Yes □ No
If yes, briefly explain:__________________________________________________________

Do you enjoy looking at your partner’s nude body? □ Yes □ No
If no, briefly explain:___________________________________________________________

Do you enjoy having your partner look at your nude body? □ Yes □ No
If no, briefly explain:___________________________________________________________

Are you particularly aware of odors during lovemaking? □ Yes □ No
If yes, describe and briefly explain:____________________________________________

Does sound or noise tend to get in the way of your enjoyment during sexual activity? □ Yes □ No
If yes, describe and explain:___________________________________________________
Innovations in Clinical Practice: Focus on Sexual Health

How does the sexual problem affect YOUR sexual functioning?

How does the problem affect your partner's sexual functioning?

How have you and your partner handled the problem up until now?

How often (on the average) do you orgasm (climax) during intercourse (e.g., every time, about half the time, never, etc.)?

FEMALE: Do you have difficulty getting lubricated during lovemaking? ☐ Yes ☐ No
If yes, please explain:

MALE: Do you have difficulty getting or keeping an erection during lovemaking? ☐ Yes ☐ No
If yes, please explain:

Do you have problems climaxing too soon during lovemaking? ☐ Yes ☐ No
If yes, please explain:

Do you ever experience unusual pain during intercourse or penetration? ☐ Yes ☐ No
If yes, please explain:

If you have any final comments you wish to make, please use another sheet of paper to do so.
APPENDIX C

BRIEF QUESTIONNAIRE

Age:

Gender:

Number of years in practice:

Are you licensed or an intern? Licensed MFT MFT Intern

How many couples, on average, do you see per week?

1. How do you define infidelity?

2. Does the way in which you treat infidelity depend on your definition of infidelity or your client’s definition of infidelity?

3. What type of training have you had for the treatment of infidelity?

4. What type of training and/or qualifications do you have in practicing sex therapy?
APPENDIX D

INTERVIEW GUIDE
Focus Group Interview Guide

Focus: themes in infidelity treatment

1. How does infidelity manifest itself as a problem in treatment?

2. Once infidelity becomes an issue, how do you structure the therapy?
   a. What models do you use?
   b. What questions do you routinely ask?
   c. When, if ever, do you address sexual issues?

3. Under what circumstances would you divert from your typical treatment approach?
   a. How do you determine if sexual issues are a factor in the infidelity?
   b. If treatment was not progressing, how would this influence how you may proceed?

4. What are some of the challenges, or areas where you become stuck?
   a. How do you then proceed?

5. To what extent are sex therapy strategies integrated into infidelity treatment?

6. What are some personal or professional challenges that you have confronted while treating infidelity?
   a. How would you describe how your training has prepared you for treating cases of infidelity?
VITA

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